

The ProQOL Manual



*THE PROFESSIONAL QUALITY OF LIFE SCALE:
Compassion Satisfaction, Burnout & Compassion
Fatigue/Secondary Trauma Scales*

B. Hudnall Stamm, Ph.D.
Institute of Rural Health
Idaho State University
www.isu.edu/~bhstamm

A Collaborative Publication with Sidran Press
www.sidran.org

Acknowledgements for their faithful contributions to the development of the ProQOL go to Joseph M. Rudolph, Edward M. Varra, Kelly Davis, Debra Larsen, Craig Higson-Smith, Amy C. Hudnall, Henry E. Stamm, and to all those from around the world who contributed their raw data to the databank. I am forever indebted to Charles F. Figley who originated the scale, and in 1996, handed the scale off to me saying “I put a semicolon there; you take it and put a period at the end of the sentence.” No one could have wished for a better mentor, colleague, and friend. BHS

Copyright B. Hudnall Stamm, 2005, all rights reserved

Published under a joint agreement with Sidran Press.

This material may be freely copied as long as (a) author is credited, (b) no changes are made, & (c) it is not sold except for in agreement specifically with the author.

Table of Contents

Topic	Page
I. Introduction	4
II. Scale Definitions	4
Compassion Satisfaction	5
Burnout	5
Compassion Fatigue/Secondary Trauma	5
Languages Available	6
III. Scale Creation Methods	7
IV Psychometric Information	7
Scale Distributional Properties	7
Reliability	8
Validity	9
Work Type Comparisons	10
V. Scoring	11
Compassion Satisfaction	12
Burnout	12
Compassion Fatigue/Secondary Trauma	12
Cut Scores	13
VI. Missing Data	14
VII. Manual References	15
VIII. Bibliography	17
Publications about Various Versions of the ProQOL (Including the CFST and the CFS)	16
Publications on the Construct of Compassion Fatigue/Secondary Traumatic Stress/Vicarious Trauma Professional Quality of Life	18
General Reference List for Construct of Compassion Fatigue/Secondary Traumatic Stress/Vicarious Traumatic Stress	19
VIV. Frequently Asked Questions	24

THE PROFESSIONAL QUALITY OF LIFE SCALE: Compassion Satisfaction, Burnout, and Compassion Fatigue/Secondary Trauma Scales

I. INTRODUCTION

The Professional Quality of Life Scale (ProQOL) is the current version of the old Compassion Fatigue Self Test (Figley, 1995). This version and the name change emerged for two reasons. First, the original scale has known psychometric problems. Second, we chose to change the name because we realized after market testing, that focusing the overall effort toward a positive thing, professional quality of life, made it easier to support positive system change to prevent or ameliorate the negative effects of caregiving and buttress the positive effects of providing care.

Multiple versions of the Compassion Fatigue test (CFST or CSF, Figley, 1995; Figley & Stamm, 1996) have been widely used in assessing compassion fatigue or secondary/vicarious trauma. Subscale psychometric difficulties have been noted (Figley & Stamm, 1996; Jenkins & Baird, 2002; Larsen, Stamm, & Davis, 2002). The ProQOL is a third revision of the CSF. This revision addresses difficulties separating burnout and secondary/vicarious trauma and reduces participant burden by shortening the test from 66 to 30 items. The revision, based on over 1000 participants from multiple studies, was developed by retaining the strongest, most theoretically salient items. Specifically, items were retained if they met both high item-to-scale criteria and were theoretically good representatives of the subscale construct. Quantitative decisions were made using Chronbach's alpha, factor analysis, and multigroup factorial invariance. Each new subscale has 10 items: 7 items from the previous CSF version and 3 new items designed to strengthen the overall theory of the subscale. New items were developed from the most recent literature on burnout and theory relating to compassion satisfaction. The ProQOL now consists of three subscales: Compassion Satisfaction, Burnout, and Compassion Fatigue. Initial data suggest that these subscales have excellent internal consistency.

II. SCALE DEFINITIONS

The ProQOL is composed of three discrete scales that do not yield a composite score. Each scale is psychometrically unique and cannot be combined with the other scores. Considerable work has been undertaken to create a composite indicator score but to date, no satisfactory arrangement has been discovered. The key reason for this is the complex relationship between

the scales. It is possible for people to report high scores on CS combined with high scores on CF; this is not atypical among those who retain their altruistic desire to help when working in distressing situations such as in war or refugee camps. Typically, we do not see high scores on burnout with high satisfaction, but there is a particularly distressing combination of burnout with trauma. These latter cases seem to be at the greatest risk for negative outcomes, including, but not limited to, depression or PTSD and bad professional judgment which may contribute to patient care error or poor administration.

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.

Burnout: 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. Higher scores on this scale mean that you are at higher risk for burnout.

Compassion Fatigue/Secondary Trauma: Compassion fatigue (CF), also called secondary trauma (STS) and related to Vicarious Trauma (VT), is about your work-related, secondary exposure to extremely stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called VT. If your work puts you directly in the path of danger, such as being a soldier or humanitarian aide worker, 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 in an emergency room or working with child protective services, this is secondary exposure. The symptoms of CF/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.

Languages Available: The ProQOL and its predecessors have been used in projects in more than 30 countries around the world. It is available in English, French, Spanish, German, and Hebrew. Other translations are invited.

The ProQOL is used across many different types of professions. Sometimes it is appropriate to change the word *helper* to one that is more specific for the group being tested. For example, if you are working with teachers, you might choose to replace *helper* with the word *teacher*. This change can be made without specific permission from the test developer.

III. SCALE CREATION METHODS

The revision was based on a database of 365 cases from the original measure known as the CFST (Figley, 1995; Stamm & Figley, 1996), 940 cases from the “middle revision” known as the CSF (Stamm, 2002) and 463 cases using the current revision, the ProQOL. The data are amalgamated from separate studies. Data are aggregated by type of participant group (e.g., therapists, teachers, nurses, humanitarian aide workers, etc.). Because it is difficult to obtain information about the sex of the participants, data are not analyzed for male/female differences, although multiple previous studies have not yielded sex differences on any of the subscales. The psychometric data reported here are from an entirely new sample of 463 people taking the ProQOL.

The revised version was developed by retaining the strongest, most theoretically salient items and bolstering the subscales with new items to best represent their respective constructs. Specifically, items that met both high item-to-scale criteria and were theoretically good representatives of the subscale construct were retained. Quantitative decisions were made using Chronbach’s alpha, item-to-scale analyses, common factor analysis, and multigroup factorial invariance. Each new subscale has 10 items: 7 items from the previous CSF version and 3 new items designed to strengthen the overall theory of the subscale. New items were developed from the most recent literature on burnout and theory relating to compassion satisfaction.

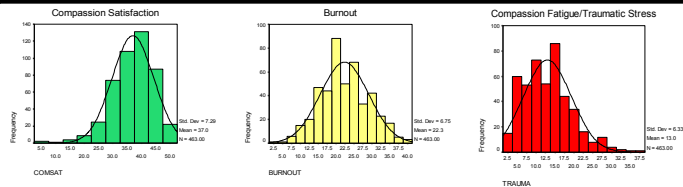
The overall length of the measure dropped from 66 to 30 items. The three subscale structure was retained—Compassion Satisfaction, Burnout, and Compassion Fatigue/Secondary Traumatic Stress. In order to reflect the changing nature of the construct, which includes positive as well as negative items, the measure was given a new name, the Professional Quality of Life Scale, or the ProQOL. The measure, psychometric information, and scoring key is located at www.isu.edu/~bhstamm.

IV. PSYCHOMETRIC INFORMATION

Scale Distributional Properties: The scales generate distributions that are generally unimodal and symmetric (figure 1). The Compassion Satisfaction Scale typically is skewed toward the positive side and the compassion fatigue/trauma is skewed toward the absent side (e.g., most people report little disruption).

Figure 1: Subscale Distributional Properties

	Mean	Median	Mode	SD	S Error	Skew	Kurtosis	Min	Max
CS	37	38	39	7.3	.34	-.88	1.77	3	50
BO	22	22	21	6.8	.31	.07	-.35	3	40
CF/STS	13	12	15	6.3	.29	.66	.43	2	37



Reliability: The alpha reliabilities for the scales are as follows (see figure 2): Compassion Satisfaction alpha = .87, Burnout alpha = .72 and Compassion Fatigue alpha = .80. While these are in absolute value somewhat lower than the original test (Compassion Satisfaction alpha = .87, Burnout alpha = .90, Compassion Fatigue alpha = .87), given that the scales are shortened by half in length, these scores are actually more reliable than the longer form (see Spearman Brown formula, for example, if original reliability was .82, a comparable reliability on the shortened scale would be .69). The measure has considerable improvement on the item-to-scale statistics due to increased specificity and reduced colinearity. In addition, the standard errors of the measure are quite small so that the test typically has less error interference improving the potential measurable effect size. This latter point is particularly important with the sample sizes common among small clinical studies. Early returns on test-retest data suggest good reliability across time with a small standard error of the estimate.

Comment: Does not match value in Figure 2 (.71 vs .72). Text uses .72 in all documents.

Figure 2: Alpha Reliabilities

	Compassion Satisfaction	Burnout	Compassion Fatigue/ Sec Traumatic Stress
Compassion Satisfaction	alpha = .89 n = 457		
Burnout		alpha = .71 n = 379	
Compassion Fatigue/ Sec Traumatic Stress			alpha = .80 n = 369

See also:

Larsen, D., Stamm, B.H., & Davis, K. (2002). Telehealth for Prevention and Intervention of the Negative Effects of Caregiving. *Traumatic StressPoints*, 16(4). <http://www.istss.org/publications/TS/Fall02/telehealth.htm>

Figley, C.R., & Stamm, B.H. (1996). Psychometric Review of Compassion Fatigue Self Test <http://www.isu.edu/~bhstamm/pdf/figleystamm.pdf>. In B.H. Stamm (Ed), *Measurement of Stress, Trauma and Adaptation*. Lutherville, MD: Sidran Press. <http://www.sidran.org/catalog/stms.html>

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, *Treating Compassion Fatigue*. New York: Brunner Mazel.

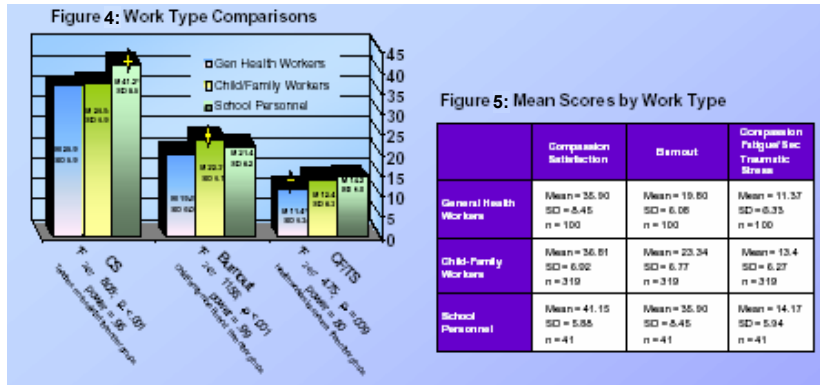
Validity: The construct validity upon which the test is based is well established with over 200 articles noted in the peer-review literature (see Stamm, 1999 or www.isu.edu/irh~bhstamm for bibliographies). Using the multi-trait multi-method mode for convergent and discriminant validity (Campbell & Fiske, 1959), the scales on the ProQOL do, in fact, measure different constructs. In addition, the ProQOL revision of the CFST reduced the known colinearity between Compassion Fatigue and Burnout. The inter-scale correlations are as small. Compassion Satisfaction has 5% shared

variance with Burnout and 2% shared variance with Compassion Fatigue/Trauma. The shared variance between Burnout and Compassion Fatigue/Trauma is somewhat higher, likely reflecting the distress that is common to both conditions (21%), but the two scales are clearly different (see figure 3). Studies of discriminant and convergent validity are underway by several doctoral students at multiple universities.

Figure 3: Convergent and Discriminant Validity Among Scales

	Compassion Satisfaction	Burnout	Compassion Fatigue/ Sec Traumatic Stress
Compassion Satisfaction			
Burnout	R = -.23 co-σ = 5%		
Compassion Fatigue/ Sec Traumatic Stress	R = -.15 co-σ = 2%	R = -.46 co-σ = 21%	

Work Type Comparisons (Figure 4 & 5): To date, three broad classes of workers have been tested: general health workers (including clinicians through administrators); child/family workers, including residential and child protective care workers; and school personnel, which includes teachers, counselors, and administrators. Teachers were significantly more satisfied with their work, child-family workers were more burned out, and general health workers reported significantly fewer CF/STS symptoms.



V. SCORING

In this revision, missing data are managed by taking a summed score across each of the three scales on the ProQOL rather than an average score. While this does not address completely the potential problem of people refusing items due to avoidance, it does reduce the potential of misinterpretation of scores. For example, if an average score is used, there is the potential of having an abnormally low average if items are skipped and no adjustment is made in the denominator. In this case, a person who scored a 5 on each of 2 items, rejecting the other 8, would have an average score of 1. If you weight the average, then you have an average score of 5, but since data are missing on the other 8 items, you would not know if the person was reporting severe difficulty (e.g., mean 5) or if they had two areas that were troublesome and 8 that were not. With a summed score, this same case would score as 10 out of 50. While this still does not speak directly to the rejected items, because the interpretation of the score is based on distributions from the databank that includes over 2000 people across the various versions, we do have an ability to interpret that score in perspective.

To score the ProQOL, reverse items 1, 4, 15, 17, and 29 then score the three scales (Compassion Satisfaction Scale, Burnout Scale, and Trauma/Compassion Fatigue Scale) of the ProQOL. It is important to note that 0 remains 0 when scores are reversed as it always denotes the absence of the construct.

```
RECODE pq1 pq4 prq15 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,p20,pq22,pq24,pq27,pq30).
```

COMPUTE BO = SUM(pq1r,pq4r,pq8,pq10,pq15r,pq17r, pq19, pq21, pq26, pq29r).
COMPUTE Trauma = SUM(pq2,pq5,pq7,pq9,pq11,pq13,pq14,pq23, pq25,pq28).

Below are the scale definitions and the average scores. This is reported on the scoring handout provided to individuals when they are given their scores.

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

The average score is 37 (SD 7; alpha scale reliability .87). About 25% of people score higher than 42 and about 25% of people score below 33. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 33, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

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

The average score on the burnout scale is 22 (SD 6.0; alpha scale reliability .72). About 25% of people score above 27 and about 25% of people score below 18. If your score is below 18, this probably reflects positive feelings about your ability to be effective in your work. If you score above 22, 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.

Compassion Fatigue/Secondary Trauma: CF/STS and related to VT is about your work-related, secondary exposure to extremely stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called VT. If your work puts you directly

in the path of danger, such as being a soldier or humanitarian aide worker, 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 in an emergency room or working with child protective services, this is secondary exposure. The symptoms of CF/STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 13 (SD 6; alpha scale reliability .80). About 25% of people score below 8 and about 25% of people score above 17. If your score is above 17, 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 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 (figure 6): The measure is best used in its continuous form. However, many people prefer to have cut scores to indicate relative risks or protective factors. Accordingly, a conservative quartile method is used with high (top 25%), middle 50%, and the low (bottom 25%), generally useful for screening, except close to the borders of the cut points. At the borders, extreme caution should be exercised with any decision making. 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. New data are being collected and if there are ways to improve the scoring, this information will be posted as soon as it is available. Currently, there are several studies using the ProQOL format. If you are willing to donate your raw data to the databank, we will run your sample against the existing database for you.

Figure 6: General Quartile Cut-Points

	Compassion Satisfaction	Burnout	Compassion Fatigue/ Sec Traumatic
Bottom Quartile	33	18	8
Mid-point	37	22	13
Top Quartile	42	27	17

VI. MISSING DATA

A decision must be made about how missing data are coded. For example, if a person chooses to score 5 items across the 30, did they mean that the blank cells were intended to be 0 (no problem) or were they rejecting the items because of avoidance typically associated with traumatic stress reactions? It is nearly impossible to discern the cause of missing data. The electronic version of the testing solves this by providing a pre-fill of 0 and asking participants to select a non-0 number if they do not agree with the 0. Based on comparisons between the pre-fill method and the paper method, it appears that a reasonably reliable decision rule is to assume 0 for missing data *if* there are items responded to across the range of the scale (*Decision Rule 1*). For example, if a person responded to items 1, 3, 6, 15, 19, and 30, it is reasonable to assume that they just assumed 0 (no problem) for the non-marked item. Alternately, if a person begins the scale, filling in data for every item and then discontinues, the decision rule is to exclude that case as incomplete (*Decision Rule 2*). Occasional missing data (the current decision rule is <10% or 3 items) may be coded as “missing” and due to the sum method of scoring is not likely to affect the overall averages (*Decision Rule 3*). Cases with more than 10% missing data that do not qualify for Decision Rule 1 or Decision Rule 2 should be excluded (*Decision Rule 4*). In rare cases, interpolation methods may be used for filling in the missing data. In this case, the sample with interpolated

data should be compared statistically to the sample with the cases excluded and a thoughtful decision should be made as to which sample to use based on the distribution shape and violations of the assumptions of the planned statistical tests. We recommend that if using interpolated data changes the shape of the distribution by any of the first four moments (e.g., mean, standard deviation, skew and kurtosis), the interpolated data should not be used.

VII. MANUAL REFERENCES

- Campbell, D.T., & Fiske, D.W. (1959). Convergent and discriminant validation by the multitrait—multimethod matrix. *Psychological Bulletin*, 56, 81-105.
- Figley, C.R. (1995). *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York: Brunner Mazel.
- 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.
- Jenkins, S.R. & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: a validation study. *Journal of Traumatic Stress*, 15, pp. 423-432.
- Larsen, D. Stamm, B.H., & Davis, K. (2002). Telehealth for Prevention and Intervention of the Negative Effects of Caregiving. *Traumatic StressPoints*, 16, (4).
- Stamm, B.H. (1999). *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers and Educators*, 2nd Ed. Lutherville, MD: Sidran Press.
- 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. *Treating Compassion Fatigue*. New York: Brunner Mazel.
- Stamm, B. H. (2005). The ProQOL. www.isu.edu/~bhstamm.

VIII. BIBLIOGRAPHY

Publications about the Various Versions of the ProQOL (including CFST and the CSF)

The Compassion Fatigue Scale has been established, presented, and published in several articles/chapters including, among others, the following:

- Clemens, L.A. (1999). Secondary traumatic stress in rape crisis counselors: A descriptive study [thesis]. California State University, Fresno, M.S. thesis; Masters Abstracts 37/06: 1965.
- Figley, C.R. (1998). Burnout as systemic traumatic stress: A model for helping traumatized family members. In C.R. Figley (Ed.), *Burnout in families: the systemic costs of caring*, pp. 15-28. Boca Raton, FL: CRC Press.
- Figley, C.R. (1995). *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York: Brunner Mazel.
<http://www.opengroup.com/open/dfbooks/087/0876307594.shtml>
- Figley, C.R. (1999). Compassion Fatigue. In B. H. Stamm, (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators*, 2nd Ed. Lutherville, MD: Sidran Press.
<http://www.sidran.org/catalog/stss.html>
- Figley, C.R. (1999). Police compassion fatigue (PCF): Theory, research, assessment, treatment, and prevention. In Violanti, J.M., & Paton, D. (Eds.). *Police trauma: Psychological aftermath of civilian combat*, 37-53. Springfield, IL: Charles C. Thomas.
- Garrett, C.. (1999). Stress, coping, empathy, secondary traumatic stress and burnout in healthcare providers working with HIV-infected individuals [dissertation]. New York University, Ph.D. dissertation; Dissertation Abstracts International 60/04-A: 1329.
- Gentry, J.E., Baranowsky, A.B., & Dunning, K. (2002). ARP: The Accelerated Recovery Program (ARP) for compassion fatigue. In Figley, C.R. (Ed.), *Treating compassion fatigue*, pp. 123-137. New York: Brunner-Routledge.

- Jenkins, S.R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress*, 15, pp. 423-432.
- Landry, L.P. (1999). Secondary traumatic stress disorder in the therapists from the Oklahoma City bombing [dissertation]. University of North Texas, 1999.
- Nelson-Gardell, D., & Harris, D. (2003). Childhood abuse history, secondary traumatic stress, and child welfare workers. *Child Welfare* 82, 5-26.
- Ortlepp, K., & Friedman, M. (2002). Prevalence and correlates of secondary traumatic stress in workplace lay trauma counselors. *Journal of Traumatic Stress*, 15, 3, pp. 213-222. Full text available at <http://dx.doi.org/10.1023/A:1015203327767>
- Ortlepp, K., & Friedman, M. (2001). The relationship between Sense of Coherence and indicators of secondary traumatic stress in non-professional trauma counsellors. *South African Journal of Psychology*, 31, 2, 38-45.
- Rudolph, J.M, Stamm, B.H., & Stamm, H.E. (November, 1997). Compassion Fatigue: A Concern for Mental Health Policy, Providers and Administration. Poster presented at the 13th Annual Conference of the International Society for Traumatic Stress Studies, Montreal, CA. <http://www.isu.edu/~bhstamm/pdf/ISTSS97cf.PDF>
- Salston, M.G. (2000). Secondary traumatic stress: a study exploring empathy and the exposure to the traumatic material of survivors of community violence [dissertation]. Florida State University, 2000. UMI, order no. AAT 9990396
- 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. *Treating Compassion Fatigue*. New York: Brunner Mazel.
- Stamm, B.H. (April 1997). Mental Health Research in Telehealth. Invited address at From Research to Practice: A Conference on Rural Mental Health Research, National Institute of Mental Health. Oxford, MS.
- Steed, L.G., & Bicknell, J. (2001) Trauma and the therapist: the experience of therapists working with the perpetrators of sexual abuse. *Australasian*

Journal of Disaster and Trauma Studies, 2001, 12(001). Available online at <http://www.massey.ac.nz/~trauma/issues/2001-1/steed.htm>

Wee, D.F., & Myers, D.G. (2002). Stress response of mental health workers following disaster: the Oklahoma City bombing. Figley, C.R. (Ed.). *Treating compassion fatigue*, pp. 57-83. New York: Brunner-Routledge.

White, G.D. (1998). Trauma treatment training for Bosnian and Croatian mental health workers. *American Journal of Orthopsychiatry*, 68(1), pp. 58-62.

White, S.D. (2001). A microethnography of secondary traumatic stress in hospice culture [dissertation]. Florida State University, 2001.

Publications on the Construct of Compassion Fatigue/Secondary Traumatic Stress/Vicarious Trauma Professional Quality of Life

Pearlman, L., et al. (2000). Traumatic Stress Institute & Center for Adult & Adolescent Psychotherapy, LLC Web site <http://www.tsicaap.com>

Pearlman, L., et al. (1999). *Risking Connections*. Sidran Press. <http://www.riskingconnection.com/>

Pearlman, L., & Saakvitne, K. (1995). *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. New York: WW Norton.

Figley, C.R. (1998). *Traumatology E-Journal* Web Site. <http://psy.uq.edu.au/PTSD/trauma/j1.html>.

Stamm, B.H. (1999). *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers and Educators*, 2nd Ed. Lutherville, MD: Sidran Press. <http://www.sidran.org/catalog/stss.html>

Stamm, B.H. (1999). Creating virtual community: Telehealth and self-care updated. In B.H. Stamm (Ed.), *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers and Educators*, 179-208, 2nd Ed. Lutherville, MD: Sidran Press. <http://www.isu.edu/~bhstamm/vircom.htm>

Stamm, B.H. (1997). Work-related Secondary Traumatic Stress. *PTSD Research Quarterly*, (8) 2, Spring. <http://www.ncptsd.org/PDF/RQ/V8N2.PDF>

- Stamm, B.H. (1997). Work-related Secondary Traumatic Stress (reprint). *Anxiety Disorders Association of America Reporters*, Summer/Fall.
- Stamm, B.H. (1998). Rural-Care: Crossroads of Health Care, Culture, Traumatic Stress & Technology Web Site
<http://www.isu.edu/~bhstamm>
- Stamm, B.H. (1998). Traumatic Stress Secondary Traumatic Stress Web Site.
<http://www.isu.edu/~bhstamm/ts.htm>

General Reference List for Construct of Compassion Fatigue/Secondary Traumatic Stress/Vicarious Traumatic Stress

- Arvay, M.J. Narratives of secondary traumatic stress: stories of struggle and hope [dissertation]. University of Victoria (Canada), 1998.
- Baranowsky, A.B. (2002). The silencing response in clinical practice: on the road to dialogue. Figley, C.R. (Ed.), *Treating compassion fatigue*, pp. 155-170. New York: Brunner-Routledge.
- Beaton, R.D., & Murphy, S.A. (1995). Working with people in crisis: Research implications. Figley, C.R. (Ed.). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 51-81. New York: Brunner/Mazel.
- Catherall, D.R. (1995). Preventing institutional secondary traumatic stress disorder. Figley, C.R. (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 232-247. New York: Brunner/Mazel.
- Cerney, M.S. (1995). Treating the "heroic treaters" Figley, C.R. (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 131-149. New York: Brunner/Mazel.
- Clemens, L.A. Secondary traumatic stress in rape crisis counselors: a descriptive study [thesis]. California State University, Fresno, 1999.
- Dutton, M.A., & Rubinstein, F.L. (1995). Working with people with PTSD: Research implications. Figley, C.R. (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 82-100. New York: Brunner/Mazel.

- Figley, C.R. (Ed.). (1995) *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel.
- Figley, C.R. (Ed.). (2002). *Treating compassion fatigue*. New York: Brunner-Routledge.
- Figley, C.R. (1998). Burnout as systemic traumatic stress: a model for helping traumatized family members. Figley, C.R. (Ed.), *Burnout in families: the systemic costs of caring*, pp. 15-28. Boca Raton, FL: CRC Press.
- Figley, C.R. (1995). Compassion fatigue as secondary traumatic stress disorder: an overview. Figley, C.R. (Ed.), *Compassion fatigue : coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 1-20. New York: Brunner/Mazel.
- Figley, C.R. (1995). Compassion fatigue: toward a new understanding of the costs of caring. Stamm, B.H. (Ed.), *Secondary traumatic stress: self-care issues for clinicians, researchers, and educators*, pp. 3-28. Lutherville, MD: Sidran Press.
- Figley, C.R. (1999). Police compassion fatigue (PCF): Theory, research, assessment, treatment, and prevention. Violanti, J.M., & Paton, D. (Eds.), *Police trauma: Psychological aftermath of civilian combat*, pp. 37-53. Springfield, IL: Charles C. Thomas.
- Figley, C.R., Giel, R., Borgo, S., Briggs, S., & Haritos-Fatouros, M. (1995). Prevention and treatment of community stress: How to be a mental health expert at the time of disaster. Hobfoll, S.E., & De Vries, M.W. (Eds.), *Extreme stress and communities: Impact and intervention*, pp. 489-497. Dordrecht, The Netherlands: Kluwer Academic Publishers.
- Garrett, C. Stress, coping, empathy, secondary traumatic stress and burnout in healthcare providers working with HIV-infected individuals [dissertation]. New York University, 1999.
- Gentry, J.E., Baranowsky, A.B., & Dunning, K. (2002). ARP: the Accelerated Recovery Program (ARP) for compassion fatigue. Figley, C.R. (Ed.), *Treating compassion fatigue*, pp. 123-137. New York: Brunner-Routledge.
- Harris, C.J. (1995). Sensory-based therapy for crisis counselors. Figley, C.R. (Ed.), *Compassion fatigue: coping with secondary traumatic stress*

- disorder in those who treat the traumatized*, pp. 101-114. New York: Brunner/Mazel.
- Horton, C.B., & Cruise, T.K. (2001). *Child abuse and neglect: the school's response*. New York: Guilford Press.
- Lahad, M. (2000). Darkness over the abyss: supervising crisis intervention teams following disaster. *Traumatology*, 6, 4, pp. 273-293.
- Landry, L.P. Secondary traumatic stress disorder in the therapists from the Oklahoma City bombing [dissertation]. University of North Texas, 1999.
- McCammon, S.L., & Allison, E.J. (1995). Debriefing and treating emergency workers. Figley, C.R. (Ed.), *Compassion fatigue : coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 115-130. New York: Brunner/Mazel.
- Meldrum, L., King, R., & Spooner, D. (2002). Secondary traumatic stress in case managers working in community mental health services. Figley, C.R. (Ed.), *Treating compassion fatigue*, pp. 85-106. New York: Brunner-Routledge.
- Meyers, T.W., & Cornille, T.A. (2002). The trauma of working with traumatized children. In Figley, C.R. (Ed.), *Treating compassion fatigue*, pp. 39-55. New York: Brunner-Routledge.
- Miller, L. (1998). Hitting home: traumatized psychotherapists and the stresses of doing therapy. In Miller, L. (Ed.), *Shocks to the system: psychotherapy of traumatic disability syndromes*, pp. 249-269. New York: Norton.
- Moran, C.C. (2002). Humor as a moderator of compassion fatigue. Figley, C.R. (Ed.), *Treating compassion fatigue*, pp. 139-154. New York: Brunner-Routledge.
- Munroe, J.F., Shay, J., Fisher, L.M., Makary, C., Rapperport, K., & Zimering, R.T. (1995). Preventing compassion fatigue: a team treatment model. Figley, C.R. (Ed.), *Compassion fatigue : coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 209-231. New York: Brunner/Mazel.

- Myers, D.G., & Wee, D.F. (2002). Strategies for managing disaster mental health worker stress. Figley, C.R. (Ed.), *Treating compassion fatigue*, pp. 181-211. New York: Brunner-Routledge.
- Ortlepp, K., & Friedman, M. (2002). Prevalence and correlates of secondary traumatic stress in workplace lay trauma counselors. *Journal of Traumatic Stress*, 15, 3, pp. 213-222.
- Ortlepp, K., & Friedman, M. (2001). The relationship between Sense of Coherence and indicators of secondary traumatic stress in non-professional trauma counsellors. *South African Journal of Psychology*, 31, 2, pp. 38-45.
- Pearlman, L.A., & Saakvitne, K.W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. Figley, C.R. (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 150-177. New York: Brunner/Mazel.
- Pickett, M., Brennan, A.M.W., Greenberg, H.S., Licht, L., & Worrell, J.D. (1994). Use of debriefing techniques to prevent compassion fatigue in research teams. *Nursing Research*, 43, 4, pp. 250-252.
- Salston, M.G. Secondary traumatic stress: a study exploring empathy and the exposure to the traumatic material of survivors of community violence [dissertation]. Florida State University, 2000.
- Schwam, K. (1998). The phenomenon of compassion fatigue in perioperative nursing. *AORN Journal*, 68, 4, pp. 642-648.
- Stamm, B.H. (2002). Measuring compassion satisfaction as well as fatigue: developmental history of the Compassion Satisfaction and Fatigue Test. Figley, C.R. (Ed.), *Treating compassion fatigue*, pp. 107-119. New York: Brunner-Routledge.
- Valent, P. (2002). Diagnosis and treatment of helper stresses, traumas, and illnesses. Figley, C.R. (Ed.). *Treating compassion fatigue*, pp. 17-37. New York: Brunner-Routledge.
- Valent, P. (1995). Survival strategies: A framework for understanding secondary traumatic stress and coping in helpers. Figley, C.R. (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 21-50. New York: Brunner/Mazel.

- Wee, D.F., & Myers, D.G. (2002). Stress response of mental health workers following disaster: The Oklahoma City bombing. Figley, C.R. (Ed.), *Treating compassion fatigue*, pp. 57-83. New York: Brunner-Routledge.
- White, G.D. (2002). Trauma treatment training for Bosnian and Croatian mental health workers. Figley, C.R. (Ed.), *Treating compassion fatigue*, pp. 171-179. New York: Brunner-Routledge.
- White, G.D. (1998). Trauma treatment training for Bosnian and Croatian mental health workers. *American Journal of Orthopsychiatry*, 68, 1, pp. 58-62.
- White, S.D. A microethnography of secondary traumatic stress in hospice culture [dissertation]. Florida State University, 2001.
- Yassen, J. (1995). Preventing secondary traumatic stress disorder. Figley, C.R. (Ed.), *Compassion fatigue : coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 178-208. New York: Brunner/Mazel.

VIV. FREQUENTLY ASKED QUESTIONS

1. I understand that the ProQOL 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.isu.edu/~bhstamm).
2. 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.
3. 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.
 - b. For Free: You may download the measure and other information about it for free from www.isu.edu/~bhstamm.
 - c. At Cost: Through an agreement with the non-profit/charity organization The Sidran Foundation (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>.
4. 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.
5. 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.
6. 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.
7. How is the ProQOL typically used?
- a. People typically use the ProQOL one of three ways
 - i. For research studies.
 - ii. To monitor the professional quality of life among staff at an organization like a state’s social workers or group such as aid workers.
 - iii. To self-monitor one’s status for personal interest.
8. 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.

9. 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.
10. 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.isu.edu/~bhstamm. We recommend that you check the PILOTS database at the National Center for PTSD for additional references <http://biblioline.nisc.com/scripts/login.dll>.
11. 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 <http://telida.isu.edu> under the Aid Worker link. There is additional more technical information at www.isu.edu/~bhstamm. Please note that much of the information at the Aid Worker site is also located at the ~bhstamm site. If you are looking for handouts and a quick overview, the Aid Worker Site is the best location. If you are looking for more scientific and research detailed information, go to www.isu.edu/~bhstamm.
12. 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!

13. 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.
14. 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.
15. Can you give me the psychometric information about the measure?
 - a. Reliability and validity information is contained in the ProQOL Manual which can be obtained from Sidran.org or at our website at www.isu.edu/~bhstamm.
16. What norms do I use?
 - a. The general norms are available in the ProQOL manual (see www.sidran.org or www.isu.edu/~bhstamm for a copy) and on the scoring sheet. These are the best norms at this time.
17. What are the cut scores for the measure?
 - a. We provide norms at the 25th and 75th 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 25th and 75% percentiles provided with the norms.

18. When I reverse the scores, what do I do with the 0 score?

- a. 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.

19. 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.

20. If I donate a copy of my data to the databank, will I loose 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.

21. 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.

22. 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.