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# The Concise ProQOL Manual



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# THE CONCISE MANUAL FOR THE PROFESSIONAL QUALITY OF LIFE SCALE

THE ProQOL

## **The Concise ProQOL Manual, 2<sup>nd</sup> Edition**

### **Reference**

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## TABLE OF CONTENTS

The ProQOL.....	3
section 1: Compassion Satisfaction and Compassion Fatigue .....	8
Figure 1: Diagram of Professional Quality of Life .....	8
Background .....	8
Figure 2: Theoretical path analysis .....	10
Section 2: Scale Definitions.....	12
Compassion Satisfaction.....	12
Compassion Fatigue.....	12
section 3: Scale Properties.....	13
Scale Distribution .....	13
Table 1: ProQOL Moments .....	13
Validity	13
Section 4: Administration of the ProQOL .....	14
Individual Administration.....	14
Group Administration .....	15
Research Administration.....	15
Section 5: Proqol scoring .....	15
Calculating the Scores on The proqol .....	15
Scale Definitions and Scores .....	17
Cut Scores .....	18
Section 6: Interpreting the ProQOL .....	18
The ProQOL Is Not Diagnostic.....	18
The Importance of Knowing More than Just the ProQOL Scores.....	18
Scores Across Demographic Categories .....	19
Table 3: Gender .....	19
Table 4: Age Group .....	20

Table 4: Race.....	20
Table 5: Income Group .....	20
Table 6: Years at Current Employer .....	20
Table 7: Years in Field .....	21
Interpreting Individual Scales.....	21
Compassion Satisfaction .....	21
Compassion Fatigue.....	21
Interpreting Scale Scores in Combination .....	22
High Compassion Satisfaction, Moderate to Low Burnout and Secondary Traumatic Stress.....	22
High Burnout, Moderate to Low Compassion Satisfaction and Secondary Traumatic Stress.....	22
High Secondary Traumatic Stress with Low Burnout and Low Compassion Satisfaction .....	22
High Secondary Traumatic Stress and High Compassion Satisfaction with Low Burnout.....	23
High Secondary Traumatic Stress and High Burnout with Low Compassion Satisfaction .....	23
Interpreting the ProQOL at a Group Level.....	23
Section 7: Using the ProQOL for Decision Making.....	24
Changing the Person-Event Interaction .....	24
Monitoring Change Across Time .....	25
Section 8: The ProQOL Test and Handout .....	26
Professional Quality of Life Scale (ProQOL).....	26
YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING .....	28
What is my score and what does it mean?.....	29
SECTION 10: Bibliography.....	31
SECTION 11: Frequently Asked Questions .....	69
About the Author.....	73

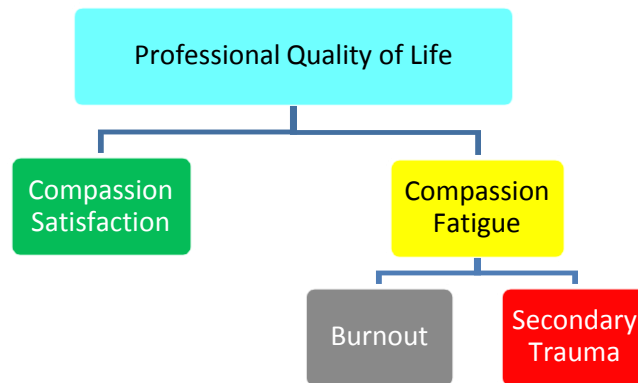


## SECTION 1: COMPASSION SATISFACTION AND COMPASSION FATIGUE

Professional quality of life is the quality one feels in relation to their work as a helper. Both the positive and negative aspects of doing one's job influence one's professional quality of life. People who work in helping professions may respond to individual, community, national, and even international crises. Helpers can be found in the health care professionals, social service workers, teachers, attorneys, police officers, firefighters, clergy, airline and other transportation staff, disaster site clean-up crews, and others who offer assistance at the time of the event or later.

Professional quality of life incorporates two aspects, the positive (Compassion Satisfaction) and the negative (Compassion Fatigue). Compassion fatigue breaks into two parts. The first part concerns things such like exhaustion, frustration, anger and depression typical of burnout. Secondary Traumatic Stress is a negative feeling driven by fear and work-related trauma. Some trauma at work can be direct (primary) trauma. In other cases, work-related trauma can be a combination of both primary and secondary trauma.

FIGURE 1: DIAGRAM OF PROFESSIONAL QUALITY OF LIFE



### BACKGROUND

Professional quality of life for those providing care has been a topic of growing interest over the past twenty years. Research has shown that those who help people that have been exposed to traumatic stressors are at risk for developing negative symptoms associated with burnout, depression, and posttraumatic stress disorder. In this body of literature, typically known as secondary traumatization or vicarious traumatization, the positive feelings about people's ability to help are known as Compassion Satisfaction (CS). The negative, secondary outcomes have variously been identified as burnout, countertransference, Compassion Fatigue (CF) and Secondary Traumatic Stress (STS), and Vicarious Traumatization (VT).

While the incidence of developing problems associated with the negative aspects of providing care seems to be low, they are serious and can affect an individual, their family and close others, the care they provide, and their organizations. The positive aspects of helping can be viewed as altruism; feeling good that you can do something to help. The negative effects of providing care are aggravated by the severity of the traumatic material to which the helper is exposed, such as direct contact with victims, particularly when the exposure is of a grotesque and graphic nature. The outcomes may include burnout, depression, increased use of



substances, and symptoms of posttraumatic stress disorder.

In 1995, three books introduced the concepts of the negative effects on caregivers who provide care to those who have been traumatized.<sup>1,2,3</sup> The terminology was at that time, and continues to be, a taxonomical conundrum. However, since that time, Figley, Stamm, and Pearlman together have produced over 50 additional scientific writings on the topic. Casting a broad net across the topic, over 500 papers, books and articles have been written, including nearly 200 peer-reviewed papers, 130 dissertations along with various unpublished studies. Among which there are and a hundred research papers using a type of measurement of the negative effects of secondary exposure to traumatic stress. Research has been conducted across multiple cultures worldwide, and across multiple types of traumatic event exposures.

As noted above, there are issues associated with the various terms used to describe negative effects. There are three accepted terms: compassion fatigue, secondary traumatic stress, and vicarious trauma. There do seem to be nuances between the terms but there is no delineation between them sufficient to say that they are truly different. There have been some papers that have tried to ferret out the specific differences between the names and the constructs.<sup>4</sup> These papers have been largely unsuccessful in identifying real differences between the concepts as presented under each name. The three terms are used often, even in writing that combines Figley (compassion fatigue), Stamm (secondary traumatic stress) and Pearlman (vicarious traumatization). The various names represent three converging lines of evidence that produced three different construct names. As the topic has matured, reconfiguration of the terms seems timely.

In general, looking beyond issues of taxonomy, there has been little negative critique of the topic as a whole. Nonetheless, there are articles that question in its entirety the concept of secondary negative effects due to work with people who have been traumatized.<sup>5,6</sup> Both articles point to a lack of research, perhaps allowable in some part given the nascent nature of the construct, particularly in the Arvay paper, which was published in 2001. Four years later, at the core of Kadambi & Ennis' (2005) suggestion to re-examine the credibility of the topic are measurement issues, that is, refined definitions of the characteristics and reliable and valid measures of the constructs. These critiques seem well earned at the point that they were written. Whether in response to the critiques, or as natural evolution, over half of the research articles that exist were written after these critiques reviews were conducted. In addition, as the authors pointed out, there were varied means of assessing the negative effects.

Based on experience and some research, organizational prevention programs are believed to help maximize helpers' well-being (CS) and reduce the risks for developing compassion fatigue and secondary trauma. At a minimum, organizational programs show the worker that they have formally addressed the potential for the

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<sup>1</sup> Figley, C. R. (Ed.) (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel.

<sup>2</sup> Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: Norton.

<sup>3</sup> Stamm, B. H. (Ed.). (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Maryland: Sidran Press: Lutherville.

<sup>4</sup> cf Baird, K., & Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly*, 19(2), 181-188.

<sup>5</sup> Kadambi, M. A., & Ennis, L. (2004). Reconsidering vicarious trauma: A review of the literature and its' limitations. *Journal of Trauma Practice*, 3(2), 1-21.

<sup>6</sup> Arvay, M. J. (2001). Secondary traumatic stress among trauma counsellors: What does the research say? *International Journal for the Advancement of Counselling*, 23(4), 283-293.

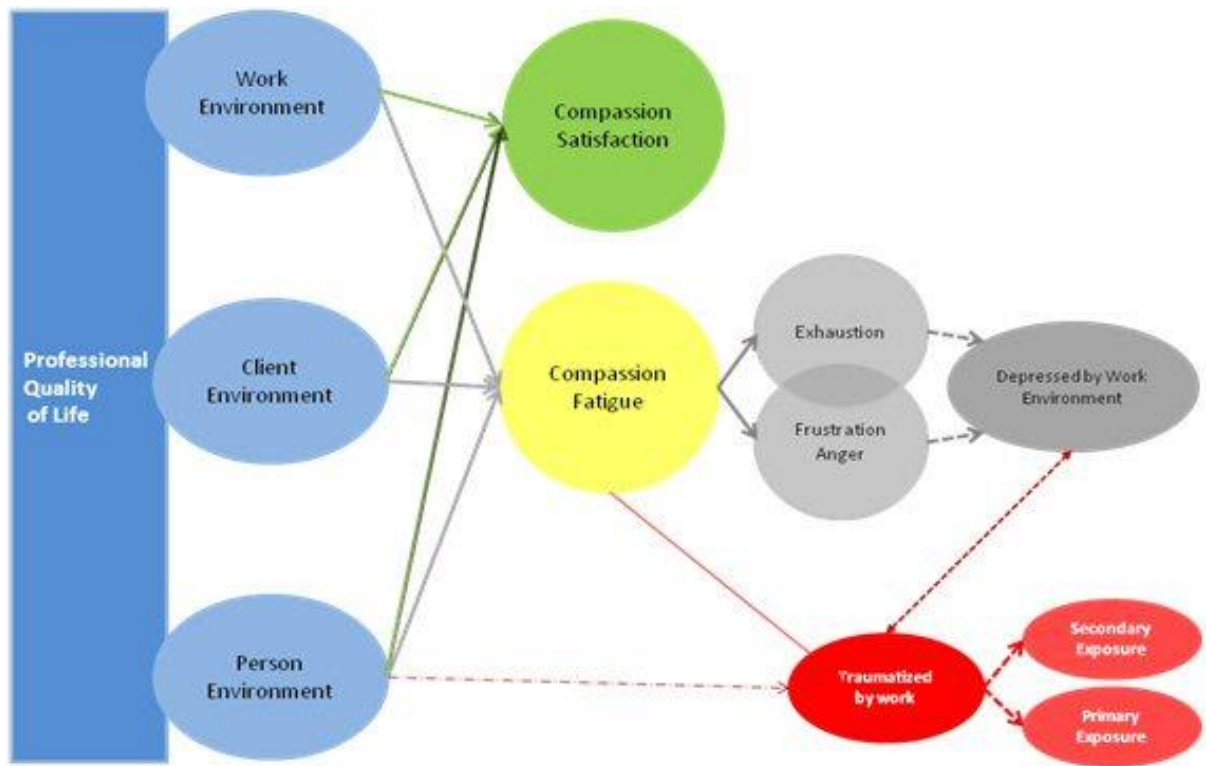
work to affect the worker. Good programs do not identify to other workers or supervisors, specific information about the worker's professional quality of life unless the information is shared by the worker. In some cases, supervisors address performance issues that they believe may be negative aspects of helping but in those cases, the principals of organizational human resources suggest that these performance issues should be handled as such, not as a flaw in the character of the employee, but a performance issue.

The overall concept of professional quality of life is complex because it is associated with characteristics of the work environment (organizational and task-wise), the individual's personal characteristics and the individual's exposure to primary and secondary trauma in the work setting. This complexity applies to paid workers (e.g. medical personnel) and volunteers (e.g. Red Cross disaster responders).

The diagram below helps illustrate the elements of Professional Quality of Life. In the center of the diagram are compassion satisfaction and compassion fatigue. Compassion Satisfaction is the positive aspects of helping others and Compassion Fatigue are the negative one. As can be seen, one work environment, client (or the person helped) environment and the person's environment all have a roll to play. For example, a poor work environment may contribute to Compassion Fatigue. At the same time, a person could feel compassion satisfaction that they could help others despite that poor work environment. Compassion Fatigue contains two very different aspects. Both have the characteristic of being negative. However, work-related trauma has a distinctive aspect of fear associated with it. While it is more rare than overall feelings of what we can call burnout, it is very powerful in its effect on a person. When both burnout and trauma are present in a person's life their life can be very difficult indeed. The diagram below shows a theoretical path analysis of positive and negative outcomes of helping those who have experienced traumatic stress.

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FIGURE 2: THEORETICAL PATH ANALYSIS



Four scales emerged in the early research. Two of them (the Impact of Event Scale and the Traumatic Stress Institute Belief Scale) were not specific to secondary exposure. They were used equally for people who were the direct victims of trauma as well as for those who were secondarily exposed in their role as helpers.<sup>7 8</sup> Two measures emerged as specific measures for secondary exposure. The Compassion Fatigue Test in its various versions<sup>9 10 11 12</sup> and the Secondary Traumatic Stress Scale.<sup>13</sup>

The Professional Quality of Life Scale, known as the ProQOL, is the most commonly used measure of the positive and negative effects of working with people who have experienced extremely stressful events. Of the 100 papers in the PILOTS database (the Published Literature in Posttraumatic Stress Disorder), 46 used a version of the ProQOL. The measure was originally called the Compassion Fatigue Self Test and developed by Charles Figley in the late 1980s Stamm and Figley began collaborating in 1988. In 1993, Stamm added the concept of compassion satisfaction and the name of the measure changed to the Compassion Satisfaction and Fatigue Test, of which there were several versions. These versions in the early 1990s were Figley and Stamm, then Stamm and Figley. Through a positive joint agreement between Figley and Stamm the measure shifted entirely to Stamm in the late 1990s and was renamed the Professional Quality of Life Scale. The ProQOL, originally developed in English, is translated into Finnish, French, German, Hebrew, Italian, Japanese, Spanish, Croat. European Portuguese and Russian translations are in process.

## SECTION 2: SCALE DEFINITIONS

### COMPASSION SATISFACTION

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society.

### COMPASSION FATIGUE

Professional quality of life incorporates two aspects, the positive (Compassion Satisfaction) and the negative (Compassion Fatigue). Compassion fatigue breaks into two parts. The first part concerns things such as exhaustion, frustration, anger and depression typical of burnout. Secondary Traumatic Stress is a negative feeling driven by fear and work-related trauma. It is important to remember that some trauma at work can be direct (primary) trauma. Work-related trauma be a combination of both primary and secondary trauma.

<sup>7</sup> Kadambi, M. A., & Ennis, L. (2004). Reconsidering vicarious trauma: A review of the literature and its' limitations. *Journal of Trauma Practice*, 3(2), 1-21.

<sup>8</sup> Arvay, M. J. (2001). Secondary traumatic stress among trauma counsellors: What does the research say? *International Journal for the Advancement of Counselling*, 23(4), 283-293.

<sup>9</sup> Figley, C.R (Ed.). (1995) *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel.

<sup>10</sup> Figley, C.R., & Stamm, B.H. (1996). Psychometric Review of Compassion Fatigue Self Test. In B.H. Stamm (Ed), *Measurement of Stress, Trauma and Adaptation*. Lutherville, MD: Sidran Press.

<sup>11</sup> Stamm, B.H. (2002). Measuring Compassion Satisfaction as Well as Fatigue: Developmental History of the Compassion Fatigue and Satisfaction Test. In C.R. Figley (Ed.), 107-119.

<sup>12</sup> Stamm, B. H. (2008). *The ProQOL Test Manual*, 2<sup>nd</sup> Ed. Towson, MD: Sidran Press and the ProQOL.org.

<sup>13</sup> Bride, B. E., Robinson, M. M., Yegidis, B. L., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice*, 14(1), 27-35.

## BURNOUT

Burnout is one element of the negative effects of caring that is known as Compassion Fatigue. Most people have an intuitive idea of what burnout is. From the research perspective, burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment.

## SECONDARY TRAUMATIC STRESS

Secondary Traumatic Stress (STS) is an element of Compassion fatigue (CF). STS is about work-related, secondary exposure to people who have experienced extremely or traumatically stressful events. The negative effects of STS may include fear sleep difficulties, intrusive images, or avoiding reminders of the person's traumatic experiences. STS is related to Vicarious Trauma as it shares many similar characteristics.

## SECTION 3: SCALE PROPERTIES

### SCALE DISTRIBUTION

Please note that the scores listed throughout this manual are based off of t-scores calculated within the databank; therefore, they may not be of immediate use to researchers with other samples and groups. We will work to provide more useful information in the next version of the manual.

TABLE 1: PROQOL MOMENTS

	CS t score	BO t score	STS t score
N	1187	1187	1187
Mean	50	50	50
Std. Error of Mean	0.29	0.29	0.29
Median	51	49	49
Mode	53	51	49
Std. Deviation	10	10	10
Skewness	-0.92	0.25	0.82
Kurtosis	1.51	-0.31	0.87

### VALIDITY

There is good construct validity with over 200 published papers. There are also more than 100,000 articles on the internet. Of the 100 published research papers on compassion fatigue, secondary traumatic stress and vicarious traumatization, nearly half have utilized the ProQOL or one of its earlier versions. The three scales measure separate constructs. The Compassion Fatigue scale is distinct. The inter-scale correlations show 2% shared variance ( $r=-.23$ ;  $co-\sigma = 5\%$ ;  $n=1187$ ) with Secondary Traumatic Stress and 5% shared variance ( $r=-.14$ ;  $co-\sigma = 2\%$ ;  $n=1187$ ) with Burnout. While there is shared variance between Burnout and Secondary Traumatic Stress the two scales measure different constructs with the shared variance likely reflecting the distress that is common to both conditions. The shared variance between these two scales is 34% ( $r=.58$ ;  $co-\sigma = 34\%$ ;

n=1187). The scales both measure negative affect but are clearly different; the BO scale does not address fear while the STS scale does.

## SECTION 4: ADMINISTRATION OF THE PROQOL

Perhaps the most important part of administration of the ProQOL, or for that matter any psychological test, is for people to understand what they are being asked to do. If they feel like they are being “observed” and measured for their (bad) behavior, they are unlikely to want to participate or, if they do, to provide reliable answers. It is important to explain the logic of the measure and to engage the person’s desire to take the test. It is also important to establish if the person has a right to refuse to take the test or if it is required as a condition of some situation such as employment.

### INDIVIDUAL ADMINISTRATION

In this type of administration, a person typically takes the test and either self-scores or receives scores computed by a computer. In this situation, the data are not recorded elsewhere and the person does not discuss his or her results unless they choose to do so. Individual administration may also be initiated by an outside source. The data may or may not be archived. For example, a person may take the ProQOL as part of job counseling or an employee assistance program. They may take the ProQOL as part of their ongoing self-care plan. It is important to establish with the individual exactly what will happen with his or her data because data security and privacy are very important issues. In many cases, the required standards exceed those of general medical records.

## GROUP ADMINISTRATION

In this type of administration, a group of people complete the ProQOL simultaneously. This may be in a classroom setting or something like individual computer workstations in a computer lab. The key aspect of the group administration is that there are others present who are doing the same activity. In a group administration it is important to consider the group effect on scores. If a few people are quite vocal about their unwillingness to participate, there is an effect on all of the participants. If people feel they are being watched by others, or are embarrassed to be in the group, the scores are unlikely to be valid and privacy rights may have been violated. People should not be singled out so as to cause embarrassment. For example, you should not set up a group administration for all people who made medical errors if the administration is based on the assumption that their mistakes occurred because of burnout.

In the case of a self-test, people may be given general information such as “others who score similarly to you...” By contrast, in the case of individual administration, feedback may be much more specific. Feedback in group settings should not be about a single individual but about things that apply to more than one person.

The most important thing about giving feedback is to be prepared. Be prepared to give specific and clear information appropriate to the setting and be prepared to answer questions. You will always get that one question you most don't want to answer!

When working in group settings, it is not uncommon for one or two individuals to provide revealing personal information that are not appropriate to the group setting. In these cases it is incumbent on the test administrator to contain and refocus the attention of the class. Good ethical behavior suggests the test administrator follow up with the person in a more appropriate setting. In situations such as these, it is usually appropriate to provide a referral for employee assistance or other help such as mental or physical health care. In the case that the administrator believes that there is an imminent danger, they should take emergency actions such as calling 911 and protecting the person, themselves, and others from harm in the best way that they can.

## RESEARCH ADMINISTRATION

The ProQOL is frequently used in research. The test may be collected as part of a survey packet in which the participant receives no information regarding their answers, or it may be given as a combined research and training activity. In either case, the data are generally recorded and scored by computer. Group results may be published. In some cases, a copy of the raw data are donated to the ProQOL databank where they are combined with other research data to support developmental work on the ProQOL.

## SECTION 5: PROQOL SCORING

### CALCULATING THE SCORES ON THE PROQOL

There are three steps to scoring the ProQOL. The first step is to reverse some items. The second step is to sum the items by subscale and the third step is to convert the raw score to a t-score. The first set below shows the scoring actions in detail. Two methods for scoring are presented. The first is to follow Steps 1-2 and then use the table at the end of this section to convert raw scores to t-scores. The second method uses computer

scoring. The computer code presented below is written for SPSS that can be converted by the user to other statistical programs if needed.

**Step 1:** Reverse items 1, 4, 15, 17, and 29 into 1r, 4r, 15r, 17r and 29r (1=5) (2=4) (3=3) (4=2) (5=1)

**Step 2:** Sum the items for each subscale.

CS = SUM(pq3,pq6,pq12,pq16,pq18,p20,pq22,pq24,pq27,pq30).

BO = SUM(pq1r,pq4r,pq8,pq10,pq15r,pq17r, pq19, pq21, pq26, pq29r).

STS = SUM(pq2,pq5,pq7,pq9,pq11,pq13,pq14,pq23, pq25,pq28).

**Step 3:** Convert the Z scores to t-scores with raw score mean = 50 and the raw score standard deviation = 10, if this is something you wish to do within your own sample. SPSS code is provided for this below.

COMMENT: Step 1: Score ProQOL IV. or 5 Variable 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 the old Compassion Fatigue scale.

```
RECODE pq1 pq4 pq15 pq17 pq29
      (1=5) (2=4) (3=3) (4=2) (5=1)
INTO 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.
```

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

```
DESCRIPTIVES
VARIABLES=CS BO STS /SAVE.
COMMENT: Step 3 Convert Z score to t score.
COMPUTE tCS = (ZCS*10)+50 .
VARIABLE LABELS tCS 'CS t score' .
EXECUTE .

COMPUTE tBO = (ZBO*10)+50 .

VARIABLE LABELS tBO 'BO t score' .
EXECUTE .
COMPUTE tSTS = (ZSTS*10)+50 .
VARIABLE LABELS tSTS 'STS t score' .
EXECUTE .
```



## SCALE DEFINITIONS AND SCORES

Below are the scale definitions. This section is the same as the scoring handout.

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

If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 23, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job. (Alpha scale reliability 0.88)

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

If your score is below 23, this probably reflects positive feelings about your ability to be effective in your work. If you score above 41, you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a “bad day” or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern. (Alpha scale reliability 0.75)

**Secondary Traumatic Stress:** The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work-related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other’s trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. You may see or provide treatment to people who have experienced horrific events. If your work puts you directly in the path of danger, for example due to your work as a emergency medical personnel, a disaster responder or as a medicine personnel, this is not secondary exposure; your exposure is primary. However, if you are exposed to others’ traumatic events as a result of your work, such as providing care to people who have sustained emotional or physical injuries, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

If your score is above 43, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

## CUT SCORES

The ProQOL measure is best used in its continuous form. However, many people prefer to have cut scores to indicate relative risks or protective factors. To address these needs, cut scores are provided. The cuts are set around the 25<sup>th</sup> and 75<sup>th</sup> percentiles based on the databank. They are potentially overly inclusive—that is they tend to Type 1 error. This means that there is a greater possibility of having a false positive than missing someone who actually belongs in a particular group. Because this is a screening and planning tool, it is probably less problematic to include someone who should not be included than to exclude someone who should be included so that supportive or corrective action is considered even if it is not needed. Scores near the borders can be particularly troublesome in that the cut point is an artificially applied criteria. Please note that while we provide cut scores based on the 75th percentile, we do not recommend that the measure be used for anything other than screening, and we prefer from a statistical perspective, to use the continuous numbers.

## SECTION 6: INTERPRETING THE ProQOL

### THE PROQOL IS NOT DIAGNOSTIC

The most important aspect about interpreting the ProQOL is that it is not a diagnostic test. There are no official diagnoses in the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) or in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000).

The body of research on burnout and posttraumatic stress disorder indicates a close kinship with each to depression. While this is useful information, depression is a general term that also is a specific diagnosis of a mental disorder and is widely and officially recognized by both the medical and the mental health communities. Therefore, it is impossible, and grievously inappropriate, to diagnose depression or any other disorder from the result of the ProQOL.

What the ProQOL can do, from a diagnostic perspective, is to raise issues to address with use of appropriate diagnostic procedures. For example, as noted above, both burnout and PTSD are frequent “co-travelers” with depression. A high score on either burnout or secondary traumatic stress, or a high score on both with a low score on compassion satisfaction, can be an augury of clinical depression that deserves treatment. Clearly the disorder most commonly associated with secondary trauma is PTSD. In fact, the DSM-IV-TR PTSD A1 criteria specify that the event may happen to self or to others. Additionally, it specifies that a person’s reaction must involve fear, helplessness, or horror. However, what it does not specify is when one has “experienced, witnessed, or was confronted” with the threat to another. Despite this parallel of compassion fatigue and/or secondary trauma to PTSD, it cannot be overemphasized that these issues are a natural consequence of trauma work and not necessarily pathological in nature (Figley, 1995; Larsen & Stamm, 2008; Stamm, 1999).

Given these concerns, the ProQOL can be a guide in regard to an individual’s or organization’s balance of positive and negative experience related to doing either paid or volunteer work. For an individual or an organization, high scores on compassion satisfaction are a reflection of engagement with the work being done.

### THE IMPORTANCE OF KNOWING MORE THAN JUST THE PROQOL SCORES

It is important to keep in mind that knowing more information about the test-taker or a group’s score is better than having less information. The interpretation section below is general and not based on covariates or demographics that must be considered when interpreting scores for specific people or specific groups. For example, scores for a person who is a deployed service man or woman might be normal for that situation but elevated for someone working in a non-deployment setting. Similarly, it may be important to know basic demographic information—is the test taker male or female.

### SCORES ACROSS DEMOGRAPHIC CATEGORIES

Some data are available across various demographic categories. These means are produced from a data bank of 1,289 cases created from multiple studies. While this is a large number and should reduce the measurement error, testing conditions and participant numbers across the variables fluctuate widely. Caution should be exercised in using these data. Additionally, these data are reported across single demographics. Other analyses of these data indicate that there may be very complex interactions that could not be reported here due to constraints within the data bank.

Two very important covariates that cannot be addressed at this time through data in the data bank are work setting and types of people assisted. Any study must include this variable.

TABLE 3: GENDER

sex	CS t score		BO t score		STS t score	
	male	female	male	female	male	female
Mean	49.01	50.14	48.99	50.37	49.05	50.18
Std. Deviation	10.81	9.77	9.75	10.26	9.95	10.15
N	315	760	315	760	315	760

No statistical differences were observed across gender.

TABLE 4: AGE GROUP

	CS t score		BO t score		STS t score	
	18-35 yrs	36 and up	18-35 yrs	36 and up	18-35 yrs	36 and up
Mean	50.12	51.00	50.11	47.74	53.61	50.75
Std. Deviation	8.76	9.50	8.50	8.25	9.74	9.27
N	106	93	106	93	106	93

No statistical differences were observed across age group.

TABLE 4: RACE

	CS t score		BO t score		STS t score	
	Non-White	White	Non-White	White	Non-White	White
Mean	50.16	49.87	52.82	47.65	51.46	48.78
Std. Deviation	9.86	10.12	10.23	9.17	9.74	10.06
N	540	647	540	647	540	647

No significant differences were observed across white and non-whites. Significant difference were observed on Burnout and on Secondary Traumatic Stress. Whites reported less burnout ( $F_{1,1183}=84,14$ ;  $p<.001$ ; Power = 1) and less STS ( $F_{1,1183}=21.38$ ;  $p<.001$ ; Power = .97).

TABLE 5: INCOME GROUP

Income Group	CS t score			BO t score			STS t score		
	Up to 45K USD	46K to 75K USD	More than 75K	Up to 45K USD	46K to 75K USD	More than 75K	Up to 45K USD	46K to 75K USD	More than 75K
Mean	49.96	48.94	51.46	47.22	48.11	46.67	49.56	48.07	48.33
Std. Dev	11.49	9.25	9.91	9.56	8.16	9.72	11.10	8.76	9.66
N	270	256	167	270	256	167	270	256	167

No statistical differences were observed across income groups.

TABLE 6: YEARS AT CURRENT EMPLOYER

	CS t score			BO t score			STS t score		
	< 5 years	5 to 15 years	> 15 years	< 5 years	5 to 15 years	> 15 years	< 5 years	5 to 15 years	> 15 years
Mean	49.85	49.49	50.31	47.55	47.32	49.43	48.93	47.95	49.10
Std. Dev	10.21	10.85	8.99	8.86	9.85	9.35	9.65	10.10	9.38
N	420	101	58	420	101	58	420	101	58

No statistical differences were observed across years with current employer groups.

TABLE 7: YEARS IN FIELD

	CS t score			BO t score			STS t score		
	< 5 years	5 to 15 years	> 15 years	< 5 years	5 to 15 years	> 15 years	< 5 years	5 to 15 years	> 15 years
Mean	49.52	49.80	50.36	47.44	48.59	47.36	48.35	47.42	47.85
Std. Dev	10.41	9.38	9.47	9.16	8.14	9.59	8.83	8.80	9.89
N	183	136	165	183	136	165	183	136	165

No statistical differences were observed across years in field groups.

## INTERPRETING INDIVIDUAL SCALES

### COMPASSION SATISFACTION

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

### COMPASSION FATIGUE

Compassion fatigue is characterized by the negative aspects of providing care to those who have experienced extreme or traumatic stressors. These negative responses include feelings of being overwhelmed by the work that are distinguished from feelings of fear associated with the work. Thus, there are two scales for Compassion Fatigue.

### BURNOUT

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

### SECONDARY TRAUMATIC STRESS

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

## INTERPRETING SCALE SCORES IN COMBINATION

### HIGH COMPASSION SATISFACTION, MODERATE TO LOW BURNOUT AND SECONDARY TRAUMATIC STRESS

This is the most positive result. This result represents a person who receives positive reinforcement from their work. They carry no significant concerns about being “bogged down” or inability to be efficacious in their work—either as an individual or within their organization. They do not suffer any noteworthy fears resulting from their work. These persons may benefit from engagement, opportunities for continuing education, and other opportunities to grow in their position. They are likely good influences on their colleagues and their organization. They are probably liked by their patients, who seek out their assistance.

### HIGH BURNOUT, MODERATE TO LOW COMPASSION SATISFACTION AND SECONDARY TRAUMATIC STRESS

People who score high on burnout, in any combination with the other scales, are at risk as individuals and may also put their organizations in high-risk situations. Burnout is a feeling of inefficacy. In the work setting, this may be a result of personal or organizational factors. The prototype burnout is associated with high workloads and poor system function. A person may feel as if there is “nothing they can do” to make things better. It is likely they are disengaged from their patients, even though this is not associated with any fear as a result of engagement with their patients. People suffering from burnout often benefit from taking time off. They may also benefit from changing their routine within the organization. Organizations that have many people with burnout should seriously consider their organizational system and the use of their human capital to identify pitfalls in the system and ways to support people in accomplishing business goals and work.

### HIGH SECONDARY TRAUMATIC STRESS WITH LOW BURNOUT AND LOW COMPASSION SATISFACTION

People who make these scores are typically overwhelmed by a negative experience at work as characterized by fear. If this fear is related to an event that happened to the person directly, such as having their life endangered as a result of participating in a dangerous rescue, or if they experienced a traumatic event such as sexual violence by a colleague, these are not secondary experiences. These are direct exposures to dangerous events. However, if the person’s fear is related to taking care of others who were directly in harm’s way, this is secondary traumatic stress. These people are likely to benefit from immediate treatment for traumatic stress and, when present, depression. Because they are neutral in regard to their feelings of inefficacy at work, or feelings of pleasure associated with their work, consider focusing on the fear-related work experiences. Countering the fear might include changing the case-load mix, the work environment (like assigning work with colleagues whom they trust), or introducing other safety measures.

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## HIGH SECONDARY TRAUMATIC STRESS AND HIGH COMPASSION SATISFACTION WITH LOW BURNOUT

This combination is typically unique to high-risk situations such as working in areas of war and civil violence. People who score in this range are often highly effective at their work because they feel their work matters. However, they have a private self that is extremely fearful because of their engagement with others. Some fear is accurate and appropriate in high-risk situation. However, high secondary traumatic stress is marked by thoughts, feelings, and memories of others' traumatic experiences mixed with their own experiences. This can be particularly difficult to understand when the experiences of those to whom the person provides help are similar to his or her own. Knowing that others have been traumatized by the same type of situations in which the person finds him or herself has the potential to change the person's interpretation of the event.

People with scores like this typically benefit from encouragement to build on their feelings of altruism and thoughts that they are contributing to the greater good. Simultaneously, their fears and fear-related symptoms should be addressed. Depression is theoretically unlikely given their high feelings of satisfaction. At times, changes in the work environment coupled with additional supportive supervision may alleviate the PTSD-like symptoms. At other times, therapy or medication or both may be a good alternative.

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## HIGH SECONDARY TRAUMATIC STRESS AND HIGH BURNOUT WITH LOW COMPASSION SATISFACTION

This combination is seemingly the most distressing. Not only does the person feel overwhelmed and useless in the work setting, they are literally frightened by it. People with this combination of scores are probably helped most by being removed from their current work setting. Assessment for PTSD and depression is important. Treatment for either or both may have positive outcomes, but a return to an unmodified work situation is unlikely to be fruitful. However, if the person is willing, it may be that he or she can change the efficacy by addressing their own skills and systems (such as additional training) or by working with the organization to identify a reorganized work assignment.

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## INTERPRETING THE PROQOL AT A GROUP LEVEL

Years of data collection and practice-based evidence have provided useful information on system and individual levels. For example, there appear to be no scale score differences by gender. None have been observed by country, although this may be reflective of the type of workers and settings that are using westernized measures. While not shown in the overall data bank, some unpublished studies as well as some individual studies that contributed to the bank showed differences based on the number of years in the field—more years in the field typically is associated with lower scores. While it is tempting to presume those with more experience do better, it is likely that those with greater exposure and low resiliency left the field, while those that remained were differentially resilient. When looking across professions, such as mental health, physical health, and child protection workers, data indicates that physical health workers (e.g., nurses, primary care doctors) experience the least trauma, while teachers remain the most satisfied. As could be expected, those workers dealing with children and families in trauma tend to experience higher levels of BO than any other group.

## SECTION 7: USING THE PROQOL FOR DECISION MAKING

Obviously, the “ideal” work environment in terms of managing stress and trauma is one that combines high CS with low BO and STS. Practice-based evidence and preliminary quantitative evidence suggest interesting results in less than ideal work environments. Those who have high levels of STS accompanied by high CS and, typically, a strong sense of altruism, may continue to be effective at their jobs and often respond well to a short STS intervention. While it is important for a worker’s supervisor to make this type of decision individually, sometimes it is possible to accomplish intervention in vivo, without changing a work assignment. In contrast, those with high levels of both BO and STS may be the most at risk, both to themselves and in a work setting. In this situation, the caregivers are afraid and see no hope for change, which potentially ruins their effectiveness. Theoretically, this negative profile is associated with medical error, but because the data are not in on that concern, it is too soon to say with certainty. Regardless of the system effects of people who are experiencing high levels of both BO and STS, it is important that interventions be pursued for them as individuals. Supervisors should consider job reassignment during the intervention time.

### CHANGING THE PERSON-EVENT INTERACTION

One of the rewarding aspects of the ProQOL is that it provides a platform for change. It can lead to introspection and to brainstorming about what is right and what can be made better and what is wrong and cannot be made better. It is important to identify things that are going well and those things that are not. It is also important to realize that some things should be horrible. Dealing with burn victims, for example, cannot really be normalized. The burns themselves are serious wounds and no one should try to pretend otherwise. However, that same burn victim may provide a good source of compassion satisfaction when the helper feels that a difference is being made. In dangerous settings, it is critically important not to try to take away people’s necessary fears. Being afraid may be the very thing that keeps them from being killed.

At the individual level, a person may review personal and work environments. This may be done individually, with family, with a friend or colleague, or with a professional. Regardless of the method, this is a plan about that person and for that person; it is his or hers and not their employer’s or their doctor’s. A plan dictated from outside is likely to lead to dissatisfaction and a marker for burnout—an organization that dictates personal beliefs is probably an organization that does not value their personnel’s thoughts and feelings.

Changing workgroups can be easy or it can be very difficult. The difference is the interest of the group in investigating and responding to issues of professional quality of life. Some workgroups just do not want to deal with the issue. There may be an attitude of “if you cannot take the heat, get out of the kitchen.” Other groups may genuinely want to change but may not know how best to change. Some groups become distressed that change is not possible without an outside source. Some groups may already be functioning well and no change is advisable. The role of the helper in this situation is to try to help the group members identify their “style” and work from there. The principles of any good group theory can assist in managing a group’s needs. It is important to remember that there will be times when a group’s needs are very clear and quite reasonable, but unattainable. This is common in civil violence or war settings. A work group’s members may decide that they wish to change shifts more often. However, there may be insufficient numbers of people to make that possible. In situations such as this, your role is to try to identify alternatives to the really needed, but impossible, intervention. The group members themselves may be the best source of alternatives.



## MONITORING CHANGE ACROSS TIME

The ProQOL itself is stable across time, which means that the scores across time reflect changes in the person, not in the measure itself. Some people self-administer the ProQOL at a regular self-determined interval to see how they are doing. Others may choose to take the test once. Some organizations will require multiple administrations while others may ignore professional quality of life altogether.

If the ProQOL is used across time, there should be a way to consider what those changes mean. This can be something as simple as a graph showing a person's ups and downs across time or it may be a formal review of one's self-care plan or the plan for a workgroup. It is important that the information be useful. One potentially important use of the information is to reevaluate and adjust one's self-care plan or even a group's or organization's plan.

**SECTION 8: THE PROQOL TEST AND HANDOUT  
PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)**

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

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

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

- \_\_\_\_\_ 1. I am happy.
- \_\_\_\_\_ 2. I am preoccupied with more than one person I *[help]*.
- \_\_\_\_\_ 3. I get satisfaction from being able to *[help]* people.
- \_\_\_\_\_ 4. I feel connected to others.
- \_\_\_\_\_ 5. I jump or am startled by unexpected sounds.
- \_\_\_\_\_ 6. I feel invigorated after working with those I *[help]*.
- \_\_\_\_\_ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
- \_\_\_\_\_ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
- \_\_\_\_\_ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
- \_\_\_\_\_ 10. I feel trapped by my job as a *[helper]*.
- \_\_\_\_\_ 11. Because of my *[helping]*, I have felt "on edge" about various things.
- \_\_\_\_\_ 12. I like my work as a *[helper]*.
- \_\_\_\_\_ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
- \_\_\_\_\_ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
- \_\_\_\_\_ 15. I have beliefs that sustain me.

- \_\_\_\_\_ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
- \_\_\_\_\_ 17. I am the person I always wanted to be.
- \_\_\_\_\_ 18. My work makes me feel satisfied.
- \_\_\_\_\_ 19. I feel worn out because of my work as a *[helper]*.
- \_\_\_\_\_ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
- \_\_\_\_\_ 21. I feel overwhelmed because my case *[work]* load seems endless.
- \_\_\_\_\_ 22. I believe I can make a difference through my work.
- \_\_\_\_\_ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
- \_\_\_\_\_ 24. I am proud of what I can do to *[help]*.
- \_\_\_\_\_ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
- \_\_\_\_\_ 26. I feel "bogged down" by the system.
- \_\_\_\_\_ 27. I have thoughts that I am a "success" as a *[helper]*.
- \_\_\_\_\_ 28. I can't recall important parts of my work with trauma victims.
- \_\_\_\_\_ 29. I am a very caring person.
- \_\_\_\_\_ 30. I am happy that I chose to do this work.
- \_\_\_\_\_

## YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

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

### **Compassion Satisfaction** \_\_\_\_\_

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

If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 23, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job. (Alpha scale reliability 0.88)

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### **Burnout** \_\_\_\_\_

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

If your score is below 23, this probably reflects positive feelings about your ability to be effective in your work. If you score above 41 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a “bad day” or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern. (Alpha scale reliability 0.75)

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### **Secondary Traumatic Stress** \_\_\_\_\_

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

If your score is above 41, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional. (Alpha scale reliability 0.81)

## WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test and then you can compare your score to the interpretation below.

To find your score on **each section**, total the questions listed on the left in each section and then find your score in the table on the right of the section.

### Compassion Satisfaction Scale:

- 3. \_\_\_\_
- 6. \_\_\_\_
- 12. \_\_\_\_
- 16. \_\_\_\_
- 18. \_\_\_\_
- 20. \_\_\_\_
- 22. \_\_\_\_
- 24. \_\_\_\_
- 27. \_\_\_\_
- 30. \_\_\_\_

The sum of my Compassion Satisfaction questions	My Level of Compassion Satisfaction
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

**Total:** \_\_\_\_

### Burnout Scale:

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

The sum of my Burnout Questions	My Level of Burnout
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Reverse the scores for those that are starred.

0=0, 1=5, 2=4, 3=3, 4=2, 5=1

**Total:** \_\_\_\_

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**Secondary Trauma Scale:**

2. \_\_\_\_

5. \_\_\_\_

7. \_\_\_\_

9. \_\_\_\_

11. \_\_\_\_

13. \_\_\_\_

14. \_\_\_\_

23. \_\_\_\_

25. \_\_\_\_

28. \_\_\_\_

**Total:** \_\_\_\_

<b>The sum of my Secondary Traumatic Stress questions</b>	<b>My Level of Secondary Traumatic Stress</b>
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

## Comprehensive Bibliography Of The Effect Of Caring For Those Who Have Experienced Extremely Stressful Events and Suffering

**Date:** 28 November, 2010

**Compiler:** Beth Hudnall Stamm

**Reference:** Stamm, B.H. (2010, November). Comprehensive Bibliography Of The Effect Of Caring For Those Who Have Experienced Extremely Stressful Events and Suffering. [www.proqol.org](http://www.proqol.org). Out of respect for the scholarly and community endeavor, if you use large portions of this bibliography, or note it as a whole, please include the reference provided here.

**Comment on the Bibliography:** This bibliography is provided for the use of anyone and is provided as a volunteer effort from the ProQOL.org. Every effort has been made to be as accurate and complete as possible. Nonetheless, it is incumbent on the user to verify the reference and the details of the reference. ProQOL.org cannot take responsibility for the specific accuracy of the details of the references.

**Search Terms in Alphabetical Order:** compassion fatigue, compassion satisfaction, compassion stress secondary trauma, secondary traumatic stress, vicarious trauma, vicarious traumatization, vicarious transformation.

**Terms Excluded From the Search:** burnout and countertransference were not included. Searches using the terms but cross-referencing with at least one of the terms above, were not sufficiently accurate to make the effort worthwhile. Papers with the search terms above that also include burnout or countertransference were not excluded. Burnout and Countertransference without the occurrence of one of the search terms above generally were excluded. Burnout and countertransference appearing with one of the terms above were included.

**Rationale for Term Exclusion:**

*Burnout* was not included in the search terms as it is a widely used term that can apply to any type of job. It is not unique to working with people who have experienced extreme suffering. It can be applied to any type of job such as working in a factory or an office.

*Countertransference* was not included in the search terms as it may or may not relate to the therapists interaction with patients who have experienced traumatic stress. Countertransference can occur even if the patient/client has not experienced an extremely stressful event or trauma-related suffering.

**Search Locations:** Medline, PsychInfo, PILOTS, Amazon.com, Google. The Google search was conducted to identify the overall size of the body of work (over 250,000 accurate hits). Some documents, particularly

organizational publications, were identified there. Individual presentations, etc. were not included in this bibliography.

**Tests and Measures Search in PILOTS:** TM=(secondary trauma questionnaire (motta et al)) or TM=(secondary trauma scale (motta et al)) or TM=(secondary traumatic stress scale (bride et al)) or TM=(secondary traumatic stress scale) or TM=(inner experience questionnaire (brock et al)) and TM=(trauma and attachment belief scale) or TM=(compassion fatigue self test for practitioners (figley)) or TM=(compassion fatigue/satisfaction scale) or TM=(compassion/satisfaction fatigue test for helpers (stamm and figley)) or TM=(professional quality of life scale (stamm)) or TM=(traumatic stress institute belief scale (stamm et al))

**Comment on Formatting:** The formatting generally follows the pattern of APA format. The italics and underlines are not present to avoid true type and other formatting errors making the bibliography more difficult to read. Some references are in formats other than APA. The technical capacity to format each reference identically exceeds greatly the capacity of the tiny volunteer ProOQL.org staff. In some cases information was not readily available. In these cases, there may be markings indicating the missing information. The most common occurrence was the lack of city information on various publishing companies. Thus, the reference may read City: ABC Books.

**To Make Comments, Additions or Corrections:** write to [info@proqol.org](mailto:info@proqol.org) or complete the form online at [www.proqol.org](http://www.proqol.org), on the Bibliography.



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## SECTION 11: FREQUENTLY ASKED QUESTIONS

**Q:** I understand that the ProQOL 5 is the current version of the Compassion Fatigue Self Test or the Compassion Satisfaction and Fatigue Test. What happens to the old tests?

**A:** The ProQOL is the current version of the earlier tests. The scales are the same and the “tone” of the measure is the same across the versions. The new version it is a much better test. It is more psychometrically sound, and it is shorter reducing the burden on the test taker. Additional information can be found in the ProQOL manual ([www.proqol.org](http://www.proqol.org)).

**Q:** Can I compare the ProQOL 5 to previous versions?

**A:** Yes. Starting with the ProQOL 5 scores are reported in standardized format, using a t-score. This allows you to compare across versions of the ProQOL simply by standardizing those scores. More information about standardizing scores is found in the ProQOL manual under scoring.

**Q:** Why did start using a standardized score?

**A:** Standardized scores have multiple advantages. The greatest advantage is for the test taker. With the raw score format, the numbers on each scale meant something different. A 23 on one scale was not equivalent to a 23 on another. By using a standardized score, scores across the scales can be interpreted the same. The mean is 50 and the standard deviation is 10, regardless of the scale.

**Q:** How do I calculate the standardized scores?

**A:** There are several methods depending on what works best for you. There is computer code on the ProQOL manual. There is also a table that you can look up scores. For applications when you do not need a great deal of information, you can use the self score version.

**Q:** May I use the ProQOL?

**A:** Yes. We encourage people to use the measure. The permission you need to use the measure is on the test itself in the footer.

**Q:** Do I have to pay for the ProQOL?

**A:** That depends. We have intentionally kept the ProQOL available at no or low cost in order to make it easy to use for anyone, anywhere in the world. The choice is up to you. If you would like to collect the materials up yourself, you can do that for free. If you would like to have them delivered to you in an organized package, Sidran will do that for you.

- **For Free:** You may download the measure and other information about it for free from [www.proqol.org](http://www.proqol.org).
- **At Cost:** Through an agreement with the non-profit/charity organization The Sidran Foundation ([www.sidran.org](http://www.sidran.org)), the ProQOL and materials are available for a small charge to cover the costs of handling. You can access the measure directly at <http://www.sidran.org/catalog/ProQOL.html>.

**Q:** May I make copies the measure?

**A:** The permission that you need is in the copyright agreement at the bottom of the measure. You may use the measure freely as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

**Q:** May I reformat the ProQOL?

**A:** You may reformat the measure to fit with your needs. Please make sure to keep the content the same.

**Q:** May I change the ProQOL to better match the people that I am working with?

**A:** Yes. We tried to use the most generic form of address we could find, “helper” but we recognize that this is not suitable for everyone. Thus, we include permission to replace the word helper and its derivatives with words that are more suited for your group. You will note on the measure that the terms are in bracket and italicized. You may replace the bracketed term with one that is more suitable for your group. If you are working with teachers, for example, you may want to replace helper with teacher and help with teach. For nurses, replace the word helper with nurse and help with nurse. For attorneys, replace the word helper with attorney and help with represent and so forth. You do not need to seek special permission to make these changes.

**Q:** How is the ProQOL typically used?

**A:** People typically use the ProQOL one of three ways

- For research studies.
- To monitor the professional quality of life among staff at an organization like a state’s social workers or group such as aid workers.
- To self-monitor one’s status for personal interest.

**Q:** Who is the “target” of the ProQOL?

**A:** While therapists were the original target, the measure is used widely with other groups including medical health professionals (particularly nurses), teachers, lawyers, humanitarian workers, social service employees, public service employees such as law enforcement, reporters and journalists, juries at trials, and even soldiers and peace keepers. The key to the ProQOL’s appropriateness is the theoretical possibility of being exposed to another’s potentially traumatizing material as a result of paid or volunteer work. If this relationship can exist, the measure is likely appropriate.

**Q:** I am interested in working with family caregivers. Is the ProQOL appropriate for these people?

**A:** We do not recommend the ProQOL for family caregivers. There are a number of measures for family caregivers available. You may wish to check The Caregiver Burden Scale which can be seen at <http://www.mywhatever.com/cifwriter/content/41/pe1278.html>, or others to find something that meets your needs.

**Q:** Can you tell me about the articles that have been published using the measure?

**A:** We try to keep a comprehensive and reasonably up-to-date bibliography at [www.proqol.org](http://www.proqol.org). We recommend that you check the PILOTS database at the National Center for PTSD for additional references <http://biblioline.nisc.com/scripts/login.dll>.

**Q:** Where can I get more information about the ProQOL, and secondary/vicarious traumatization or Compassion Fatigue?

**A:** You can find many handouts and documents at [www.proqol.org](http://www.proqol.org) the “Handouts” link. There is more technical information on the “Research” link at [www.proqol.org](http://www.proqol.org). If you are looking for handouts and a quick overview, the handouts section is the best location. If you are looking for more scientific and research detailed information, go to the research section of [www.proqol.org](http://www.proqol.org).

**Q:** Is there a single score for the measure across all of the three scales?

**A:** No. We have tried for years to create a composite score without success. However, we are not giving up! The reason there is no sensible composite score is that we as yet do not fully understand the relationship between Compassion Satisfaction, Burnout and Compassion Fatigue/Secondary Trauma. One of the problems encountered over the years was the problems with the original scale that clearly showed collinearity between the scales. Thus, we revised the scales to minimize the destructive effects of collinearity and are now re-collecting data to see if we can understand the inter-relatedness of the three scales. In fact, this would be a great dissertation for someone!

**Q:** I am only interested in Compassion Fatigue/Secondary Trauma. Can I use just the Compassion Fatigue Scale?

**A:** We strongly suggest this is not a good idea. While we do not as yet fully understand the relationship between the three subscales, we do know that Compassion Satisfaction is a moderator, if not a mediator of Compassion Fatigue/Secondary Trauma. Burnout rarely exists at the same time as Compassion Satisfaction and when both Burnout and Compassion Fatigue/Secondary Trauma are present, it seems to suggest the most negative outcome. Thus, we believe it is important to know all three scores. Moreover, including the positive items reduces negative response set, improving the psychometric properties of the scale.

**Q:** Can I diagnose PTSD from the ProQOL?

**A:** No. The ProQOL is a screening and research tool that provides information but does not yield a diagnosis. If you suspect PTSD or any other psychopathology as a result of work-related trauma exposure, we suggest you use a clinical diagnostic tool such as the SCID or CAPS. More information about these tools may be obtained using any search engine online.

**Q:** Can you give me the psychometric information about the measure?

**A:** Reliability and validity information is contained in the ProQOL Manual which can be found at our website at [www.proqol.org](http://www.proqol.org).

**Q:** What norms do I use?

**A:** The general norms are available in the ProQOL manual at [www.proqol.org](http://www.proqol.org), There are also general norms on the scoring sheet handout. These are the best norms at this time.

**Q:** What are the cut scores for the measure?

**A:** We provide norms at the 25<sup>th</sup> and 75<sup>th</sup> percentiles. However, we strongly suggest that the measure is most sensitive when using the continuous scores. Please note that the measure is not to be used for diagnostic purposes, and thus, cut scores are typically not used. If your study design requires the less powerful categorization of participants (as opposed to using continuous scores), we suggest the 25<sup>th</sup> and 75% percentiles provided with the norms.

**Q:** When I reverse the scores, what do I do with the 0 score?

**A:** The ProQOL 5 uses the more familiar 1-5 Likert scale so the 0 is no longer an issue.

If you have used the ProQOL IV, below is information about the 0. Please do remember that all of the versions of the ProQOL scores can be compared by using the standardized score.

On the ProQOL IV, the 0 remains 0 and all other scores are reversed. While this seems odd at first, conceptually, you can understand it. The person answering the item selects never/not at all which translates mathematically to a null set, that is 0. The other items are reversed because of the way that they load on the different scales. This is because the concept is the “other side” of the item asked. For example, if I ask if you are happy and you say never, that is a 0. If you say sometimes (2) that can be reverse scored to mostly (4) I am not happy. It is a way to allow the item to be phrased in the positive while addressing the flip side of the concept. Frankly, from a scoring perspective if we had it all to do over again, we would not include 0 in the score. It worked easily originally since all of the items were positive scored. Over time and thousands of data points, we realized that the test was more effective reflecting people’s perceptions when we reverse scored some of the items. Sadly, for the researcher, this causes moments of mathematical consternation. However, for the person taking the measure, it is vastly useful to have an option to respond “not at all, 0” so we have learned to live with the mathematical oddities of the reverse scoring. All of the psychometric analysis has been done using the 0-5 scoring with the items reverse scored 0=0, 1=5, 2=4, 3=3.

**Q:** I have heard that if I donate a copy of my raw data to the databank, you will run comparisons to specific groups for me.

**A:** Yes, if you donate a copy of your data to the data bank, we will run a comparison to the closest group for you. Please be aware that this is largely a volunteer effort on our part so we need some time to schedule your request.

**Q:** If I donate a copy of my data to the databank, will I lose the ownership of my study?

**A:** No. We never publish any one dataset alone. We always combine databank data so your study will never be published by us. For example, we run analyses by country, types of participants, rural/urban, male/female, etc.

**Q:** If I send you my study, will you review it and make comments on it?

**A:** We try as much as possible to support research with the ProQOL. If you would like us to make comments on your study, please send us <irh@isu.edu> an overview (not more than 5 pages) of the study and we will try to



respond to you with our thoughts. We cannot promise to review every study, but we do make an effort to assist in every way possible.

**Q:** Will someone on your team be on my thesis or dissertation committee?

**A:** We have in the past been able to participate in a number of studies. However, please realize that we receive many requests each year. If you would like us to work with you on your thesis or dissertation, send us <irh@isu.edu> a request that includes (a) your university, (b) the area and level of degree, (c) the name of your chair and as many of your other committee members as you know of, (d) an abstract of your proposal not longer than one page, and (e) a brief details of the way your university includes outside participants. We will review the information and see if there is anyone on our larger team who can work with you.

## ABOUT THE AUTHOR



Beth Hudnall Stamm, Ph.D., educated in psychology and statistics at Appalachian State University (BS, MA) and University of Wyoming (Ph.D.), is a Research Professor at the Idaho State University Institute of Rural Health. She has held appointments at the Veterans Affairs National Center for Posttraumatic Stress Disorder, Dartmouth Medical School, State University of New York at Oswego, and at the University of Alaska Anchorage.

Working primarily with helpers and underserved people; Stamm's efforts focuses on secondary trauma among helpers and cultural trauma. She has served on boards and committees for multiple organizations including The International Society for Traumatic Stress Studies (ISTSS), the American Psychological Association (APA), the National Association for Rural Mental Health (NARMH), the National Association of Rural Health (NRHA), and the American Telemedicine Association (ATA). She has been a principal on \$27 million dollars worth of grants focusing on rural and urban children and adults address the effects of difficult life events.

Stamm has worked with secondary traumatic stress and professional quality of life since 1990. She originally became interested in the topic when she was directing a longitudinal study on self-reported perceptions of traumatic stress at which time she discovered the research on trauma had a negative effect on the researchers. Since that time she has worked with humanitarian aid organizations from around the world assisting them in developing professional quality of life resiliency programs that focus on prevention and intervention of burnout and secondary trauma. She has worked with health professionals of all types in in North and South America, Europe, New Zealand, Australia and several countries in Asia and Africa. She has also

worked with military and Red Cross/Red Crescent personnel in the United States, The Palestinian Territories, and Jordan.

Stamm's activities focus on recovery from exposure to war and civil violence as well as to terrorism and disaster for all people in community, including helpers. Among her other activities, in 2008, she testified on Post-Traumatic Stress Disorder (PTSD) Health Care Symposium to the House Committee on Veterans' Affairs regarding the needs of our service men and women who have experienced injury in Iraq and Afghanistan. In 2006 she traveled to Amman, Jordan to a NATO Advanced Research Workshop to help identify ways to mitigate the effects of terrorism on individuals and communities. Following that work, she was an invited speaker at the 10th International Torture Rehabilitation Council Meeting, in Berlin, Germany. In the aftermath of the South Asian Tsunami in 2004, Stamm was the U.S. Representative to the Inter-Governmental Meeting of Experts To Formulate Psychosocial Programme for Rehabilitation of Tsunami Survivors. She also provided technical assistance to the Indonesia's oldest psychosocial recovery program, Pulih, who were providing local rehabilitation to tsunami survivors. In 2003, as part of a U.S. State Department program, Stamm worked with the Palestine Red Crescent Society to address using technology to address secondary trauma among emergency and primary care health professionals. In 1992, she was a delegate with the Truman Foundation, People to People Program teaching about posttraumatic stress disorder across eastern China.

Her work has been recognized by multiple organizations. In 2005, she received a *Presidential Citation* from the American Psychological Association naming her as one of the "outstanding psychologists of this generation." She was credited with helping to establish the fields of traumatic stress, telehealth, and their effects on rural health. In 2004, she received the International Society for Traumatic Stress Studies *Public Interest Award* for "fundamental and outstanding contributions to the public's understanding of trauma." With her colleagues, she has been recognized multiple times by the American Telemedicine Association for "scientific rigor and contributions to the field." In 2004, Stamm was selected as the Idaho State University Distinguished Researcher. In 2003, she was recognized by the National Rural Health Association as one of the nation's *Distinguished Researchers*. She is a fellow in the Division of Traumatic Stress and the Division of Public Service of the American Psychological Association.

Stamm is a traumatic brain injury survivor from 1987 and 2004. As a person with a disability, she is an advocate for the use of assistance animals to mitigate disabilities. She is an Associate Animal Behavior Consultant (AABC) with the International Association of Animal Behavior Consultants; a member of the International Association of Assistance Dog Partners; and is listed in the Delta Society Service Animal Training Registry.

Stamm has over 100 professional publications and is the Editor of the *Journal of Rural Mental Health*. Her books include *Secondary Traumatic Stress* (1995, 1999, Sidran Press, English Editions, 2002 Japanese edition and 2004, German); *Measurement of Stress, Trauma and Adaptation* (1996, Sidran Press); *Cultural Issues and the Treatment of Trauma and Loss* (with Kathleen Nader and Nancy Dubrow, 1999, Brunner/Mazel); *Rural Behavioral Health Care* with APA Books (2003); and *The Professional Quality of Life Test Manual* (Sidran, 2005, 2008).

Her work is used in over 30 countries and diverse fields including health care, bioterrorism and disaster responding, news media, and the military. She makes her home in a log cabin in the mountains of Idaho with her historian-husband and her service dog Sophie. See [www.proqol.org](http://www.proqol.org) and [www.isu.edu/irh](http://www.isu.edu/irh) for more information.