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How Early Education and Pet Therapy May Help Nurses With Compassion Fatigue

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Doctor of Education in Organizational Leadership

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by

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Dedication

I dedicate this research to all the nurses and health care workers who are experiencing compassion fatigue. Please know that you are not alone and it will get better. Also, I dedicate this study to the future nurses who are on their path to learning. Please remember to care for yourself as well as you will care for your patients.

I also dedicate this work to my past and current fur babies, and all the furry friends I have made along the way and will make in the future. I believe your unconditional love makes our lives better by teaching us to be kinder and more compassionate to others. Thank you for being you.

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Abstract

Although there is a great deal of research on the causes of compassion fatigue, there is little research on prevention techniques or ways to combat compassion fatigue. The purpose of this qualitative phenomenological study was to discover if nurses are prepared to cope with occupational stress and compassion fatigue. A secondary purpose was to examine the perceived benefit that pet therapy can have as a possible stress reduction technique to decrease the effects of compassion fatigue. This research was conducted by gathering data via semistructured interviews. The researcher interviewed nurses who were currently practicing patient care and scored as moderate or high risk for compassion fatigue on the Professional Quality of Life Scale. The study sample consisted of six nurses. Data were analyzed using an interpretative phenomenological analysis approach. The research findings indicated that compassion fatigue elevates the level of distress nurses experience while caring for patients, affecting their ability to be servant leaders. The results also illuminated a perceived lack of education to prepare nurses for the challenges they would likely face during their career, as well as the perceived benefit of pet therapy on nurses' ability to manage their occupational stress and possibly decrease the effects of or cope with compassion fatigue.

Keywords: nurses, compassion fatigue, pet therapy, servant leader, education

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Chapter 1: Introduction

Houck (2014) described a traditional Native American teaching regarding health care workers: “It is said that each time you heal someone you give away a piece of yourself until at some point, you will require healing” (p. 455). Unique challenges face health care workers who care for patients. Nursing, in particular, is viewed as a stressful occupation because of the emotionally demanding nature of a nurse’s work. Unfortunately, stress may be an unavoidable part of a nurse’s job. It can lead to unhealthy behaviors and is associated with negative physical health outcomes and psychological distress (Deasy et al., 2014). To cope with stress, Houck (2014) recommended nurses learn the importance of work–life balance, self-care strategies, and communication skills.

Just as nurses care for patients and their families, they must care for themselves too. Strategies for managing the effects of stress are recommended to prevent and treat compassion fatigue (Houck, 2014). According to the American Nurses Association, nurses who prioritize self-care practices may see work–life balance, a sense of coherence, and reduced feelings of burnout, which is a precursor to compassion fatigue (Mac Leod Dyess et al., 2018). Compassion fatigue is emotional and physical exhaustion that leads to diminished ability to empathize or feel compassion for others (Houck, 2014). Since nurses are servant leaders, if they suffer from compassion fatigue, they may not be able to lead their patients or coworkers successfully.

Background

It is essential for nurses to learn a healthy way to manage their stress. If they do not do so, a possible result is compassion fatigue, which can lead to nurses leaving their bedside patient care role (Sacco et al., 2015). Researchers have explored this problem from the perspective of the causes of compassion fatigue. Still, there is a lack of research regarding prevention techniques or

ways to combat compassion fatigue. If researchers do not study this problem, the nursing shortage may continue. Since compassion fatigue can affect nurses at any stage of their career, it is important they learn the risks and prevention techniques early and have continued access to resources and support from their organizational leadership. According to Sinclair et al. (2017), the physical, social, emotional, and spiritual health of health care professionals is impaired by the growing stress related to their work, which can impact their ability to perform their work. The repetitive task of caring for others is a daily responsibility for nurses, which can lead to compassion fatigue. In addition, the emotional burden of caring for critically ill patients and their families, combined with the increasingly complex issues of health care, significantly drives the prevalence of compassion fatigue (Romano et al., 2013). Not only can it manifest as physical signs and symptoms in the nurse, but it can impact the patient care given as well.

Since nurses are servant leaders, their inability to lead their patients and other members of the medical community can have detrimental outcomes (Penny, 2017). Servant leadership begins with the natural feeling of wanting to serve others, followed by the choice to lead (van Dierendonck, 2011). A primary role of nurses is to be a patient servant. Being a patient servant requires compassion (Penny, 2017). Servant leadership is directly related to patient satisfaction through nurse job satisfaction (Neubert et al., 2016). Compassion fatigue decreases job satisfaction (Sacco et al., 2015). Therefore, if a nurse is experiencing compassion fatigue, they will have difficulty being a servant leader. According to Kelly and Todd (2017), nearly 20% of nurses leave their positions within the first year, and many leave the profession altogether. In addition to the damaging effects of stress on nurses' health and well-being, stress is a major contributor to shortages in the nursing profession (Hersch et al., 2016). Therefore, coping with occupational stress is important for nurses.

Coping can help people reduce, minimize, or tolerate stress and prevent psychological distress (Deasy et al., 2014). Coping is a process involving cognitive and emotional attempts to deal with the internal or external demands of the current stressor (Deasy et al., 2014). Managing stress may look different for everyone, but it is crucial to ensure coping mechanisms are healthy. There is a significant volume of literature on approaching compassion fatigue as a condition to be treated after showing signs both in personal and work life. Unfortunately, by this time, compassion fatigue is already a problem, and possible interventions may no longer be effective. This is why a focus on stress reduction and coping mechanisms is critical for nurses throughout their careers, beginning in their training. There have been limited studies examining the effectiveness of stress reduction and coping with stress programs for health care providers (Meyer et al., 2015). By preventing nurses from reaching this point, administrators can improve nurses' health and job satisfaction, create organizational engagement, increase retention rates, and reduce nurses' risk of developing compassion fatigue.

Statement of the Problem

Compassion fatigue is a problem in health care. It is stress caused by the emotional burden of helping people who are suffering (Gentry, 2018). Between 40% and 85% of individuals in a helping profession develop compassion fatigue and may also proceed to develop traumatic stress symptoms (Dreher et al., 2019). Nurses have a higher incidence of developing this condition because of the connection they can make with their patients and families (Henson, 2017). Unfortunately, compassion fatigue is not always avoidable. Causes of this, such as a low nurse–patient ratio, lack of support, patient demographics, and understaffed conditions are out of the nurse's control (Ko & Kiser-Larson, 2016; Mattioli et al., 2018). Compassion fatigue can lead to an unsatisfactory work environment, burnout, or leaving the profession (Sacco et al.,

2015). As more nurses leave the profession, the already present shortage worsens, putting additional strain on nurses who remain (Austin et al., 2017; Howard & Navega, 2018).

A contributing factor to compassion fatigue is the lack of early education in a nurse's career, such as during nursing school (Merriman, 2015). Novice nurses can develop compassion fatigue and may be more at risk because they have not learned what activities can reenergize them to help better respond to the needs of others (Kolthoff & Hickman, 2017). Mattioli et al. (2018) claimed that "knowledge of compassion fatigue can increase awareness and lead to better implementation of preventive strategies" for nurses (p. 323). If nurses can identify and recognize burnout and compassion fatigue early, then health care organizations may enhance long-term retention, increase nurse engagement and satisfaction, and promote nursing professional development (Kolthoff & Hickman, 2017). As stated previously, researchers have not adequately addressed mechanisms or techniques to help nurses combat compassion fatigue. If these could be introduced to nursing students, then nurses may be able to increase their likelihood of recognizing compassion fatigue and managing it early.

Purpose of the Study

The purpose of this phenomenological research study was to discover if nurses are prepared to cope with occupational stress and compassion fatigue. Another purpose was to examine one form of coping—what nurses think about pet therapy as a possible stress reduction technique to decrease the effects of compassion fatigue. I anticipated this study would take place at a large hospital located in north-central Texas. Changes to recruitment and the study's sample are detailed in Chapter 4.

Research Questions

The following research questions guided this study:

RQ1: What effects does compassion fatigue have on the level of distress experienced by nurses while serving patients?

RQ2: What education do nursing schools offer to prepare nurses to cope with occupational stress and combat compassion fatigue in their role as a servant leader?

RQ3: What perception of pet therapy do nurses have as a potential management technique for occupational stress and compassion fatigue?

Definition of Key Terms

The following key terms are an important part of this research study.

Burnout. Burnout is long-term stress that causes difficulty in performing daily responsibilities, resulting in ineffectiveness and exhaustion (Sacco & Copel, 2018). It may be considered both a precursor to and result of compassion fatigue, and it occurs in other professions outside of nursing.

Compassion fatigue. Compassion fatigue is emotional and physical exhaustion that can lead to diminished ability to empathize or feel compassion for others (Houck, 2014). It is more commonly found in caregivers and is sometimes considered the negative cost of caring for others.

Compassion satisfaction. Compassion satisfaction is the positive feelings derived from caregiving and the desire to help others in their time of need (Sacco & Copel, 2018). When compassion satisfaction is low, a nurse is at greater risk of developing compassion fatigue.

Coping. Coping is the act of managing something difficult, particularly a situation. Coping strategies are important to manage stress, which is especially true for nurses (Houck, 2014).

Moral distress. Moral distress occurs when one knows the right thing to do but is unable to pursue the correct course of action due to factors outside their control (Fernandez-Parsons et al., 2013). It can lead to burnout, compassion fatigue, and nurse attrition.

Occupational stress. Occupational stress is ongoing pressure an employee experiences due to the responsibilities, conditions, or environment of the workplace. For nurses, occupational stress is normal, but if it progresses without coping strategies, it can lead to negative outcomes (Laukhuf & Laukhuf, 2016).

Pet therapy. Pet therapy is a form of complementary and alternative medicine where animals are used as an integral part of the treatment (Goddard & Gilmer, 2015). This health intervention is meant to improve physical, social, emotional, or cognitive functioning (Bert et al., 2016). It can also be referred to as animal-assisted therapy.

Servant leadership. Servant leadership is a proposed leadership style where the leader's main purpose is to serve. Nurses are examples of servant leaders (Northouse, 2016).

Summary

As stated, compassion fatigue is a problem in nursing (Houck, 2014). It can lead to negative consequences for the nurses experiencing it and for their coworkers, patients, and family members. It can also decrease the effectiveness of servant leadership (Penny, 2017). Early exposure to the topics of managing occupational stress and compassion fatigue in nurses' careers can better prepare them to adapt and cope (Merriman, 2015). However, since compassion fatigue may be unavoidable in some cases, alternative medicine treatments such as pet therapy can be effective coping mechanisms. This study focused on experiences nurses have with compassion fatigue, how it affects their ability to serve their patients, and whether nursing school prepared them for occupational stress reduction and recognizing compassion fatigue. A secondary focus

was to obtain nurses' perspectives on the effect of pet therapy as a stress management technique and potential intervention for coping with compassion fatigue.

Chapter 2: Literature Review

Nurses must learn to manage and reduce their stress to care for themselves and their patients adequately. As stated, poor management of stress can have negative consequences, including compassion fatigue and burnout (He et al., 2018). These problems can cause nurses to leave the profession, further contributing to understaffed conditions due to existing shortages and placing more stress on current nursing staff (Hersch et al., 2016; Sacco et al., 2015). Since nurses are considered servant leaders, compassion fatigue can also lead to poor leadership due to their inability to serve patients adequately (Penny, 2017). Early exposure in a nurse's career or education to the topics of compassion fatigue and managing occupational stress may help with early recognition of the problem (Merriman, 2015).

There are several ways to manage stress, which can help nurses prevent or decrease the effects of compassion fatigue. Self-care is one important strategy that is often neglected by nurses. Self-care is the process of engaging in activities to establish and maintain health (Andrews et al., 2020). It ensures people's fundamental needs are met so they have the ability to respond to conflict, overcome challenges, and cope more effectively with stress (Keesler & Troxel, 2020). Far too often, nurses push aside their needs while serving others, a quality of servant leadership. "Care for yourself so you can care for others" is an adage that is easy to forget during a busy nursing shift (Halm, 2017, p. 344). Existing literature reveals that nurses believe their self-care and well-being are not priorities because they lack an awareness of how ignoring their own needs may jeopardize their ability to care for others (Andrews et al., 2020; Couser, 2020; Halm, 2017). Poor self-care practice is found to be associated with greater compassion fatigue (Keesler & Troxel, 2020). Nurses are known to be compassionate to their patients, but it is important they learn to be compassionate towards themselves. Increasing

compassion for oneself was found to decrease stress and improve staff well-being and patient care (Andrews et al., 2020). One way to improve self-care and compassion is through the support of others. Social and emotional support can positively influence an individual's self-care behaviors (Graven & Grant, 2014). This support can come from coworkers, work leaders, family members, friends, and support groups. Family members can include pets and support groups, and the work environment can include pet therapy. I believe pet therapy is one effective social and emotional support method that has been relatively unexplored for nurses.

Pet owners reported that their pet was a strong source of motivation, companionship, and social support (Friedmann et al., 2015). Thus, pet therapy is one possible way to help nurses with stress relief, but more research is needed. There is documented evidence of the benefits animals can have on stress relief and mental and physical health (Bert et al., 2016; González-Ramírez et al., 2013; González-Ramírez & Hernandez, 2014; Levine et al., 2013; Polheber & Matchock, 2014; Utz, 2014). However, these studies are usually aimed toward helping patients with documented medical illness, not health care workers. Since interacting with animals usually involves touch and since physical contact combined with emotional support have been found effective in reducing stress responses, it is reasonable to assume pet therapy would be beneficial to reduce stress in nurses (Beetz, 2017). Animal interactions can force nurses to slow down and take some time for themselves while providing nurses the opportunity to be taken care of since they are usually the ones who do the caring. Interacting with a therapy or family pet has been identified as an effective behavioral strategy that results in a form of social support (Friedmann et al., 2015). Companion animals can provide social support through reducing loneliness, being constantly available, and providing nonjudgmental support and unconditional love (O'Haire, 2010). These conditions are often not present in human relationships. Animal intervention can

help nurses because of the stress-buffering effect that can occur while interacting with an animal, causing a moment of relaxation (O'Haire, 2010). Again, I believe that pet therapy is an effective method to provide support for nurses and improve their self-care practices, but more research is needed.

In this study, I focused on nursing stress and compassion fatigue, including the education the participants received on these topics while in nursing school and whether that had any effect on their ability to combat compassion fatigue. I also examined their perception of what effects pet therapy can have on this problem. The problem explored in this study was the effects of compassion fatigue in the nursing field. The purpose was to discover if early education on compassion fatigue could help nurses identify it in themselves or their coworkers, therefore managing this problem before negative consequences could occur. A secondary purpose was to explore whether nurses believed pet therapy could help them better manage their occupational stress and cope with compassion fatigue. Ultimately, the goal was to discover possible ways for nurses to manage their occupational stress and cope with compassion fatigue to improve their mental health and career longevity and find one possible way to slow the increasing nursing shortage. This chapter has two main sections. The first section is the theoretical framework for this study. Three theories are presented below to support this research: the servant leadership theory, moral distress theory, and the human–animal bond theory. In the second section, I present the literature on compassion fatigue in nursing, stress in undergraduate nursing students, and the benefits of, as well as barriers to, pet therapy with this population.

Literature Search Methods

Even though compassion fatigue has been identified as a problem in nursing, there has been little focus on prevention or coping (Deasy et al., 2014; Houck 2014; Kelly & Todd, 2017;

Mac Leod Dyess et al., 2018; Romano et al., 2013; Sacco et al., 2015; Sinclair et al., 2017). To begin the research, the focus was on the main topics of compassion fatigue and occupational stress and the conceptual frameworks of servant leadership, moral distress, and human–animal bond theories. Only peer-reviewed literature was used. I searched for articles using the following terms: *servant leadership theory*, *nurses*, *compassion fatigue*, *human-animal bond*, *animal-assisted therapy*, *pet therapy*, *occupational stress*, *college students,* and *stress*. Then I expanded my search to include more topics, such as moral distress, burnout, and compassion satisfaction.

Theoretical Framework Discussion

Servant Leadership Theory

Nurses are servant leaders. They have a responsibility to place patients' needs first. Although an exact definition of servant leadership varies, it can be described by multiple characteristics. Listening, hearing, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of others, and building community are characteristics identified by Greenleaf, the first person to outline the theory of servant leadership (Fields et al., 2015). Although nurses may not fulfill every one of these descriptions, they perform most of them daily. Nurses must listen and understand what their patients say so that they can help them. Through this understanding and feeling others' emotions, nurses can help their patients, which extends beyond empathy into compassion (Mattioli et al., 2018). Awareness of what is happening with all their patients is important to prioritize multiple responsibilities simultaneously, a requirement for most nurses (Sacco et al., 2015). Foresight, another characteristic of servant leadership, is also important because nurses need to anticipate potential outcomes or changes to be prepared to intervene if needed. Another role for a servant leader is to be a steward. Stewardship is the willingness to take responsibility for someone else and focus on

service instead of control and self-interest (van Dierendonck, 2011). For nurses, this is as a patient advocate. The notion of serving is more important than leading for servant leaders (Fields et al., 2015).

Putting Others First. Putting others first is the defining characteristic of servant leadership. Servant leaders decide to serve first and place the good of followers over the leaders' self-interest (Northouse, 2016). This may not be an easy task but is necessary for helping professions such as health care. In patient-centered care, the patient is the primary focus, but nurses also serve other members of the patient care team (Savel & Munro, 2017). Nurses truly put others first. According to Northouse (2016), a servant leader is also determined to remain modest, calm, and focused on giving credit to others. Nurses usually work as part of a team, so not taking credit and practicing humility are common in their practice (Northouse, 2016; Weinand, 2010). Another way nurses put others first is by remaining calm to avoid panicking patients, their family members, and other members of the patient care team. Servant leadership stresses that leaders pay attention to the concerns of their followers, empathize with them, and nurture them (Northouse, 2016). For nurses, the followers are their patients, so it is important they embody these characteristics. Servant leadership characteristics help define personal responsibility for human growth and relationships, which is essential for the helping professional (Fields et al., 2015). In a study by Neubert et al. (2016), results showed a relationship exists between servant leadership and nurse behavior, leading to increased patient satisfaction. Therefore, patients can benefit from nurses who successfully fill the role of a servant leader. Ultimately, nurses should continually research to gain knowledge about the concepts of service and leadership to adapt to a constantly changing health care environment (Penny, 2017). This continuing education is necessary to provide the best individualized patient care and effective

servant leadership methods. For example, van Dierendonck (2011) recommended that leaders act as caretakers. Nurses already fill this role by caring for patients. Still, nurses must care for themselves as well.

Emotional Support. Emotional healing can function as a responsibility of the servant leader. It involves being sensitive to the personal concerns and well-being of others. It includes recognizing others' problems while being willing to take the time to address them (Northouse, 2016). It is also important that these leaders take time to heal emotionally. Servant leaders who display emotional healing make themselves available to others, stand by them, and support them (Northouse, 2016). To be an effective servant leader, it is important that nurses take the time for self-care. If not, a result can be compassion fatigue and poor leadership (Mac Leod Dyess et al., 2018; Penny, 2017). However, in health care, being a patient servant requires compassion. Providing continuous emotional support and having compassion for others can take a toll on the nurse's mental health (Romano et al., 2013). Nurses also need emotional support, so they can continue to support others. This needs to be a continuous effort to maintain good mental health and be effective in their role (Mac Leod Dyess et al., 2018).

Moral Distress Theory

Moral distress is another negative condition that can affect nurses. Moral distress is the "painful feelings and/or the psychological disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires, but cannot carry out that action because of institutionalized obstacles" (Jameton, 1984, as cited in Corley, 2002, pp. 636–637). Such obstacles include understaffed conditions, inadequate training or preparation, lack of leadership support, hospital policies, family legal rights and wishes, and patient insurance status. The term "moral distress" was originally applied to nurses but has since expanded to doctors and other

health care workers. Moral distress theory, first coined by Corley (2002), explains and predicts the distress that occurs in a nurse because of moral conflict or, in other words, what can happen when they cannot act according to their moral values and convictions (Wilson, 2018). The theory focuses on what happens when a nurse is unable, or feels unable, to advocate for a patient, leading to the experience of moral distress (Corley, 2002). As stated, part of the servant leadership role that nurses fulfill is stewardship in the form of a patient advocate. Since serving as a patient advocate is one of the key responsibilities of a nurse, the inability to do this may cause an internal conflict (van Dierendonck, 2011). The context of this theory includes an internal and external component (Corley, 2002). A nurse's psychological response is internal and includes perceived powerlessness or self-doubt. A nurse's work environment, such as differing caregiver perspectives or inadequate communication, is external (Wilson, 2018). Moral distress will always be present in health care (Corley, 2002; Wilson, 2018). However, more than institutional obstacles can be the cause.

Moral distress may also occur because of the many choices nurses face, many of which can lead to unpredictable outcomes. Nurses encounter moral and ethical situations that influence how they act and their decisions, which directly impacts patient health outcomes (Wilson, 2018). Dilemmas such as providing futile care to a terminal patient, poor communication, and questioning physician orders or diagnoses can lead to stress (Wilson, 2018). The repetition of these decisions can lead to psychological distress and painful feelings, or in other words, moral distress. Jameton (1984, as cited in Fernandez-Parsons et al., 2013) identified two different types of moral distress in nurses: initial and reactive distress. Initial distress appears as frustration, anger, and anxiety when nurses face institutional obstacles and interpersonal conflicts. Reactive distress occurs when a nurse is unable to act on their initial distress and has been shown to lead

to physical symptoms such as anxiety and sadness (Fernandez-Parsons et al., 2013). Moral distress often goes unrecognized in the nurse and can result in emotional anguish, leaving nurses feeling powerless and resulting in job dissatisfaction, resignation, burnout, and feeling the need to distance oneself from patients and families (Fernandez-Parsons et al., 2013; Wilson, 2018). These can all lead to compassion fatigue (Hersch et al., 2016; Houck, 2014; Sacco et al., 2015).

Correlation With Compassion Fatigue. Increased levels of moral distress in nurses have been found to lead to medical errors and compassion fatigue (Fernandez-Parsons et al., 2013). Several of the consequences of moral distress are also consequences of compassion fatigue. Likewise, many of the factors that lead to moral distress can lead to compassion fatigue. Although these terms are not interchangeable, there is a link between them. Studies showed that compassion fatigue had a significant positive correlation with the intensity of moral distress experienced by nurses (Fernandez-Parsons et al., 2013; Saleh et al., 2019). Van Wijlen (2017) claimed moral distress can intensify compassion fatigue. For nurses who provide direct care, the close and continuous contact with the patients they care for can elicit a deep and emotional caring response. This may increase experiences with compassion fatigue, moral distress, and the physical and emotional manifestations associated with both (van Wiljen, 2017). Certain nurse populations may experience moral distress more than others, particularly those who work with extremely sick or terminal patients. Delivering treatments to patients who may not get better, especially when it happens repeatedly, can be a factor in developing moral distress (Wilson, 2018). This is similar to nurses who develop compassion fatigue as a result of the delivery of the continuous compassionate care required by the nursing profession. The chance of developing moral distress and compassion fatigue is increased when nurses do not have the proper training or a good support system in place (Meyer et al., 2015; Sacco et al., 2015; van Wijlen, 2017).

Another common factor between compassion fatigue and moral distress is their effect on new nurses. Although either of these problems can happen to any nurse at any point in their career, newer nurses may not have had the chance to develop moral comfort. Moral comfort, the opposite of moral distress, is the optimal outcome of a moral encounter (Wilson, 2018). In Corley's (2002) model for the moral distress theory, certain moral concepts, such as judgment, conflict, and autonomy, can result in two ways. They can lead to a moral intent to act, which results in moral courage and moral comfort. Conversely, these concepts can also lead to moral suffering and distress, which impacts the nurses negatively and leads to other consequences. Nurses with less experience may not be equipped to handle these concepts yet, leading them down the moral suffering path more often than the comfort path. Fortunately, these are all concepts that can be learned and come naturally with experience. However, the reality remains that many new graduates are already facing compassion fatigue and moral distress and lack the coping mechanisms needed to overcome them (van Wijlen, 2017).

Other Impacts on Nurses. Compassion fatigue is not the only consequence of moral distress. Nurses who experience moral distress are at risk of losing the ability to deliver quality patient care and making clinical mistakes (Giannetta et al., 2020). Not only can this lead to patient safety issues and disciplinary action for the nurse, but that nurse may become deterred from working with patients, forcing the decision to leave bedside care. Like compassion fatigue, nurse turnover can be a result of moral distress. Multiple studies have reported more than 20% of nurses have resigned or have considered leaving a position because of experiencing moral distress (Borhani et al., 2014; Fernandez-Parsons et al., 2013; Rushton et al., 2015). This number increased to 33% in younger nurses (Fernandez-Parsons et al., 2013). This turnover further contributes to understaffed conditions. Besides nurse turnover, other studies highlight the effect

of moral distress on burnout, job satisfaction, and the psychological and physical health of health care workers. These signs and symptoms include anger, anxiety, sadness, headaches, digestive disorders, feelings of guilt, frustration, helplessness, stress, depression, and negative changes in self-image and spirituality (Fernandez-Parsons et al., 2013). Moral distress has a negative impact on nurses and other health care providers, patients, and even the entire health care system (Wilson, 2018).

Human–Animal Bond Theory

Animals have played an important supportive role in humans' lives for many centuries, serving as companions (Silcox et al., 2014). Researchers in the field of anthrozoology, or human–animal studies, developed theories as to why a bond exists between humans and animals (Hosey & Melfi, 2014; Silcox et al., 2014). This study was influenced by the human–animal bond (HAB) theory, specifically the health benefits of the unique bond between humans and animals. Drawing on attachment theory, the HAB theory "provides a comprehensive basis for the explanation of human–animal relationships and the positive effects of human–animal interaction, including the regulation of stress and negative emotions via social support" (Beetz, 2017, p. 144). Attachment theory is an evolutionary theory concerning relationships between humans to promote their social and emotional development (Beetz, 2017). Under attachment theory, the goal of social support is to establish protection and care through the regulation of stress and comfort during negative emotional states. The feeling of safety and security from a social support system enables an exploration of the environment. Animals can also be a part of this relationship, according to HAB theory. An effective HAB involves having (a) a relationship between a human and an individual animal (b) that is reciprocal and persistent and (c) promotes an increase in well-being for both parties (Hosey & Melfi, 2014). Family pets and therapy

animals fall into these categories. As stated, animals can provide the social support nurses need as part of their self-care routines to manage their stress. There are multiple benefits that humans can gain from their connection with animals, and perhaps that connection comes from an instinctual nature.

Biophilia. Under the HAB theory, the biophilia hypothesis suggests there is an instinctive bond between animals and other living systems. As humans evolved, they started depending on animals for survival, creating an instinctive concern and connection hardwired into the human brain (Silcox et al., 2014). The biophilia hypothesis also asserts that a fundamental, genetically based human desire to be around nature exists and that living creatures provide a calming and relaxing effect on nature viewers (Beetz, 2017). Unfortunately, with the increasingly busy lifestyles of modern societies, many people find fewer opportunities to interact with animals and nature (O'Haire, 2010). Frequent exposure to animals may provide a link to human evolutionary history that enhances psychological well-being by allowing humans to reconnect with nature.

Humans have a deep-rooted tendency to feel compassion, closeness, and love toward other living creatures (Weaver, 2015). These feelings can apply to other humans and even animals because of the emotional relationship that exists between humans and animals (Silcox et al., 2014). This relationship can contribute to decreasing the effects of compassion fatigue by allowing the animals to serve in a supportive role for the nurse. Since nurses fill a supportive role for everyone they work with, allowing them to feel supported is needed (Blair & Perry, 2017). Animals can also provide a sense of protection, security, and unconditional love that affects the general well-being of individuals (Silcox et al., 2014). This is important for nurses who experience a high level of occupational stress. Social support and ways to improve their mental health are important to help manage that stress and decrease the likelihood of developing

compassion fatigue (Sacco et al., 2015). In human and companion animal relationships, emotional attachment to an animal may benefit psychological well-being (Silcox et al., 2014).

Benefits. The human–animal bond can benefit people in several ways, including medical, social, behavioral, and psychological aspects. Developing a relationship with an animal leads to positive changes in cognition and behavior due to the development of new skills and the acceptance of responsibility (Krueger & Serpell, 2010, as cited in Silcox et al., 2014, p. 28). Animals can fulfill emotional needs, facilitate learning, provide comfort, promote a sense of safety, and improve self-esteem (O'Haire, 2010). Personal growth, empathy through building rapport, increasing trust, and facilitating a feeling of safety are all characteristics that can be achieved with a companion animal (Silcox et al., 2014). These behaviors are positive and important to improve mental health (Beetz, 2017). Nurses need to maintain good mental health to avoid developing burnout or compassion fatigue (Mac Leod Dyess et al., 2018). Previous research has shown that pet owners have lower blood pressure, a decreased heart rate, reduced feelings of solitude, an improved mood, and high self-esteem, and they handle stressful situations better (Silcox et al., 2014).

Furthermore, pet owners confide in their pets about their feelings, problems, and even daily life stories. Animals can help provide social support. Having a pet as a confidant allows a person to openly disclose emotions and thoughts without any harmful emotional risk (Silcox et al., 2014). Frequent interactions with animals can decrease physiologic stress responses (Friedmann et al., 2015). Since nurses experience significant occupational stress that can lead to compassion fatigue, it is possible the human–animal bond can allow nurses to manage their occupational stress, therefore reducing their risk of developing compassion fatigue. As previously stated, nurses need to find ways to manage their stress. The HAB is one possible

theory to explain how they can accomplish this. The use of animals as a therapeutic method is gaining popularity because it has proven to be effective in addressing many different concerns (Silcox et al., 2014).

Additional Factors Related to Compassion Fatigue

Many factors surround compassion fatigue. There are contributing factors such as moral distress, burnout, low compassion satisfaction, occupational stress, and lack of support both in and out of the work environment (Fernandez-Parsons et al., 2013; Rajeswari et al., 2020). However, each nurse's experience with compassion fatigue stems from different contributing factors and situations. Also, compassion fatigue can have an impact on several other negative outcomes not only for the nurse but also for patients, specific hospitals and facilities, and the health care system as a whole. All these factors can affect the professional quality of life of a nurse.

Compassion Satisfaction

Expressing long-term compassion does not always lead to negative emotional states or outcomes. The literature on compassion satisfaction is directly linked to compassion fatigue. Compassion satisfaction is a positive feeling associated with helping others (Durkin et al., 2016). It is the term used for health care workers when they reap the emotional rewards of caring for others (Stamm, 2010). These emotional rewards cause clinicians to feel a sense of return or incentive by seeing an improvement in their patients (Slocum-Gori et al., 2011). Compassion satisfaction occurs when empathy "drives altruistic behaviors" of the helper, resulting in "the alleviation of patient suffering" (Sacco & Copel, 2018, p. 76). This can allow nurses to cope with the negative aspects of their work life, therefore diminishing the effects of compassion fatigue and leading to the desire to continue in the nursing role.

The motivation for nurses to remain in the profession and at the bedside is likely related to the positive feelings derived from caregiving and the desire to help others in their time of need (Sacco & Copel, 2018). These positive feelings are great for the individual experiencing them but can be difficult to spread to coworkers. Unfortunately, positive feelings do not spread to coworkers as easily as negative ones (Tallo, 2017). Therefore, compassion satisfaction is an internal feeling that nurses must find themselves. Whether compassion can be taught is a question in the nursing literature (Durkin et al., 2018). Perhaps it is only an innate quality that one can possess instead of a skill that can be learned. Nevertheless, compassion is a topic that can be discussed in nursing school, as it is recognized as a professional value that nurses must demonstrate (American Nurses Association, 2015, as cited in Durkin et al., 2018, p. 50). Compassion satisfaction, along with compassion fatigue, should be included in that education. Although feeling compassion satisfaction may be difficult to teach, what it is and how to achieve it can be learned. Compassion satisfaction is a possible factor to counterbalance the risks of compassion fatigue. A nurse's professional quality of life is improved when compassion satisfaction is high and burnout and compassion fatigue are low (Durkin et al., 2016). This equilibrium can lead to a more thriving career.

Burnout

Burnout in nursing is described as long-term stress and diminished interest with detachment and lowered effectiveness (Berg et al., 2016). It is associated with compassion fatigue as a precursor for or a consequence of it and is even used interchangeably with compassion fatigue. Stamm (2010) suggested that burnout is a broad term related to a stress response in any profession, while compassion fatigue is a term specific to caregiver roles and professions. Burnout is a progressively worsening condition that makes performing a job

effectively difficult due to feelings of hopelessness and a nonsupportive environment (van Wiljen, 2017). It can also be explained as experiencing job-related difficulties while performing a job where there is increasing stress, resulting in a declining energy level and a sense of exhaustion (Sacco & Copel, 2018). Therefore, burnout can be caused by unmanaged occupational stress.

Nurses exposed to this long-term or chronic stress while caring for patients can experience compassion fatigue (Rajeswari et al., 2020). As with compassion fatigue, there is little research on interventions for burnout (Bogue & Carter, 2019). Nurses experiencing burnout may find it difficult to provide the level of care their patients need. Literature shows that preventing burnout among staff is a key strategy in reducing sick time and staffing issues, as well as improving morale and retaining valuable skilled employees (van Wijlen, 2017). Commonly reported symptoms of burnout include fatigue, headaches, eating disorders, insomnia, and emotional instability (Berg et al., 2016). The negative feelings associated with burnout can reflect the impression that hard work and efforts make no difference (Stamm, 2010). This can cause frustration and decreased work satisfaction, leading to further negativity in the workplace. Unlike the positive aspects associated with compassion satisfaction, the negative feelings associated with burnout can be contagious among nurses working in the same unit (Berg et al., 2016). Burnout and its negative consequences can also lead to increased staff turnover and patient safety concerns. Burnout is not considered a medical disorder; however, the International Classification of Diseases now provides guidance on burnout as a work-related medical disorder (Bogue & Carter, 2019). Therefore, burnout is a condition that needs intervention or, if possible, prevention.

Causes of Compassion Fatigue

Every day, nurses may need to respond to urgent and life-threatening emergencies that require complex cognitive work while simultaneously delivering emotional counsel to patients and their families. Yet nurses frequently lack a formal support system to counter the potentially negative emotional experiences of their work (Boyle, 2011). Compassion fatigue characterizes a state of emotional unease. The emotional "cost of caring" (Slocum-Gori et al., 2011, p. 173) for others associated with compassion fatigue can manifest acutely or progressively (Henson, 2020). However, it is typically prolonged, continuous contact with patients that is explained in the literature as leading to an exhaustion of resources for expressing empathy and compassion (Henson, 2017).

There may be several triggers to developing compassion fatigue. Secondary exposure to the traumatic events experienced by patients is one possible antecedent (Henson, 2020). This can also be described as experiencing trauma vicariously through the perception of the patient. Since nurses develop relationships with their patients, they create an ability to recognize and comprehend what the patient is feeling through empathy. Firsthand exposure to the death of a patient, a fatal diagnosis, or abuse can happen to a nurse and trigger compassion fatigue (Henson, 2020). Burnout and moral distress, as mentioned, can also be precursors of compassion fatigue (Rajeswari et al., 2020; van Wijlen, 2017). Other causes include inadequate staffing, unhealthy work environments, high workloads, the increasing complexity of health care, decreased job satisfaction, insufficient leadership, stress, and personal experiences outside of work (Henson, 2017). A lack of an existing coping system to handle stress can lead to an increased risk of developing compassion fatigue (Howard & Navega, 2018). Another trigger for compassion fatigue is lack of emotional regulation. Some nurses may choose to block or hide their emotions

while at work. This requires emotional regulation and self-control (Banks van Zyl & Noonan, 2018). Strategies for emotional recovery and reflection may be needed or the result may be emotional exhaustion or depletion, which can lead to compassion fatigue. Some of these causes can be prevented to decrease the risk of developing compassion fatigue, but the threat remains.

Impacts of Compassion Fatigue

Compassion fatigue can lead to many other problems. When nurses can no longer feel compassion for patients, satisfaction is replaced with apathy, and their ability to connect with patients may be lost (Henson, 2020). When a nurse experiences compassion fatigue, providing patient care becomes emotionally, physically, socially, and spiritually exhausting, which causes desensitization or depersonalization for others. Although nurses may continue to function, it is possible they can no longer feel empathy for their patients (Figley, 2015, as cited in Henson, 2020, p. 79). In a healing attempt to relieve themselves of this distress, nurses may seek a fellow nursing colleague with whom they can share their frustrations and pain. This can create an unintentional domino effect that fuels cynicism and negative emotions and worsens the condition (van Wijlen, 2017). Inversely, nurses with compassion fatigue may perceive that no one or nothing can help and do not attempt to reach out to anyone.

Nurses with compassion fatigue have reported symptoms of stress manifested through anxiety at work, errors in judgment, and difficulty sleeping, which can result in physical and emotional exhaustion (Henson, 2020). Physical implications of compassion fatigue are similar to those of other mental health disorders such as depression and anxiety. These include a decline in the immune system, forgetfulness, headaches, high blood pressure, weight fluctuations, and gastrointestinal distress (Henson, 2020). Compassion fatigue may be cyclical, meaning the

factors that cause compassion fatigue are also worsened by compassion fatigue, resulting in a loop that can be difficult to break.

Some nurses may feel the only way to stop compassion fatigue is to leave their bedside role or the profession. Just as a high compassion satisfaction can improve nursing retention rates, compassion fatigue can decrease them (Sacco & Copel, 2018). High turnover rates worsening the current nursing shortage is a critical issue facing health care systems today (McDermid et al., 2020). Patient safety is another result of compassion fatigue alone, but the increased nursing turnover associated with compassion fatigue leads to understaffed working conditions, which can also place patients at risk for unsafe situations. Difficult to identify and even more difficult to combat, compassion fatigue not only negatively impacts the personal and professional quality of life of nurses but also compromises patient care, as nurses may become desensitized toward patient suffering (Mooney et al., 2017). That, along with the difficulty concentrating and focusing on details, memory problems, and a decreased interest in their work, makes characterizing and addressing compassion fatigue in nursing populations necessary to ensure that patients and nurses receive optimal care. A negative working environment caused by inadequate nursing staff and the negative attitudes from nurses experiencing compassion fatigue can also create an unsafe environment for patient care.

Aside from the serious problems of the nursing shortage and patient safety risks, nurses experiencing compassion fatigue can develop severe psychological challenges as well. Substance abuse, poor judgment, depression, and anxiety are disorders that can develop because of compassion fatigue, so intervention at the earliest is essential (McDermid et al., 2020; Rajeswari et al., 2020). Recognizing the early signs and symptoms of compassion fatigue can make it easier to combat. Trying to intervene in the late stages of compassion fatigue may be too late to avoid

the impacts it can have on other areas. Hospital administrators, nursing leaders, and nurses themselves are integral to the early identification of nurses at risk for compassion fatigue. By working together to develop a caring work environment, nurses may improve job satisfaction, enhance patient safety, and decrease staff turnover (Perrigrini, 2019).

Early Detection. Since compassion fatigue is not a diagnosable condition, it can be difficult to detect. Understanding the risk factors for compassion fatigue may help assist with early detection. One factor, working with certain patient populations, can place nurses at increased risk for compassion fatigue (Houck, 2014). Critical care, oncology, pediatrics, palliative care, and the emergency department are the most studied areas of nursing related to compassion fatigue. They are thought to be the nursing populations most at risk for developing compassion fatigue because of their work with terminal patients and special populations. The additional preventable causes of insufficient nursing leadership support or an absent support system outside of work can increase the prevalence of developing compassion fatigue (Sacco et al., 2015). If health care facilities make supporting their nurses' health and well-being a priority, it can lessen the risk of developing compassion fatigue (McDermid et al., 2020). If nurses create a support system for themselves, both inside and outside of work, they may be better able to cope with or combat compassion fatigue. If compassion fatigue is not addressed early, it can permanently alter the ability of a caregiver to provide compassionate care (Boyle, 2011). Nurses experiencing compassion fatigue can place themselves and their patients at risk. Since there is no guaranteed method for preventing compassion fatigue in every nurse, finding ways to cope with it may be necessary.

Coping With Compassion Fatigue

Compassion fatigue can have a crippling effect on a nurse (Myatt, 2015). The daily routine of caring for others leaves limited emotional resources available for self-care or recognizing and managing the stress associated with nursing. Feelings of helplessness may result when no coping strategies for stress exist (Henson, 2020). There is a lack of research on prevention strategies and coping mechanisms related to compassion fatigue (Kiley et al., 2018; Pehlivan & Güner, 2017). As mentioned previously, compassion fatigue is an emotional and physical exhaustion that leads to a diminished ability to empathize or feel compassion for others (Houck, 2014). It can occur when the job brings more distress than satisfaction (Sheppard, 2015). This can happen from providing repeated empathetic support to patients, their families, and other caregivers (Blair & Perry, 2017; Sacco et al., 2015; Yılmaz & Üstün, 2018). As an ongoing problem, the number of nurses experiencing compassion fatigue has been on the rise, according to the American Nurses Association (Perrigrini, 2019).

There are multiple ways to cope with or even prevent compassion fatigue. Finding support inside and outside the hospital system is important in combating compassion fatigue. This could come from leadership, coworkers, friends, and family, including furry family members. Another potential method is identifying compassion fatigue early. Early recognition and intervention are key to moving past compassion fatigue and remaining in the nursing profession (Rushton et al., 2015). Early recognition and intervention paired with expanding support services and developing a nurturing work environment may help improve nurse job satisfaction, enhance patient safety, and decrease staff turnover (Perrigrini, 2019). Nurses need to understand the importance of work–life balance, self-care strategies, and communication skills to help cope with their stress and compassion fatigue (Houck, 2014). The risk for compassion

fatigue will always remain in nursing, but knowing how to recognize and combat it can decrease the possible detrimental effects for patients, nurses, and the nursing profession.

Nurses with less experience may be more at risk of developing compassion fatigue than seasoned nurses. Communication for the purposes of emotional support is seldom taught in nursing programs (Boyle, 2011). Lack of education on this subject leaves recently graduated nurses with a lack of competency in expressing compassion to a patient and their family. This can further lead to decreased compassion satisfaction and an increased risk of developing compassion fatigue. One specific finding shows that age is a significant factor in the development of compassion fatigue. Seasoned nurses showed a higher level of compassion satisfaction, leading the researchers of this study to believe life and work experience may play a part in stress management (Sacco et al., 2015). Meyer et al. (2015) suggested health care systems emphasize a supportive workplace culture to assist novice nurses' transition into the workforce to help them handle their newfound occupational stress and decrease their risk of developing compassion fatigue.

Stress Management in Undergraduate Students

Occupational stress may be a new experience for novice nurses. Unmanaged occupational stress has been associated with decreased productivity and morale, impaired concentration, absenteeism, high turnover, diminished work engagement, and medical errors, all of which can compromise the quality of care (Berg et al., 2016). As previously mentioned, the inability to manage occupational stress can also lead to compassion fatigue. Research shows that nurses with less experience are at a greater risk for compassion fatigue (Kelly & Lefton, 2017). Therefore, students must start learning stress management techniques early, and nursing students in particular must understand the stressors that are unique to this profession. In the United States,

there is an increasing trend of reported stress in college students, which may be negatively impacting their health (Sajid et al., 2017). There is a lack of stress reduction techniques being introduced to undergraduate students. Undergraduates face increased pressures for academic success and adjusting to new surroundings and responsibilities (Jafari, 2017). He et al. (2018) suggested "identifying strategies that better enable students to cope with their work environment and reduce anxiety and stress" because it "is both desirable and plausible" (p. 5). Yusufov et al. (2018) reported an increase in students who experienced high stress, which resulted in adverse emotional, academic, and health outcomes. The introduction of stress management techniques to undergraduate students could be beneficial to their future success.

In one study of the prevalence of psychological problems in college students, more than 90% of students in a medical program reported multiple episodes of stress during their program (Sajid et al., 2017). Teaching them coping mechanisms early can help them manage their stress and prepare them for handling future stress. It is not always part of a nursing program curriculum to teach ways for students to cope with emotional distress or to manage the stressors that accompany daily nursing tasks (Cheli et al., 2020). Results from an Australian study emphasize the need for specific curriculum preparation in nursing programs to promote positive coping strategies to better prepare new graduates to engage with the complex, demanding, and ever-changing work involved in nursing (He et al., 2018). It is important for nurses and nursing students to learn healthy ways to cope with stress. Furthermore, they should also be educated on compassion fatigue (Boyle, 2011). Learning about compassion fatigue may help future nurses recognize it early, making it easier to combat or prevent. They can also recognize it in their colleagues, allowing them the opportunity to address it. The American Nurses Association

recommends that compassion fatigue be integrated into every undergraduate and graduate nursing curriculum, as well as nursing orientation programs (Boyle, 2011).

Knowing that students are going into a profession with compassion fatigue and burnout as possible outcomes suggests the need to prepare these students with prevention techniques. College institutions need effective methods to encourage student well-being and help students recognize and manage their stress (Jafari, 2017). This will help prepare them for occupational stress they will likely experience in the future. In general, increased awareness of the emotional demands facing today's nurses is of extreme importance so they might be better prepared to manage the stressors that come their way.

Alternative Medicine Practices

One possible intervention for stress and compassion fatigue in nurses is alternative medicine practices. There have been limited studies examining the effectiveness of stress reduction programs for health care providers (Meyer et al., 2015). Complementary and alternative medicine (CAM) is the term for medical products, practices, and treatments that are not part of standard medical care. It predates contemporary medicine and includes Western approaches (homeopathy and naturopathy), mind–body medicine (meditation, music therapy), biologically based medicine (herbal remedies), manipulative and body-based practices (chiropractic care), and energy medicine (Reiki) (Warren, 2018). These alternative practices are gaining popularity in the United States, as some health care providers are aiming to take a more holistic approach to care for their patients, which includes aspects of physiology, psychology, and spirituality. It is now common to find combined medicine practices in health care (Warren, 2018).

CAM could aid in stress relief for nurses (González-Ramírez et al., 2013). In one small study, nurses were found to report a decrease in stress when accessing CAM practices outside of work and claimed they would consider accessing it in the future (Wright et al., 2016). The purpose of this study by Wright et al. was to allow nurses to utilize CAM practices during their shifts. Still, the researchers found difficulty finding quiet areas in the hospital where nurses could take breaks (Wright et al., 2016). It may not be possible to find moments of relaxation or stress relief during work hours, but at the very least, nurses should make time to destress after work. For some, this may be spending time with their family, including the furry members. Pet therapy falls into the category of CAM, but there is little research on the benefits of pet therapy on health care staff (Goddard & Gilmer, 2015).

Incorporating Pets in Stress Relief

Humans can benefit from living with a pet (Utz, 2014). Pets provide several beneficial effects, such as increased physical activity, favorable lipid profiles, lower systemic blood pressure, improved autonomic tone, diminished sympathetic responses to stress, and improved survival after a cardiac event (Levine et al., 2013). Pet owners have more positive physical health outcomes when compared to non–pet owners (Utz, 2014). Dog owners report lower stress levels and good emotional, mental, and overall general health, feelings of vitality, decreased pain, and social functioning (González-Ramírez & Hernandez, 2014). This shows that dog owners perceive themselves as healthier than nonowners. However, this does not mean only pet owners can reap the benefits received from animal support. Polheber and Matchock (2014) measured stress in the form of cortisol levels and heart rate in groups with no support, a human companion as support, or a support dog. They found a decrease in cortisol levels and heart rate in the group

that included the support dog, and these results were not specific to pet owners (Polheber & Matchock, 2014).

Animal intervention programs show various benefits such as reduced stress, anxiety, pain, and depression while also improving vital signs and nutritional intake (Bert et al., 2016). Based on the results of these studies, it is possible that the incorporation of animals in a nurse's life can help decrease their stress, therefore leading to a decreased likelihood of suffering from compassion fatigue. Whether an approved therapy pet comes to visit nurses during their shift or nurses go home to a family pet after their shift, I believe there is a benefit to having an animal in a nurse's life to comfort and support them. Even Florence Nightingale, one of the best-known names in nursing, believed the benefits that animals could bring to long-term care (Nightingale, 1969). However, as previously stated, there is little research on the impact of pet therapy, specifically on nurses.

Even when animals are not physically present, they can be helpful. In a study that used animal videos during a work break, participants had a decrease in reported distress and an increase in morale (Finkbeiner et al., 2016). Google headquarters has a pet-friendly campus. Although there are restrictions on the animals allowed on campus, many employees indulge in this opportunity. Google can be considered a very productive company, according to Kuntze and Matulich (2010, as cited in Finkbeiner et al., 2016), so the presence of pets in the workplace may play a role in increased productivity. Other studies found that the presence of a therapy animal improves session attendance and engagement (Ginex et al., 2013; Schramm et al., 2015). A study by González-Ramírez et al. (2013) compared pet therapy to other cognitive-based therapies and groups without therapy for stress management and found that the groups that included animals resulted in a higher decrease in stress than the other groups. Although there are many reported

benefits for the use of pet therapy, there are also some risks or reasons why it may not be effective.

Barriers. In some situations, pet therapy might not be an option. Pet ownership is not beneficial for everyone. Animal-related allergies and phobias are concerns that cannot be ignored (Creagan et al., 2015). Humans can contract pathogens from animals called zoonotic infections. Transmission can occur via scratches, bites, lacerations, abrasions, fecal matter, and ticks or fleas (Sehr et al., 2013). Animal, patient, and handler hygiene is an easy way to prevent zoonoses. This is one reason therapy pets and their handlers go through thorough training and screening practices. In pet therapy, it is also important to consider the therapy animal. Animals can become stressed in certain situations and environments. Newly visited places may make the therapy animal uncomfortable. In a study observing dog behavior and cortisol levels to determine stress in different environments, the researchers found cortisol levels to be higher in the novel settings, indicating these situations may be more stressful for the dogs (Ng et al., 2014). No matter the situation, it is important that the handler remain with the dog to ensure its comfort and decrease stress. Social interactions can be stressful for dogs because they can be unpredictable (Ng et al., 2014). If the animal is stressed, it will make the therapy session less useful for the patient. Risks identified in the literature include animal allergy, infection, and accidents related to the animal (Bert et al., 2016; Creagan et al., 2015). Simple hygiene guidelines and screening programs for the animal and its handler are easy fixes to limit these risks. The benefits of pet therapy far outweigh the risks, making animal therapy programs useful for patient improvement in most situations (Bert et al., 2016).

Animal-Assisted Therapy and Health Care

It is also possible that animal therapy programs can help health care workers. Animal-assisted therapy (AAT), or pet therapy, uses trained animals for the therapeutic, motivational, or educational benefit of people (Ginex et al., 2018). AAT is most commonly used in conjunction with traditional medicine for patients, especially in pediatrics, but health care staff can benefit from animal visits as well. Geriatric, pediatric, and psychiatric populations are the most common participants in patient-centered studies involving AAT, with dogs being the most common animals involved (Bert et al., 2016). The use of dogs in clinics, hospitals, and home visits is becoming more common (Urbanksi & Lazenby, 2012). One hospital created a new process for including family pets in patient treatments. This nurse-led program resulted in a positive outcome for patients, as measured by a feeling of comfort and support, who had the opportunity to see their pets while not at home. In an unintended outcome, the nursing staff reported a decrease in loneliness and an increase in relaxation for staff members (Sehr et al., 2013).

Much of AAT is focused on patient care, but there is a lack of research on health care workers. Abrahamson et al. (2016) found one hospital's animal therapy program positively impacted its staff, including reductions in stress and promotion of social interactions. For Ginex et al. (2018), animal visits during working hours improved compassion satisfaction and decreased burnout. Burnout is a precursor to compassion fatigue (Perrigrini, 2019). A decrease in burnout can lead to less stress while working. Decreased compassion satisfaction is another precursor to compassion fatigue (Sacco et al., 2015). Compassion satisfaction is the positive feelings a person gets from helping and caring for others (Sacco et al., 2015). Nurses need higher levels of compassion satisfaction to decrease their risk for compassion fatigue. It would also be useful if work environment interventions can be directed toward increasing compassion

satisfaction in conjunction with preventing compassion fatigue (Sacco et al., 2015). Since AAT can be an effective stress relief technique for patients, it is possible it could benefit nurses as well and should be further explored.

Summary

As stated, compassion fatigue is a problem in the nurse community. It can lead to detrimental outcomes for nurses and the patients for whom they care (Houck, 2014). Nurses need to learn about compassion fatigue early in their careers. Nurses are at risk of developing compassion fatigue at any point in their careers, even when they are new to the profession (Kelly & Lefton, 2017). Early exposure to this knowledge can help nurses recognize if they or their coworkers are at an increased risk for developing compassion fatigue (Cheli et al., 2020; He et al., 2018). Nurses need to find ways to manage their occupational stress and cope with or decrease the risk of developing compassion fatigue. One possible way to do this is through AAT. Based on the human–animal bond theory, there is an emotional connection between humans and animals. Animals can provide the support that nurses need (O'Haire, 2010). As servant leaders, nurses need to care for themselves to be able to effectively serve their patients and other members of the patient care team (Penny, 2017). Animals can help with stress relief, and the benefits outweigh the barriers (Bert et al., 2016; Creagan et al., 2015; Sehr et al., 2013).

This research study aimed to shed light on the importance of educating nursing students on compassion fatigue, as well as why managing stress should be a priority. There was also a goal to discover if nurses perceive any benefits to pet therapy on their occupational stress reduction and management of compassion fatigue. Because this is relatively unexplored territory, as described, I used a phenomenological design approach to collect this information. In the next chapter, I explain the research methods and design.

Chapter 3: Research Method

Several researchers have studied the problem of compassion fatigue in nursing, but there is limited research on prevention and coping (Henson, 2017; Houck, 2014; Kolthoff & Hickman, 2017; Mattioli et al., 2018; Sacco et al., 2015; Sheppard, 2015; Sinclair et al., 2017). As previously discussed, compassion fatigue can develop as a result of unmanaged stress (Gentry, 2018). This can impair a nurse's ability to be an effective servant leader to their patients and coworkers (Penny, 2017). Since nursing can be a stressful occupation, managing that stress is essential to career longevity. Early education on the topics of compassion fatigue and occupational stress and interventions such as pet therapy are possible ways nurses can combat the effects of compassion fatigue. The primary purpose of this study was to discover if nurses were prepared to cope with occupational stress and compassion fatigue when they began their nursing careers. A secondary focus of this study was to examine pet therapy as a stress reduction technique for nurses to decrease the effects of compassion fatigue. The research questions that were answered by this research included the following:

RQ1: What effects does compassion fatigue have on the level of distress experienced by nurses while serving patients?

RQ2: What education do nursing schools offer to prepare nurses to cope with occupational stress and combat compassion fatigue in their role as a servant leader?

RQ3: What perception of pet therapy do nurses have as a potential management technique for occupational stress and compassion fatigue?

This chapter begins with a discussion of the research method and design for this study and the role of the researcher as an investigator. Next is a description of the population and sample, the role of participants, the instruments to be used, and the data collection and analysis

methods. Last, a discussion of ethical considerations, assumptions, and design limitations are shared.

Research Design and Method

Qualitative research is the best choice for a researcher when insight into the personal and social lives of people is necessary to answer the research questions (Saldaña & Omasta, 2018). There are many different methods and approaches in qualitative research designs, each producing findings from lived experiences (Terrell, 2016). In this study, I explored the lived experiences of nurses who suffer from compassion fatigue or were at a high risk of developing it. Therefore, I utilized a qualitative phenomenological research investigation to understand the perceptions of bedside nurses whose professional experiences were relevant to the study's contextual phenomenon. The phenomenon that was studied in this research was compassion fatigue and occupational stress in nurses, including the occurrence of education on compassion fatigue in nursing school. In addition, a secondary phenomenon was the perception nurses have of pet therapy as an intervention. This design approach can be used to study the relational nature of qualitative methodology and examine participants' perspectives as they attempt to connect personal and professional experiences (Saldaña & Omasta, 2018). Qualitative research relies on nonnumerical data collected through studying phenomena in their natural setting (Busetto et al., 2020). As a type of qualitative research methodology, phenomenology studies the nature and thoughts of lived experiences (Leavy, 2017; Saldaña & Omasta, 2018). Since phenomenology provides information about unique individual experiences, this method was appropriate to study the research questions.

To obtain information about participants' lived experiences, interviews are a logical choice. Interviews are a commonly used data collection tool in phenomenological inquiry

(Phillips-Pula et al., 2011). Individual interviews can provide an in-depth understanding of nurses' experiences in nursing school and the education they have received about occupational stress and compassion fatigue (Deasy et al., 2014). Interviews can be described as a conversation with a goal and are used to gain insights into subjective experiences, opinions, and individual motivation (Busetto et al., 2020). There are different types of interview styles with various levels of structure (Leavy, 2017). Semistructured interviews, a common method in qualitative inquiry, are characterized by open-ended questions and the use of an interview to guide the conversation, sometimes including subquestions (Busetto et al., 2020; Saldaña & Omasta, 2018). It is common for semistructured interviews to be conducted only once with an individual or with a group and generally cover 30 minutes to over an hour (Jamshed, 2014). Since people tend to be naturally conversational, interviews may make the participants feel more comfortable sharing their experiences by drawing on something they are accustomed to participating in, no matter the setting (Leavy, 2017).

Before conducting the interviews, I administered a survey to narrow down my target sample group and add a source of triangulation with the interview data to display a more comprehensive understanding of the phenomena. These responses also helped me develop or modify some of the interview questions. The current interview questions were developed based on my research questions; however, survey data allowed for the opportunity to modify the interview questions once I got a better idea of the participants' viewpoints. Survey participants completed the Professional Quality of Life (ProQOL) scale to determine if they qualified to participate in the interview process. The results of this scale provided some insight into their current levels of compassion satisfaction and compassion fatigue. I invited those with high levels

of compassion fatigue to participate in the interview. This allowed me to assess the experiences of nurses currently suffering from compassion fatigue.

The semistructured interviews were useful in this phenomenological design to explore nurses' perception of pet therapy as an intervention to manage their occupational stress and cope with or prevent compassion fatigue. I also wanted to explore if these nurses thought the level of education they received on compassion fatigue during nursing school had any effect on their experiences with compassion fatigue. I chose semistructured interviews because they can be dependent on how the participants respond. One might share an experience or thought that spawns new questions or a new outlook on the phenomena. My goal was to include at least eight participants in this study. The participants shared their experiences with compassion fatigue and coping with stress, education they had received on these topics, and whether they could anticipate benefits to having pet therapy as an intervention. Phenomenology is an appropriate design for this study because it attempts to obtain meaning from individuals' perceptions by turning subjective statements into objective data while examining an abstract concept from multiple angles to answer the research questions, guiding further inquiry (Moustakas, 1994).

In summary, to understand the experiences nurses have with compassion fatigue, to discover if there is a potential for a positive effect of pet therapy on nurses' occupational stress and compassion fatigue, and to learn the level of education they have received on compassion fatigue and occupational stress, I believed qualitative phenomenological research was the best method to approach this topic. The phenomenological research approach explores the intentional relationship between people and situations (Finlay, 2009). I strove to understand nurses' experiences with compassion fatigue and their perceptions of the importance of education on the topic and how a potential intervention can affect it. The information collected will help

demonstrate the need to address prevention and interventions for compassion fatigue. The interviews helped show if a lack of early education can contribute to the development of compassion fatigue, the level of importance placed on stress management in nursing school, and if pet therapy is one possible way to cope with occupational stress and combat compassion fatigue. These conclusions are important because it can spotlight the importance of the need to lessen the potentially detrimental effects of compassion fatigue, including nurses leaving their bedside role, unhealthy behaviors, potential unsafe patient situations, and more (Deasy et al., 2014; Sacco et al., 2015). If successful, this method can help nurses remain effective servant leaders.

Researcher Role

Phenomenology requires that the interviewer guide participants through carefully crafted questions about the topics of interest because it can be difficult for some to articulate what something is or means to them (Phillips-Pula et al., 2011). This involves more than simply listening to a response and writing it down. Semistructured interviews require that the researcher be a coparticipant in the process (Saldaña & Omasta, 2018). By taking an active role in the participation of the interview, I led the participant through the questions and encouraged transparency in their responses. This required active listening, a component of successful interview research, which involves not only listening but also observing the speaker's behaviors, nonverbal cues, and tone of voice (Leavy, 2017). Observing nonverbal cues in an interview is also important because they make up over 50% of communication (Subramanian, 2019). I used nonverbal communication by visually observing the participant to help guide them through the interview. Being an active, attentive listener can help a researcher be a successful interviewer because this type of data collection depends on building rapport with participants (Leavy, 2017;

Saldaña & Omasta, 2018). I aimed to make my participants feel comfortable answering these questions so they felt safe to be open and honest in their responses.

Also, in a semistructured interview, it is important to listen for more than simply recording answers because a participant's response may spark a new line of questioning. In this case, the researcher should analyze the necessity of developing a new line of questions or stick to the original topics of inquiry (Saldaña & Omasta, 2018). Asking probing questions can expand the current line of questioning, encourage participants to share more details, allow the researcher to collect richer data, and show the participants that the researcher is actively participating in the interview process with them (Leavy, 2017). Because of this, it is also important to allow the participant to finish their thoughts before asking more questions. I took notes during the interview so I could refer to a specific detail to inquire more about it, if needed.

Once I had conducted the interviews, I gathered and analyzed the qualitative data to assess if pet therapy could be a viable intervention for combating compassion fatigue and managing stress and to discover if early education can help nurses prevent compassion fatigue. I reviewed the interview transcripts for common themes to understand the meaning of what the participants shared. As part of the data analysis process, I needed to practice epoché. Epoché in phenomenological research means blocking biases and assumptions about the research topic by keeping an "open mind so as not to contaminate the data with personal opinions and preconceptions" (Terrell, 2016, p. 167). I am considered an insider since I am a nurse with similar thoughts and feelings to my participants. I found that we shared similar experiences with compassion fatigue during the interviews. Therefore, using bracketing, a method for practicing epoché, allowed me to focus on my participants' perspectives instead of using my own. Bracketing allows the researcher to suspend their own beliefs, judgments, and personal

knowledge so the phenomena can be seen clearly to gain insight by accepting what is stated by each participant (Phillips-Pula et al., 2011). While practicing epoché and bracketing my personal opinions, I sought to understand the phenomena through nurses who have experience with compassion fatigue and are interested in participating in the study.

Population

The target population for this study was supposed to include nurses who currently work at the bedside for most of their shift for a large hospital in north-central Texas. This is important to note because certain positions, such as nursing supervisors, may work in patient care to help their staff as needed but spend the majority of their time performing administrative responsibilities away from patients. This hospital has a diverse group of nurses and a therapy pet who frequents the facility to visit with patients, making it an ideal location to conduct this study. As mentioned previously, changes to the recruitment process and sample are included in Chapter 4. The nurses qualified based on the results from the ProQOL scale. This meant they were at a high risk for or were currently experiencing compassion fatigue. These nurses were any gender and included those from any work shift, unit of the hospital, and level of experience. I hoped to have at least 25 nurses complete the survey because I believed this would increase my chances of having at least eight of them agree to participate in an interview. There were approximately 700 nurses employed at this hospital who practiced bedside patient care. Including nurses with different backgrounds and experiences provided depth to this study because many studies about compassion fatigue focus on very specific areas of nursing, such as critical care, oncology, and palliative care (Houck, 2014; Kelly & Lefton, 2017; Kelly & Todd, 2017; Rushton et al., 2015; Sacco et al., 2015). Nurses with difficulty managing their stress and suffering from compassion fatigue can be found at any hospital.

Study Sample

As previously stated, ideally, participants should have similar experiences to share related to the study's phenomena (Moustakas, 1994). This would make the selection of participants very deliberate so the researcher can confirm their experiences are similar. A commonly used selection method in qualitative research is purposeful sampling (Terrell, 2016). In purposeful sampling, the participants are selected intentionally to provide insight into the phenomena being investigated due to their experiences (Saldaña & Omasta, 2018). Purposeful sampling also allows the researcher to seek out the best candidates for the study to produce the best data (Leavy, 2017). Therefore, being strategic in the sampling process is a must for a phenomenological researcher so the participants are appropriate for the study. Using the ProQOL, I chose my participants purposefully based on whether they were currently experiencing or at a high risk for developing compassion fatigue. It was important that the participants in this study could share their personal and secondhand experiences with compassion fatigue, as well as their perceptions of pet therapy as an intervention and the importance of the level of education needed on compassion fatigue and stress management.

Participant selection should also focus on representative qualities, an element of triangulation that can improve the validity of a study (Saldaña & Omasta, 2018). As stated, I hoped to include participants from multiple different backgrounds. By collecting data from a wide spectrum of the population in terms of age, ethnicity, gender, and level of experience, researchers can include a greater diversity of human experiences and ensure a stronger depth of data analysis (Saldaña & Omasta, 2018). The number of participants can vary based on the focus and type of qualitative study (Leavy, 2017; Saldaña & Omasta, 2018). Creswell and Creswell (2017) recommended that an appropriate sample size for phenomenological research is 3–10

participants who share similar experiences. Since I planned to use purposeful sampling in a phenomenological study, I needed to find nurses who had real experiences with compassion fatigue. The study's inclusion criteria for participants included nurses who (a) spent at least 50% of their role practicing patient care and (b) scored high on the ProQOL.

Recruitment. To obtain a list of potential participants, I asked for the email list of those who the hospital defined as bedside nurses. If needed, I would have expanded this list to include their supervisors but would have had to determine their level of involvement at patients' bedsides. In the email, I explained my study, its purpose, and the inclusion criteria. I also explained the sampling process using the results from the ProQOL to determine who would be interviewed. I explained the approximate time I expected the interviews to take and the topics under which the interview questions fell. I also gave details about the ProQOL and how long it should take to complete. I also gave a deadline for response in order to stick with my research timeline. If needed, I would have emailed the unit managers separately to ask for their help with recruiting nurses. Not only could managers advertise the study during their staff meetings, but they also would be able to identify nurses on their unit whom they suspected were struggling with stress and compassion fatigue.

The nurses who expressed interest in participating in my study received the necessary documents and consent forms to complete and send the ProQOL scale. This created an email chain, so I created a special folder in my email dedicated to participant communication to help organize and archive emails. I created scripted emails to send to those who expressed interest in participating in taking the ProQOL scale that also contained details about the interviews to ensure all potential participants received the same information. I anticipated the need to check my email multiple times a day to ensure timely communication with all potential volunteers. I

sent all instructions and scheduled interviews via email as well. If the emails became too numerous, I planned to switch to the email marketing company, Mailchimp. This all-in-one platform helps manage mailing lists, track communication, set up automated responses, and create email templates.

Data Saturation. Again, I hoped to interview eight nurses in this study. However, it was possible that informational redundancy would occur before I interviewed all eight. Data saturation, or redundancy, occurs when there are no new themes developed from the data. Instead of waiting until formal data analysis, it is possible to identify saturation early in the process, such as while listening to interview responses (Saunders et al., 2018). According to Creswell and Creswell (2017), the researcher can stop collecting data when the categories or themes are saturated and when gathering fresh data no longer sparks new insights. This is when the researcher has attained an adequate sample. Since saturation is used in qualitative research as a criterion for discontinuing data collection, I stopped interviewing when I reached this point before getting to eight participants (Saunders et al., 2018). If I had not been able to find consistency in the human experience after eight interviews, I had a plan to reach out to others who qualified based on their ProQOL scale score to continue the interviews.

Materials/Instruments

Interviews are the most common way to collect qualitative data (Terrell, 2016). Interviews are common in phenomenology because they allow for flexibility and are participant-oriented, encouraging participants to tell stories about their experiences to learn more about themselves (Alase, 2017). Saldaña and Omasta (2018) advised researchers to prepare a detailed list of questions that covers all the topics they wish to discuss during the interview. Having follow-up questions prepared can help the researcher continue the flow of the interview if a

participant gives an unexpected answer. The researcher is responsible for developing the interview protocol to facilitate the process and gather data. To prepare for data collection, researchers create interview guides that can range from a list of inquiries to themes they intend to cover to the open-ended questions that will be used during the interview (Leavy, 2017).

Professional Quality of Life Scale

All the study's research questions were addressed by qualitative interview data in this phenomenological study. I used the ProQOL scale to provide preliminary data and serve as an element of the inclusion criteria. This scale has been validated through research, and I found it to be appropriate for choosing participants for this study based on the phenomena on which I was focusing. The ProQOL scale is a commonly used measure of compassion fatigue and compassion satisfaction in the nursing literature. Created by Stamm, it is intended to be used as a screening tool for the positive and negative aspects of working in a helping profession such as nursing (Heritage et al., 2018; Center for Victims of Torture, 2019; Stamm, 2010). For this study, the most recent version of the scale, the ProQOL 5, was used (see Appendix A). I asked participants to be interviewed based on the results of this scale.

The ProQOL scale consists of 30 items that measure compassion satisfaction, burnout, and secondary traumatic stress, with the latter two being indicative of compassion fatigue (Stamm, 2010). Participants answered the statements based on a Likert scale (1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *often*, 5 = *very often*). Sample statements include "I am happy that I chose to do this work" and "I feel worn out because of my work as a [helper]" (Stamm, 2009). In this scale, the bracketed term "helper" can be substituted with another term, such as "nurse" or "teacher." To score the ProQOL scale, some of the items need to be reverse scored, and the rest are summed by subscale (Stamm, 2010). If participants score 22 or less on the compassion

satisfaction subscale, it indicates a problem with deriving satisfaction from their work, while scoring 42 or above on the burnout and secondary traumatic stress subscales is considered high risk for compassion fatigue (Stamm, 2010). The scale has been in use since 1995, translated into almost 30 languages, and updated many times to the current version, ProQOL 5 (Center for Victims of Torture, 2019).

In a study of 1,187 people, Stamm found three scales measuring separate constructs: (a) compassion satisfaction, (b) burnout, and (c) secondary traumatic stress. Compassion fatigue was distinct. The intercorrelations with burnout and secondary traumatic stress were minimal (r = –0.14 and r = –0.23, respectively). Burnout and secondary traumatic stress had a strong positive correlation (r = 0.58). This was also confirmed in a study by Geoffrion et al. (2019). Stamm (2010) assessed the scale to have good construct validity. Internal consistency was also assessed. Cronbach alphas ranged from 0.86 to 0.88 for compassion satisfaction (Kiley et al., 2018; Stamm, 2010, as cited in Geoffrion et al., 2019; Sullivan et al., 2019), 0.75 for burnout (Kiley et al., 2018; Stamm, 2010, as cited in Geoffrion et al., 2019; Sullivan et al., 2019), and 0.81 to 0.86 for secondary traumatic stress (Kiley et al., 2018; Stamm, 2010, as cited in Geoffrion et al., 2019; Sullivan et al., 2019; Yang & Kim, 2016).

Interviews

Creswell and Creswell (2017) suggested developing a protocol for the interview that included the questions that would be asked and the process for recording answers. When preparing the interview guide, Leavy (2017) suggested using a funnel method for the order of questions to make the participants more comfortable while building rapport with the researcher. The funnel approach requires starting with broad, general questions and leading into more specific ones. As a novice researcher, I created a more detailed interview guide with open-ended

questions using a funnel approach and the themes I intend to cover (Leavy, 2017). There were a few introductory questions to obtain demographic information and approximately 20 questions and subquestions created for the interview. Still, the likelihood of having all of them answered by each participant was unrealistic. Instead, the questions were used as a guide for the interview, knowing existing questions may be changed or new questions created based on the results from the ProQOL scale and what the participants shared while answering previous questions. The goal in most semistructured interviews is to have participants share as much information as possible (Saldaña & Omasta, 2018). There may be specific inquiries the researcher has within the context of a broad question, but the participant may touch on them during their answer, so having follow-up questions ready in advance is good on an as-needed basis. The interview protocol also included opening instructions and a closing script. All interview questions were guided by the larger research questions and the aim of this study (see Appendix B).

The interview questions were field-tested by an expert panel, which provided feedback. The expert panel consisted of three nurses and one nurse practitioner. All of them had more than six years of experience in direct patient care. Each of the expert panelists were known to me to have a significant level of nursing experience in patient care, leadership roles, and reading and understanding research articles. I contacted them individually via email and requested they participate in my study by reviewing my interview questions and providing constructive feedback. The purpose of field testing the questions was to ensure the wording was easily understood, to ensure a natural flow to the questions existed, and to "assess potential researcher biases especially if the investigator has a strong affinity for the participants being studied or is a member of the population itself," which I do (Chenail, 2011, p. 254). The interviews facilitated

an understanding of the participants' experiences and their rationale as to why they felt a certain way. I collected data for my research study from these interviews, which I then analyzed.

Data Collection and Analysis Procedures

Saldaña and Omasta (2018) recommended using qualitative research if the researcher desires to understand the human condition through narratives and images instead of numbers for a more divulging form of data collection and analysis. The data collected to be analyzed in this study were obtained through interviews with participants who had valuable experiences and perspectives relative to the study's problem and purpose.

Data Collection

Due to the nature of qualitative research, the researcher serves as the data collection tool (Terrell, 2016). I sent an email to the target population introducing my study, including its problem and purpose, along with any risks for participating; the involvement requirements to participate in this study, including the length of time to complete the ProQOL scale and interviews; and the timeline over which this study occurred. Based on the responses I received from this email, I determined who was going to be recruited into my initial population. The initial study population had the opportunity to take the ProQOL scale via Google Forms after I obtained informed consent. In the introductory email, I outlined the process for using the scale results to invite participants to be interviewed. Based on the results of the scale, I obtained my sample. The interviews were semistructured with open-ended questions and took 30–45 minutes to complete. Plans for recording, transcribing, and taking notes during the interview are described in the following section on interview protocol.

Interview Protocol. I conducted and recorded the interviews by videoconferencing via Zoom. I planned for them to last approximately 1 hour. I read an opening script with an outline

of the interview process and instructions to each participant at the start of the interview. I used the predeveloped questions as a guide through the interview, and I read a closing script to each participant at the end of the interview, thanking them for their time and participation. I transcribed the interviews and took notes during the interviews, including a section about any nonverbal cues I observed. Many researchers choose to transcribe the interview verbatim to preserve a complete record (Leavy, 2017). Using Zoom has many benefits for an interview, including the ability to record the interview and have it automatically transcribed when saved to the cloud. I obtained permission to record the interview from each participant, and I confirmed at the start of each interview before pressing record. I used the recordings as a reference to compare to the notes I took during each interview. Recording helped ensure I captured all parts of the interview, including nonverbal communication, ensuring accuracy. When reviewing the transcript, it is important to mark or label it in a form that is easy to analyze (Leavy, 2017).

Data Analysis

When analyzing qualitative data, the researcher deals with meanings, not numbers (Henderson, 2016). Developing themes may also generate further research inquiries on the topic (Moustakas, 1994). Although analysis can begin during the interview and transcribing process, the formal analysis occurs after transcribing (Saldaña & Omasta, 2018). Data analysis intends to make sense out of the text through segmenting and taking apart the data and putting it back together (Creswell & Creswell, 2017). There are many methods for qualitative data analysis, but for this study I used interpretive phenomenological analysis (IPA).

The intention of IPA is to explore participants' personal experiences to understand their perception or account of an object or event (Smith & Osborn, 2007). In IPA, the researcher must take an active role by trying to understand the point of view of the participants. In other words,

the researcher is trying to make sense of the participant who is trying to make sense of what is happening to them (Smith & Osborn, 2015). As a qualitative research approach, IPA provides the opportunity for multiple participants who experienced similar events to tell their stories without any distortions or judgment (Alase, 2017). Smith et al. (2009, as cited in Alase, 2017) describe IPA as an interpretative and navigating research approach. IPA can be a useful methodology to use for the researcher examining topics that are "complex, ambiguous and emotionally laden" (Smith & Osborn, 2015, p. 43). I believe the term "emotionally laden" can apply to compassion fatigue. When using a phenomenological approach, the researcher will get in-depth descriptions and interpretations of the research participants' lived experiences, which allows them to understand how the phenomenon being studied has impacted the lives of the research participants (Alase, 2017). Since I attempted to accomplish this, I believed IPA was a good approach for analyzing the data that was collected in my study.

Once I had gathered the qualitative data, I used IPA to analyze them. During the interviews, I made notes as we went, highlighting content that I wanted to return to during the analysis phase. Once the interviews were complete, I read each transcript as many times as needed until I was familiar with its content. I made initial notes in the margins and highlighted any phrases or responses that stood out as relevant. Next, I identified any emergent themes from the data by reviewing my notes. Themes can originate from initial categories or be independently constructed by a holistic review of the data (Saldaña & Omasta, 2018). To organize the themes, I prioritized them in order of importance and included reoccurring or common themes. Saldaña and Omasta (2018) explained this approach as outlining according to commonality and hierarchy. I then categorized each theme to identify any theoretical constructs. I analyzed each transcript individually and identified themes and important passages before comparing them to

the other transcripts. I looked for repeated themes and the richness of particular themes that illuminated other aspects of the phenomena. It is important to note that just like analysis can begin during data collection, it will also be expanded on during the writing phase (Smith & Osborn, 2007). Alase (2017) described this as the last step of the structured phenomenological traditional method of analysis: The researcher must explain to the readers what the research participants experienced and how they experienced the phenomenon in a contextual format.

Establishing Trustworthiness

In research, it is important to consider the extent to which readers can trust the research process and findings (Leavy, 2017). Ensuring trustworthiness in phenomenological research involves the ability to assess the quality of the research (Alase, 2017). Establishing trustworthiness in qualitative research is different than in quantitative research. In quantitative research, reliability and validity are the main methods to establish trustworthiness (Saldaña & Omasta, 2018). In qualitative research, credibility, transferability, dependability, and confirmability are used (Terrell, 2016).

Credibility. Credibility in qualitative research can be used similarly to internal validity in quantitative research (Creswell & Creswell, 2017; Leavy, 2017; Terrell, 2016). Credibility expresses the quality of the research, the rigor of the methodology, and if the research findings are believable from the perspective of the participant (Leavy, 2017; Terrell, 2016). One way to accomplish credibility is through triangulation. Triangulation occurs when multiple sources address the same question, such as interviewing multiple participants and seeing how their responses are similar or establishing themes based on converging several perspectives (Creswell & Creswell, 2017; Leavy, 2017; Terrell, 2016). I established credibility through triangulation by

interviewing multiple people about a phenomenon and attempted to converge the combined themes identified from the participants.

Another way to demonstrate credibility is through using a thick description to convey the findings (Creswell & Creswell, 2017). Providing a detailed description of the setting, offering many perspectives about a theme, and describing the shared experience between participants can make the results "more realistic and richer" (Creswell & Creswell, 2017, p. 200). I provided detailed perspectives from my participants in the discussion to explain their shared experiences and settings.

Transferability. Transferability is the ability to transfer research findings from one context to another and can be compared to external validity in quantitative research (Leavy, 2017; Terrell, 2016). Using a thick description in the discussion, as described, applies to transferability too (Terrell, 2016). The research findings can be useful in other contexts or settings, so they extend beyond my data, demonstrating trustworthiness. Since compassion fatigue is a problem that can affect anyone in a caregiver role and many roles have a high level of occupational stress, I believe my research findings extend to other settings and situations.

Dependability. The reliability of quantitative data can be compared to dependability in qualitative research (Terrell, 2016). Dependability results in the ability of the research to be repeated with consistent results. This can be established by providing a detailed approach to the research study (Shenton, 2004). I addressed dependability by sharing relevant information and checked each interview transcript against the recorded interview to ensure there were no errors between what was said by the participant and what was written in the transcript.

Confirmability. In confirmability, the researcher must discuss how they were able to remain neutral throughout the study, and the results do not reflect any outside influence (Terrell,

2016). This can be done through triangulation, as mentioned, and through reflexivity. Reflexivity entails a continued awareness that any action taken by the researcher during the study can influence the outcome because they are conducting the study and collecting and analyzing the data (Terrell, 2016). Confirmability can also be described as objectivity (Shenton, 2004). I am aware of my biases on the research phenomena because I used to be a member of my target population. I also practiced epoché, as described above, by blocking any assumptions I had about my research topic and remained neutral during the data collection and analysis processes.

Ethical Considerations

To prepare for conducting research with human participants, I completed the Responsible Conduct of Research and the Protecting Human Research Participants training courses through Abilene Christian University (ACU). Before I gathered data for this research, I sought approval from ACU's Institutional Review Board (IRB; see Appendix C). I did not contact any potential participant about my study until IRB approval was achieved or collect any data until consent forms were signed. I gave my participants a detailed informed consent form, including any risks or benefits to participating in the study and the purpose of this research, and made sure they fully understood what was being asked of them for the study before they signed anything. Although the study posed minimal risk to participants, some of the interview questions might have been considered sensitive because compassion fatigue is an emotional experience for some.

To protect my research participants, I followed the regulations stated in *The Belmont Report*. The ethical principles listed in the report include participant respect, beneficence, and justice (U.S. Department of Health and Human Services, 1979). This study did not include any participants who needed additional protection or who were considered vulnerable as outlined by *The Belmont Report*, and all participants were treated fairly and equally, ensuring justice (U.S.

Department of Health and Human Services, 1979). Therefore, I did not attempt to influence or pressure any potential participant's decision to join my research study (Creswell & Creswell, 2017). Also, the potential benefits of this study outweighed any minimal risk to participants, ensuring beneficence.

After IRB approval, I started emailing potential participants. Once I started receiving consent forms and collecting data, I stored all files on my password-protected computer at my house. They were not accessed by anyone other than me. I anticipated all files from this study would be electronic. I maintained participant confidentiality by not discussing their participation in my study with anyone, and I did not include any names in the study's results.

Assumptions

While certain beliefs enabled me to conduct this research, some of those beliefs may be characterized as assumptions. I assumed that each participant would answer honestly when they complete the ProQOL scale. Likewise, during their interview responses, I assumed they would be honest and transparent when they shared their experiences, opinions, and perceptions. My knowledge and experience with nursing and the impact compassion fatigue can have on us gave me a unique insight into my participants' thoughts and the ability to express empathy during the interview phase of the study. Because of my personal experiences, I set aside any assumptions I had on the research topics to maintain neutrality as I analyzed and reported the data. I did not let assumptions made through my experience as a nurse influence the data. Finally, I also assumed that a phenomenological research methodology provided me with a greater understanding of the phenomena I studied by analyzing participants' responses and the meanings of their lived experiences.

Limitations

A limitation of this study is the inclusion of only one facility. Although nurses anywhere can experience compassion fatigue, other factors specific to this facility, such as employee morale and leadership styles, may influence the responses given by the participants. Another limitation to this study is the requirement of social distancing during the current COVID-19 pandemic. This caused restricted access to my participants, leading to the use of virtual, instead of in-person, interviewing.

Although I was not currently practicing nursing at the bedside at the start of this study, I did for many years and was personally plagued with compassion fatigue. I also have a love for animals. These experiences and opinions may have created personal biases that can place limitations on the analysis of the data. I understood that my experience with compassion fatigue may not have impacted me the same way as others. Also, I perceived pet therapy as beneficial to nurses experiencing compassion fatigue, but that does not mean that others will. Being objective is an essential aspect of research inquiry, so researchers must examine methods and conclusions for bias (Creswell & Creswell, 2017). However, I strived to set aside my assumptions and biases to not impact the data or results.

Delimitations

To control factors that may affect a study's results or to focus specifically on a problem, further limitations may be put in place by the researcher, known as delimitations (Terrell, 2016). One delimitation was the use of purposeful sampling based on attributes of the participants. Only those who scored as high risk for compassion fatigue on the ProQOL were going to be interviewed. A nurse may have had past experiences with compassion fatigue but not be presently afflicted by it. However, I chose to study nurses currently affected by compassion

fatigue, so their experiences would be at the forefront of their mind instead of asking them to recall memories from years ago. Another delimitation in this study was the attempt to find a link between compassion fatigue and a specific intervention: pet therapy. While other methods for coping with or combating compassion fatigue and techniques for managing stress arose in the interviews, the data analysis focused on the research questions only.

Summary

The primary purpose of this study was to discover if nurses are prepared to cope with occupational stress and compassion fatigue when they begin their nursing careers. A secondary focus was to investigate whether nurses considered pet therapy as an effective stress reduction technique in attempts to decrease the effects of compassion fatigue or prevent it altogether. A review of the existing literature showed the need to find interventions to help nurses manage their occupational stress and prevent compassion fatigue and to provide more exposure on these topics during nursing school (Gentry, 2018; Houck, 2014; Merriman, 2015). A phenomenological research design was chosen because it allows for the study of the nature and thoughts of lived experiences (Leavy, 2017; Saldaña & Omasta, 2018). Since I wanted to learn about the individual experiences that nurses have with managing their stress and compassion fatigue, this method was appropriate for this study.

I sought to gain insight from purposefully selected participants. The participants were nurses who spent most of their career practicing at the patient's bedside. They were actively experiencing or at a high risk of developing compassion fatigue. Anyone who met the inclusion criteria and wished to participate completed the ProQOL scale. Based on these results, certain nurses were interviewed to gain insight on their experiences with managing their occupational stress and coping with or combating compassion fatigue and their perspectives on the level of

education needed on these topics and pet therapy as an intervention. Semistructured interviews were used, recorded, and transcribed. After I collected the data, I analyzed them using the IPA approach. Smith et al. (2009, as cited in Alase, 2017) argued that the IPA research approach could deeply explore the lived experiences of research participants to help understand the phenomenological significance of this experience and how it impacted each participant. Since I had insider knowledge and experiences with the phenomena I studied, I practiced epoché by bracketing my judgment and worked with an open mind (Terrell, 2016). I intended for this qualitative phenomenological study to shed light on the need for interventions and increased educational exposure to occupational stress and compassion fatigue in nurses, making them more effective servant leaders.

Chapter 4: Results

The primary purpose of this qualitative phenomenological research study was to discover if nurses are prepared to cope with occupational stress and compassion fatigue. Compassion fatigue can be considered a "cost to caring" (Wakefield, 2018, p. 21) and is defined as emotional and physical exhaustion that can lead to a diminished ability to empathize or feel compassion for others. Another purpose was to examine one potential stress management technique: if nurses believe pet therapy will reduce stress, therefore decreasing the effects of compassion fatigue. Pet therapy, as described earlier, is a form of complementary and alternative medicine where animals are used as an essential part of the treatment plan (Goddard & Gilmer, 2015). The ultimate aim of this study was to explore whether or not educating nursing students on compassion fatigue, as well as the importance of managing stress, should be a priority in nursing school. An additional focus was to learn if nurses perceived any benefits to pet therapy on their occupational stress reduction and management of compassion fatigue.

The study's context was nurses who had experience in and currently cared for patients in a medical facility, either a hospital or a clinic. The sample was nurses in this setting who had real experiences with compassion fatigue. Relative to the study's purpose, three research questions served as a guide:

RQ1: What effects does compassion fatigue have on the level of distress experienced by nurses while serving patients?

RQ2: What education do nursing schools offer to prepare nurses to cope with occupational stress and combat compassion fatigue in their role as a servant leader?

RQ3: What perception of pet therapy do nurses have as a potential management technique for occupational stress and compassion fatigue?

This chapter contains a presentation of the findings of this qualitative phenomenological study, including the presentation of interview data with descriptions of how the analysis aligned with IPA and an analysis of meaning that emerged in response to the research questions. As mentioned in Chapter 3, IPA was used to explore participants' personal experiences to understand their perception or account of an event (Smith & Osborn, 2007). Emergent themes were derived from the rich descriptions of lived experiences and perceptions gathered during virtual interviews. Participant demographic information is detailed first, followed by interview data organized by the codes and themes that resulted from IPA.

Demographic Data

As stated in Chapter 3, the inclusion criteria for this study were as follows: nurses who (a) spent at least 50% of their role practicing patient care and (b) scored high on the ProQOL scale (see Appendix A). I posted an invitation to participate in my study in two different Facebook social groups that were specific to nurses after receiving administrator approval. The invite included a brief description of the study, along with requirements of a participant, the main objective of the study, and an introduction about me. Four people responded to the post, but none returned a signed informed consent form.

Purposeful Sampling

Due to a lack of volunteers to aid in my study, I added an incentive for the participants: a $10 electronic gift card to Amazon to be sent upon completion of the interview. I sought IRB approval (see Appendix C) for this change before making an additional post to both groups with this update. After adding the incentive to a new post to both groups, 15 people responded with their interest in participating, and I contacted them via Facebook Messenger to follow up. Eight of those 15 signed the research study consent form. After obtaining consent, I sent them the link

to the ProQOL scale. Out of the eight who returned a completed consent form, five completed the ProQOL. Because of the limited response from volunteers to participate in the study, the criteria were changed to accept participants who scored moderate or high risk on the ProQOL. Three of the five qualified for this study and agreed to an interview.

Snowball Sampling

An additional strategy to elicit interest in participation was to use snowball sampling by asking my original participants if they knew anyone they believed would qualify and be interested in participating. Snowball sampling occurs when a participant leads the researcher to another participant via referral (Leavy, 2017). This led me to add four additional participants, who completed a consent form and the ProQOL scale. One did not meet inclusion criteria by scoring low risk on the scale and was not interviewed. The other three qualified and agreed to an interview, leading to six total participants in this study.

Participants

I recorded participant demographics to provide a greater understanding of the individual participants and their diversity of experiences. I interviewed six participants in total: five women and one man. Their areas of nursing included emergency, intensive care, traveling intensive care and trauma, medical–surgical, urgent care, and progressive care. The years they spent practicing nursing ranged from 2 years to more than 18 years. Four of the six participants currently worked day shifts, and the other two worked nights. All of them included both weekday and weekend shifts. Five of the participants were Caucasian, and one was African American. All participants had, at minimum, a Bachelor of Science in nursing.

Interview Results

I conducted interviews via Zoom and recorded them with participants' permission. I conducted one of the interviews over the phone due to the participant's location and difficulty accessing a computer; therefore it was not recorded. Detailed notes were taken during each interview, including participants' responses to the questions, observations made during the interviews, and any assumptions I was making. The recorded interviews were transcribed automatically via Zoom cloud recording. Body language and nonverbal cues were observed for all of the Zoom interviews. Although convenient, the transcriptions created automatically by Zoom were not entirely accurate. Therefore, I watched each recording again and compared the responses to my notes to ensure data reliability. They were saved to Google Drive so they would not be automatically deleted from the Zoom cloud after 126 days, per Zoom's policy.

The qualitative inquiry allowed me to engage with nurses to explore their lived experiences with compassion fatigue and their perspectives on education about this topic and stress management, along with pet therapy as an intervention. The participants shared their thoughts, feelings, opinions, and personal experiences regarding firsthand and secondhand accounts with compassion fatigue, occupational stress management, and pet therapy. The research study and design adhered to ACU's IRB research standards and guidance. During the interviews, I followed the interview protocol with the omission of questions if they had already been addressed during a previous question and the addition of questions if the current discussion opened a new avenue for exploration related to the study's topics and research questions.

Data Analysis

Upon collection of the qualitative data via Zoom and phone interviews, I immersed myself in the qualitative data by watching the recordings once and reading through each

transcript at least twice. I analyzed interview transcripts through the IPA process (Alase, 2017). This process requires researchers to read and reread the transcripts to familiarize themselves with the data. The next step included making initial notes of quotes or statements that stood out, finding emerging themes, and making connections in the first transcript. I was able to make quotes and highlight statements that stood out as I was interviewing each candidate and then compare the notes from reading the transcripts to the initial notes made during the interview to make sure they matched. Finally, the process required me to compare findings across transcripts in order to identify patterns.

Responses. Specific participant responses are included in the following sections. A general discussion of each interview, along with quotations from the participants, is provided. Most of the participants focused on the new stressors related to the ongoing COVID-19 pandemic when asked questions about stress management and compassion fatigue, so I also asked them to explore their prepandemic experiences to discover if their answers and perceptions differed before the new stress was added into their daily work lives.

***Participant 1*.** Participant 1 had been a nurse for over 7 years and currently worked full-time as a charge nurse in the emergency department (ED) of their hospital. They scored at moderate risk of developing compassion fatigue on the ProQOL scale and were mostly satisfied with their current position. They reported that they believed there was not enough education in nursing school regarding occupational stress management and none at all about compassion fatigue. They provided their opinions on how to improve this and why it was important. In addition, they admitted to experiencing occupational stress daily and the effect it has on them outside of work. They mentioned not sleeping well as the main negative effect caused by stress. Specifically, staying asleep and dreaming about work were the biggest deterrents to their sleep.

They found successful ways to manage their stress over time and used them daily. One method included their own version of pet therapy:

> I have about an acre of land where I live, and I have chickens. They are my little hobby. Yes, I have to clean up after them, but that's therapeutic to me. I look forward to coming home, sitting in my yard, and letting my chickens come up to me. I have a little betta fish in a tank in my kitchen, and I enjoy doting on him. I also have a dog.

They had experienced firsthand and secondhand compassion fatigue and learned to recognize the signs in themselves and their coworkers. New stressors related to the ongoing COVID-19 pandemic only worsened the stress levels they experienced. They believed continuing education on compassion fatigue, in addition to an introduction to this topic in nursing school, would be beneficial to all staff. They were familiar with pet therapy but had never seen it used at their workplace. They believed pet therapy would be helpful during work shifts because "how can you not pet an animal and smile?" and it would serve as a positive, momentary distraction during the workday.

Participant 2. Participant 2 had been a nurse for over 18 years. They currently worked the night shift in the float pool, usually staffed in the progressive care unit, medical–surgical unit, or mother–baby (postpartum) unit. They occasionally floated to the intensive care unit (ICU) and ED but did not take independent patient loads there. They scored at moderate risk of developing compassion fatigue on the ProQOL and were generally satisfied with their shift and current work conditions. They did not remember any discussion of stress management or compassion fatigue in nursing school but believed both topics would be beneficial to learn about in school. They reported experiencing occupational stress during most shifts, at least two out of three per week. They admitted to "bringing home" the negative feelings associated with occupational stress in

the beginning but had developed the skill of "compartmentalizing stress" over time. They reported not needing to use any stress relievers at home because they "make the conscious decision to shut out" the stress as a "protective mechanism." However, they also explained that they had a long commute, and the drive helped provide time to "consciously shut off" the stress before reaching home.

They also had experienced compassion fatigue both firsthand and secondhand, which had worsened with the COVID-19 pandemic. They learned to recognize it in themselves over time and in others by hearing what their coworkers said, such as "I can't do it anymore," "I'm tired," and "I'm not going back in there." They referred to this as "los[ing] my compassion" versus the term "fatigue." They were familiar with pet therapy because it was offered at the hospital but did not see it often during the night shift. This participant had a goat and a chicken at home and reported they would participate in pet therapy at work if it did not involve dogs because they are allergic to dogs. Regardless of the animal used in pet therapy, they agreed this could benefit most staff by resetting emotions and "changing [their] feelings for the day."

Participant 3. Participant 3 had been a nurse for 10 years. They currently worked full-time days in the postanesthesia care unit (PACU) but floated to the ICU when needed, as this was where they had worked most of their nursing career. They scored at high risk for developing compassion fatigue on the ProQOL and were only mildly satisfied with their current position, a factor that worsened with the COVID-19 pandemic. They reported stress management may have been a topic in nursing school, but if it was, then the schools could "do a better job at preparing nurses on just how stressful it can be." They admitted to experiencing occupational stress daily and reported that it impacted everything outside of work. They reported feeling exhausted

outside of work because their “energy is zapped” while at work and found sleep to be their stress reliever.

They had experienced compassion fatigue firsthand and secondhand and had seen this change after the COVID-19 pandemic began. Their experience with compassion fatigue even led to a change in the area of nursing where they worked, from ICU to PACU, because “PACU is a walk in the park compared to ICU.” In their experience, prepandemic compassion fatigue involved seeing older nurses burned out, tired, and losing the reason they wanted to be a nurse in the first place. Compassion fatigue during the COVID-19 pandemic seemed to affect everyone because the “people we’re caring for are going to die, so we’re not as emotionally invested in this population,” referring to COVID-positive patients in the ICU. They reported still trying to give the best care possible but admitted it was hard because the patients would likely die and there would be more patients to come right after in the same condition. They also reported seeing compassion fatigue in the new graduate nurses now more than ever before. In their opinion, the new nurses seem to be on autopilot: They “show up and work, hoping it will end soon.” Other observations included seeing them looking exhausted and no longer seeing them seek future growth opportunities, such as studying for nursing certifications or taking continuing education courses.

Their experience with pet therapy was minimal. At their hospital, a pet therapy program was announced before the COVID-19 pandemic and one visit even occurred, which they missed. However, additional visits had not occurred since the COVID-19 pandemic started. They believed nurses could benefit from pet therapy. They even gave an example of chair massages that were offered to the staff but said they would rather see an animal on the unit because they would be “more willing to spend 15 minutes with a pup than a massage.” Their perception on

how pet therapy could benefit nurses was related to how interaction with animals is an immediate stress reliever "especially during dark times." Nurses can "get a rest" from these "dark times" because it is "not all dark" if there are "still puppies around."

Participant 4. Participant 4 had been a nurse for 2 years and started working in the burn ICU for 7 months right out of nursing school. They then switched to a medical–surgical unit, where they currently worked nights. They scored at moderate to high risk for developing compassion fatigue on the ProQOL, and they were not very satisfied with their current position. They switched out of the burn ICU due to the stress and "things outside [their] control" but were still trying to determine the area of nursing they wanted to pursue more permanently. They reported not being very well prepared for how to handle the stress that comes with a career in nursing after not covering it in nursing school. They remembered hearing the term "compassion fatigue" in nursing school mentioned briefly in a chapter about a different topic. They believe both of these topics require more attention in nursing school and early in one's nursing career. They reported experiencing occupational stress every day, and they used their stress reduction techniques after every shift and on their off days if they worked consecutive days. The negative effects of occupational stress experienced outside of work included physical signs and symptoms such as "increased anxiety, heart palpitations," and feeling "like something needs to be done." They had difficulty relaxing because they felt like there was work that needed to be done right now. They admitted to these feelings before the COVID-19 pandemic but said they were worse now. Initially, they found stress management methods that helped, but as their anxiety increased, these techniques were becoming less effective.

Compassion fatigue was a new experience for Participant 4, and they reported feeling like they were heading there rapidly. For secondhand experience, they had heard coworkers describe

compassion fatigue as being “mentally” or “physically tired” and “burned out.” They even stated the need to “get out of” their current nursing role because “it’s changing me.” They were familiar with what pet therapy is but had never experienced it. They believed it could serve as a good distraction for the medical staff by providing something to look forward to that was not sad and by helping them to find a calming, positive attitude. They also believe that pet therapy may be more popular with newer nurses because, in their opinion, seasoned nurses seem to be less open to trying new stress management methods.

Participant 5. Participant 5 had been a nurse for almost 14 years and currently worked days and weekends in an urgent care facility but had spent most of their career working in the ICU, both day and night shifts. They scored at moderate risk for developing compassion fatigue on the ProQOL and were satisfied with their current role in nursing as compared to previous areas worked. They reported no education on occupational stress management or compassion fatigue in nursing school and were not prepared for the realities of nursing as they only learned about the “textbook” world of nursing that prepares future nurses to take their licensure exam. They experienced occupational stress during the entirety of their shift, which sometimes extended beyond 12 hours. They experienced negative effects of this stress outside of work in the form of losing sleep and being preoccupied with thoughts about work such as “what did I do right or wrong?” and “what will be on my patient reviews?” They also admitted to having a difficult time relaxing, all of which affected their “family time.” They found that venting to a coworker or friend in the health care field had helped them manage their stress and did this after every shift. The COVID-19 pandemic had caused additional stress because now they were required to check their emails daily, including off days, and respond when needed, so they no longer felt that they had a full day off.

The participant had experienced compassion fatigue firsthand and secondhand. They experienced this earlier in their career when they formed emotional attachments to their patients and families but said they were forced to "harden myself" to move on more quickly because "how much emotional support can you give to others?" They would discuss their days with coworkers, and hearing their stories sounded like experiences of compassion fatigue. They believe that after the COVID-19 pandemic started, everyone's threshold for caring for patients had changed: Patients "need to be really sick to be concerned." They also were disappointed with the new inability to "provide holistic patient care, which is what we learned as nurses," due to the volume of patients, the limited time they could dedicate to each patient, and the lack of communication with patient family members. They believed all of this contributed to developing compassion fatigue. They were not familiar with pet therapy and had not experienced it in their career. However, they had grown up with and currently had dogs that they used as a daily stress reliever. They perceived pet therapy to be beneficial because animals do not expect anything from humans, so it might lead to nurse retention and help manage posttraumatic stress disorder.

Participant 6. Participant 6 had been a nurse for 11 years in the ICU and trauma department and for the past year and a half had been taking traveling assignments where they stayed for 6 months in one place at a time working the day shift. They scored at moderate risk of developing compassion fatigue on the ProQOL and were mostly satisfied in their current role. They did not learn about occupational stress management in nursing school and believed school stressors were different than real work and bedside stressors. They said clinicals may have given them some exposure but nothing significant to prepare them. They admitted to experiencing stress daily and had learned ways to manage it. At the beginning of their nursing career, they admitted to using temporary coping mechanisms, including alcohol, but then learned how to deal

with and process things by “changing emotional baggage” and “emotional dynamics.” They reported it took them over a year to find healthy, long-term ways to manage their occupational stress, which occurred after working in leadership roles that were admittedly more stressful and burdensome than regular bedside roles. These activities now included outdoor activities such as archery, biking, hiking, and short travels. They would like more time to do these activities after each shift but instead did them on days off.

They experienced compassion fatigue both firsthand and secondhand, but this had changed significantly since the start of the COVID-19 pandemic. They also did not remember learning about this topic during nursing school. They learned to become “emotionally separated” by “shutting it off” when dealing with patient care. The example provided was “I don’t cry anymore when holding the tablet up for family to see loved ones take their last breath.” They admitted to getting attached to patients they lost before the COVID-19 pandemic, but the effects of that were nothing compared to the daily deaths they saw now. They reported seeing more nurses “shutting down” and giving up “careers” no matter their years of experience. Newer nurses seem to be overwhelmed, while seasoned nurses appear to be “over it” and did not want to see or deal with it anymore. They believed nurses were burnt out because they were not helping anyone anymore and “just maintaining while the illness takes its course,” referring to COVID-19.

Regarding pet therapy, they were exposed to it at one hospital, but it was for the patients, not employees. They believe pet therapy could be used as a distraction from shift work and as a way to “recharge.” They also perceived pet therapy to be beneficial even if the interactions were brief.

Codes and Themes. I analyzed the data for significant statements. There were many repeated responses and similar opinions across the participant interviews. While watching the recordings and reading the transcripts and my notes, I saw several themes emerge. After listing out the themes from each interview, I looked for connections between them. I was able to condense the themes into codes. This process helped me be mentally aware of the keywords and phrases expressed by the participants. This allowed for better representation of the thoughts and lived experiences of my participants (Alase, 2017). The codes are detailed in the following section, and the themes are listed in Table 1.

Table 1

Repeated Responses and Themes

Repeated responses	Themes
Little to no education on occupational stress management or compassion fatigue in nursing school	Lack of education
No disadvantages to education on compassion fatigue in nursing school	No perceived disadvantages to education
Would like to see continuing education offered on compassion fatigue	Want/need education through all stages of nursing career
Experienced occupational stress most shifts worked and utilized management techniques often	Stress management techniques are important.
Compassion fatigue has negative effects on patient care.	Compassion fatigue is a problem.
Expressed interest in participating in a pet therapy program at work and believed coworkers would also be interested	Perceived benefits of pet therapy for nurses
Current levels of occupational stress and compassion fatigue are worse for me and/or coworkers.	COVID-19 pandemic worsened occupational stress and compassion fatigue.

Education Needed. All participants responded that education on occupational stress management and compassion fatigue was lacking in nursing school and that these topics should be a focus. Participants 3, 5, and 6 mentioned that there needs to be more of a focus on the realities of nursing during school to better prepare future nurses on what to expect when they enter the field. No one believed there were disadvantages to the introduction of these topics in nursing school. Participant 5 stated that education on compassion fatigue might deter some students from entering a certain area of nursing but ultimately viewed this as a positive circumstance. Participant 2 also mentioned that learning about compassion fatigue in nursing school may "scare off" some students but again did not see this as being a common occurrence and therefore not a true disadvantage. Participant 1 commented that nursing students are "bombarded" with knowledge and that nursing school is already "overwhelming" but still believed compassion fatigue should be an area of concentration in school.

All participants acknowledged that education on compassion fatigue would be beneficial not only in nursing school but also after entering the field, such as a continuing education (CE) offering. Most also agreed there was a lack of current resources at their job. Participant 1 would like to see education on compassion fatigue in their hospital and specific to their department. Participant 2 admitted having difficulty asking coworkers for help because they "don't want to admit I'm exhausted," which led to a connection with Participant 3, who had many thoughts on why education on compassion fatigue is critical for nurses in all stages of their career. They believed that new nurses needed help with it because people can be "judgy when [they] first heard about it." They stressed that it was important to "normalize it." They also suggested annual training through a CE or mentoring "because this topic will impact you differently during different parts of your life." Participant 6 stated that education on compassion fatigue should

occur “pre and early career” and CE activity should be ongoing to cover all the experience levels of nurses.

Stress Management Needed. All participants reported experiencing occupational stress during most, if not all, of their workdays. They all found ways to manage their stress outside of work and admitted needing to use these methods after every shift, though their methods differed. Participant 4 reported that their stress reduction techniques were not as effective as they had been in the past, and Participant 2 described using emotional regulation by “compartmentalizing” and “shutting off” their stress before bringing it home. Participants 1, 3, 4, and 5 all reported physical signs and symptoms of occupational stress, and Participant 6 mentioned also experiencing this during their first year of nursing but not as often now. The most common physical symptom was feeling physically “tired” or “exhausted.”

Negative Effects. All participants understood the term “compassion fatigue.” Although their thoughts and feelings were similar, the meaning of the term and their lived experiences differed. All the participants had stories to share about their firsthand and secondhand experiences with compassion fatigue. Everyone agreed that compassion fatigue negatively impacted patient care and the ability to help coworkers. Participant 1 reported compassion fatigue causing a slow of the flow in their department, which led to longer wait times and “shorter tempers” of staff and patients, but they did not believe it caused any changes in the care provided. Participant 4 reported that it was easier to make mistakes when it comes to patient care because it was harder to listen to patients’ concerns. Regarding the impact on coworkers, they explained that dwelling on the negativity “makes each other worse,” and they had witnessed the spread of negativity amongst coworkers stemming most often from the seasoned “mother” nurses. Participant 5 described their feelings associated with compassion fatigue cut down on the

time they spent with patients and that repetition made empathizing hard. They explained this as a situation in which "everyone is going through hard times right now, not just you." They also explained that it was hard to empathize with coworkers when they felt the exact same way. They did, however, believe that there was no negative impact on critical thinking regarding patient care. Participant 6 mentioned experiencing compassion fatigue made it harder to be optimistic about a patient's possible outcome, forcing them to focus on short-term goals versus the end result. They also shared that it was harder to help coworkers while trying to manage their own load, both at and outside of work. They expressed being "on your own for emotional support."

In an incidental finding, everyone mentioned that the ongoing COVID-19 pandemic had worsened compassion fatigue, either in themselves or their coworkers. Although the interview questions did not mention or focus on experiences related to the COVID-19 pandemic, everyone shared their recent experiences with compassion fatigue that involved the current COVID-19 pandemic in some way. That required me to add questions asking my participants to recall their experiences with compassion fatigue prior to the COVID-19 pandemic to discover if compassion fatigue was a new experience solely because of the COVID-19 pandemic. However, all participants were able to share their lived experiences with compassion fatigue before the COVID-19 pandemic.

Pet Therapy Is Beneficial. All participants were familiar with the term "pet therapy" but differed in their knowledge of what a program involves and their experience level with a formal pet therapy program. Most assumed pet therapy programs involved a dog versus other types of animals. Participants 1, 2, and 5 shared that they had pets and had incorporated them as part of their stress management routine. All of the participants perceived pet therapy would help nurses (and other health care staff) in some way. They shared very few disadvantages to having a pet

therapy program dedicated to health care staff. Participants 2, 4, and 6 mentioned allergies as a possible disadvantage but also believed there could be a variety of animals used to avoid this. Participant 6 also mentioned people being "scared of dogs" as a possible disadvantage. Participant 5 mentioned the cost of starting or maintaining a pet therapy program could be a disadvantage but also admitted not being very knowledgeable about these programs. Participant 1 believed pet therapy would be a great addition to their hospital but in a "well-controlled environment."

Every participant agreed that they would partake in a pet therapy program if offered at their facility. The exception was Participant 2, who because of their dog allergy thought they were in favor of participating if another animal was available. Participants 1, 3, and 6 believed pet therapy could be a good distraction for staff. When asked if there was an ideal time for a pet therapy visit during the workday, everyone agreed that during the shift would serve as the most beneficial time for staff, assuming there was time allotted for it. Participant 2 also mentioned at the end of the shift would be a good time for staff to participate in pet therapy before they left for the day.

Summary

Chapter 4 detailed findings from the semistructured interviews, which explored currently practicing bedside nurses' feelings about and perceptions of occupational stress management, compassion fatigue, education on these topics, and pet therapy as a possible intervention. The lived experiences of the nurses and the narratives that originated from them were the source of significant and relevant data. Their responses and shared experiences provided insight that led to the themes found in this study.

In this chapter, I presented rich and detailed descriptions of perceptions developed through the collection and analysis of the qualitative data. I was able to establish credibility in my study through triangulation by interviewing multiple nurses and by using a thick description to convey my study's findings. I also achieved confirmability through triangulation and reflexivity. I was able to practice epoché by maintaining awareness of the assumptions I had about the topics. I was not able to remain completely neutral during the data collection and analysis process because I am a nurse and advocate of pet therapy. This chapter contained information related to a qualitative phenomenological examination, which was the research methodology used in this study. I used IPA to analyze and interpret the data, develop themes, and condense these themes into codes to describe the phenomenon. This chapter also included a description of the data collection and analysis techniques.

The data collected for this research study were relevant to the purpose and research questions. The qualitative data and research findings suggested that compassion fatigue has negative effects on a nurse experiencing it and it can worsen the level of distress experienced while serving patients. The study's findings also suggested that there is a lack of education on occupational stress management and compassion fatigue in nursing school. Lastly, there was a perception that pet therapy would be effective for nurses experiencing occupational stress and compassion fatigue. A detailed discussion of how these findings fit the research questions, implications for future research, and recommendations for the field of nursing is provided in Chapter 5, along with the limitations to the study.

Chapter 5: Discussion, Implications, and Recommendations

Compassion fatigue is a problem within the nursing profession. Helping people who are suffering is a common component of nursing, which can create an emotional burden, leading to stress and a diminished ability to empathize or feel compassion for others (Gentry, 2018; Houck, 2014). Compassion fatigue can manifest as physical signs and symptoms in the nurse, as well as negatively impact the patient care given. Compassion fatigue can have unfortunate repercussions on nurses' health and well-being, resulting in mental health concerns leading to work impairment, job dissatisfaction, and leaving the bedside patient care role, further contributing to the nursing shortage (Labrague & de los Santos, 2021; Sacco et al., 2015). Since compassion fatigue can affect nurses at any stage of their career, they must learn the risks and prevention techniques early and have continued access to resources and support from their organizational leadership. Unfortunately, according to Boyle (2011), education on this topic is lacking in nursing school. The current COVID-19 pandemic has only worsened the rates of compassion fatigue in nurses. Research has shown that 70% of frontline nurses suffered from moderate to severe compassion fatigue during the COVID-19 pandemic, with 97% of nurses experiencing at least one symptom (Erkin, Konakçı, & Duran, 2021, as cited in Labrague & de los Santos, 2021). This further drives the importance of why a focus on stress reduction, compassion fatigue, and coping mechanisms is critical for nurses throughout their careers, starting in school.

The purpose of this phenomenological research study was to discover if nurses had been prepared to cope with occupational stress and compassion fatigue. Another purpose was to examine one form of coping (pet therapy) as a possible stress reduction technique to decrease the effects of compassion fatigue. Pet therapy is a form of treatment meant to help people recover from or better cope with health problems (Bert et al., 2016). Pet therapy is one possible

intervention that can help nurses manage their stress and cope with or prevent the negative effects of compassion fatigue. Ultimately, the goal of this study was to discover possible ways for nurses to manage their occupational stress, cope with compassion fatigue to improve their mental health and career longevity, and find one possible way to slow the increasing nursing shortage.

The phenomenon studied in this research was compassion fatigue and occupational stress in nurses, including education received on these topics in nursing school. In addition, a secondary phenomenon studied was the perception nurses had of pet therapy as an intervention. I used a qualitative phenomenological research approach to explore the lived experiences of nurses who suffered from compassion fatigue or were at moderate to high risk of developing compassion fatigue. The study's population was nurses who had experience in and currently cared for patients in a medical facility, either in a hospital or clinic. These nurses had real experiences with compassion fatigue. Relative to the study's purpose, three research questions served as a guide:

RQ1: What effect does compassion fatigue have on the level of distress experienced by nurses while serving patients?

RQ2: What education do nursing schools offer to prepare nurses to cope with occupational stress and combat compassion fatigue in their role as a servant leader?

RQ3: What perception of pet therapy do nurses have as a potential management technique for occupational stress and compassion fatigue?

The participants' responses to the interview questions, along with my observations during the interview process, provided insight into the phenomena as experienced by the nurses. I recruited the participants via social media, expanding the population to nurses anywhere in the

world. However, all those who participated currently worked in the United States. Inclusion criteria for this study were as follows: nurses who (a) spent at least 50% of their role practicing patient care and (b) scored high or moderate on the ProQOL scale. I used semistructured interviews to collect data and IPA to analyze the data and identify important themes. Nurses shared their personal and secondhand experiences with compassion fatigue, how often they experienced occupational stress and needed to use their learned management techniques, their exposure to the topics of occupational stress and compassion fatigue in nursing school, and their perceptions on the benefits pet therapy may have for nurses.

As mentioned in Chapter 4, the qualitative data and research findings suggested that compassion fatigue has negative effects on a nurse's ability to serve their patients and coworkers. The study's findings also suggested that nurses could benefit from education on occupational stress management and compassion fatigue during nursing school, as well as throughout their careers. Lastly, there was a perception by the participants that pet therapy would be effective for nurses experiencing occupational stress and compassion fatigue. This chapter contains a discussion and interpretation of the results, including an incidental finding, the study's limitations, practical recommendations based on the results, future research opportunities, and conclusions drawn from the research.

Discussion

The participants willingly shared their perceptions and lived experiences of the study's phenomena and included examples of what it was like to be a nurse during the current COVID-19 pandemic. The nurses who participated in this study have all experienced compassion fatigue either currently or at some point in their career. They have witnessed their coworkers suffer through it and recognize it is a problem that needs to be addressed. The current state of health

care in response to the COVID-19 pandemic has only worsened the issue of compassion fatigue. The following discussion of the findings in relation to the existing literature further demonstrates the problem of practice on which this study was based.

Effects of Compassion Fatigue

Research Question 1 was as follows: What effects does compassion fatigue have on the level of distress experienced by nurses while serving patients? Although each participant had a different definition of compassion fatigue, they described it in the same way and with a negative connotation. The interview data revealed that compassion fatigue made delivering high-quality patient care more challenging for nurses. In addition, the data also revealed that compassion fatigue made it more difficult to help and support their coworkers, which also impacted patient care. This places an additional strain on nurses and can impact them outside of work as well, therefore further contributing to their stress. Participant 6 mentioned that compassion fatigue made it hard to be optimistic about a patient's possible outcome. Participants 1 and 5 both reported that compassion fatigue did not affect their ability to maintain a safe patient care environment for their patient assignment but did not say the same for their coworkers or departments. Participant 5 also reported compassion fatigue "cuts the time I am able to spend with my patients," while Participant 1 said it shortens the tempers of staff and patients, both of which could arguably create less-than-ideal situations for patients. Participant 4 explained that compassion fatigue made it easier for nurses to make mistakes and harder to listen to patient concerns. Most of the participants agreed that it was harder to help their coworkers while struggling to manage their own workload. Participant 2 even found it difficult to ask for help when they knew their coworkers were also struggling. Stress is frequently accompanied by pressure and guilt due to the limitations nurses face when providing care, which can decrease the

quality of care they provide. Factors such as errors in patient care, the inability to communicate effectively with coworkers, and the lack of support available for patients can all contribute to stress and the development of compassion fatigue and can impact a nurse's ability to serve their patients (Mattioli et al., 2018).

One component that can lead to the development of compassion fatigue is nurses' inability to keep their energy. Healthy nurses can learn to acquire an awareness of how much energy they can afford to give to other people (Mattioli et al., 2018). Unfortunately, with compassion fatigue, there is a depletion of emotional energy, making it difficult for nurses to serve their patients. Participant 3 was the only one who discussed their ability to help their coworkers while experiencing compassion fatigue. They shared more secondhand experiences witnessing the effects of compassion fatigue in others, specifically newer nurses. They shared their ability to help the new nurses as much as possible. When asked where they find the energy to help them, they explained that they think of the new nurses as their kids, having to help and be there for them, and they even referred to themselves as a "mother hen taking someone under my wing" because "it's what I do." This awareness of how much energy they can expend on others may be a characteristic of a more seasoned nurse versus one who is new to nursing. Nurses with less experience may be more at risk of developing compassion fatigue than more experienced or seasoned nurses (Boyle, 2011). Seasoned nurses may have a higher level of compassion satisfaction due to their life and work experiences and the stress management techniques and coping mechanisms they have developed over time (Sacco et al., 2015). Compassion satisfaction is a positive feeling associated with helping others (Durkin et al., 2016). Nurses newer to the field may not have had the opportunity to learn strategies that work for them.

Participant 2 described “compartmentalizing” their stress as their way of managing it. This is a form of emotional regulation and requires self-control. As described in Chapter 3, emotional regulation includes all efforts to change aspects of emotion to manage emotional demand by modifying the felt emotion or suppressing it and possibly displaying an inauthentic one (Banks van Zyl & Noonan, 2018). Newer nurses may react negatively to emotional demands, putting them at an increased risk for developing compassion fatigue. Participants 2 and 3 both had over 10 years of nursing experience, while Participant 4 had only 2 and was currently struggling most with managing their occupational stress. Ultimately, the data showed that no matter how much experience a nurse had, all participants were either currently experiencing or at risk for developing compassion fatigue. However, current experiences with compassion fatigue could be related to the current COVID-19 pandemic, an incidental finding in this study.

The COVID-19 pandemic started while this research study was in progress but before data collection. All the nurses who participated in this study were working directly in patient care, as required by the inclusion criteria, so they were considered frontline workers. Nurses on the frontline have encountered new stressors while also experiencing ones found in usual circumstances. These new stressors included increased patient workloads, lack of reliable personal protective equipment, constantly changing COVID-19 pandemic protocols and infection control requirements, inadequate preparation related to care of infected patients, and poor working conditions, making it difficult to effectively carry out their duties (Labrague & de los Santos, 2021). These conditions, along with a heightened fear of being infected or infecting their loved ones, could negatively affect nurses’ ability to be compassionate and increase their risk of developing compassion fatigue. Every participant shared their recent experiences with compassion fatigue, which occurred during the COVID-19 pandemic, and how compassion

fatigue affected their ability to serve their patients. When asked, they were also able to recall their experiences with compassion fatigue before the COVID-19 pandemic started. Although the COVID-19 pandemic seems to be causing or making compassion fatigue worse in the participants, it is something that everyone had experienced prior to it. In other words, compassion fatigue was not found to be a COVID-19 pandemic–specific response. It was a problem for nurses before the recent state of the health care system.

Managing stress and coping with compassion fatigue are important components in nursing. Doing so in healthy ways is especially important. Participant 6 mentioned using a temporary form of coping, specifically alcohol, early in their career until they learned how to process their experiences and regulate their emotions. Multiple participants mentioned sleeping as their way to manage, or avoid, stress and the feelings of anxiety they experience both at and outside of work. Sleeping might help temporarily, but the feelings of stress remained when they were awake. Unmanaged stress can affect how nurses perform in the workplace, causing even more stress, which can lead to compassion fatigue. This increased level of distress not only negatively impacts the personal and professional quality of life of nurses, but it also compromises a nurse's ability to serve their patients (Mooney et al., 2017). Since the negative effects of stress and negative coping mechanisms can lead to compassion fatigue, it is critical for nurses to find healthy and effective ways to manage. Stress management and compassion fatigue are topics that should be addressed before they start their careers.

Educational Preparation

Research Question 2 was as follows: What education do nursing schools offer to prepare nurses to cope with occupational stress and combat compassion fatigue in their role as a servant leader? All participants saw education on compassion fatigue, both during nursing school and

continuing throughout their career, as a necessity. Exposure to “real world” scenarios in school that can be experienced while working as a nurse was believed to help future nurses be better prepared to cope with situations they might encounter during their career. Learning about compassion fatigue in nursing school may help future nurses recognize it early, making it easier to combat or prevent. Learning about compassion fatigue can also help them recognize it in their colleagues, allowing them the opportunity to address it. According to the American Nurses Association, compassion fatigue is a topic that should be integrated into every undergraduate and graduate nursing curriculum (Boyle, 2011). Participant 3 would like to see the normalization of compassion fatigue. They described their introduction to compassion fatigue, which occurred after they were already working as a nurse, as those experiencing it being looked down upon by other nurses. Perhaps the negative views about compassion fatigue are due to a lack of understanding of what it is. Education on this topic would allow nurses to see how common compassion fatigue is and that every person who works in a caring profession is at risk for developing it.

Education on compassion fatigue should not stop after nursing school. Every participant wanted to see continuing education opportunities offered throughout their career. Since compassion fatigue can occur any time during a nurse’s career, education that is readily available for a nurse to access would be beneficial. Participant 1 even wanted to see education on compassion fatigue specific to their department (emergency), which is one common area of nursing that experiences compassion fatigue (Adams et al., 2019). Participants 3, 4, 5, and 6 mentioned also needing education during the early stages of their training as a nurse, such as during a residency program. Several hospitals have specialty training programs for new nurses that are specific to the area in which they will be working. These are sometimes referred to as a

nurse residency. None of the participants mentioned support offered by their employers. Facilities that employ nurses should make supporting them a priority, whether they are new to the field or have been in practice for a while (McDermid et al., 2020; Meyer et al., 2015).

Pet Therapy as a Management Technique

Research Question 3 was as follows: What perception of pet therapy do nurses have as a potential management technique for occupational stress and compassion fatigue? None of the participants had experienced pet therapy in their work environment; however, they agreed that it would be enjoyed by most nurses. They all expressed their opinions on how pet therapy could help a nurse manage their stress, even if only temporarily. There was a limited number of disadvantages to pet therapy shared by the participants. Only 2 participants could think of a disadvantage of pet therapy: "allergies" to and "fear" of an animal. Some of the participants were not familiar with what a pet therapy program entails. For example, dogs are not the only animal that can be used, so allergies and fear may not be applicable. Participant 1 believed a pet therapy program would be beneficial but only in a "well-controlled environment." Pet therapy programs have certain guidelines in place to ensure this, and it is usually part of the agreement made between the animal handler or program administrators and the facility with whom they partner (Bert et al., 2016).

Two of the participants mentioned incorporating their family pets as one of their occupational stress management techniques. Several of them mentioned knowing their coworkers had pets, which is why they believed they would participate in and benefit from a pet therapy program if it were offered at their workplace. All participants agreed that during their shift would be a good time for a pet therapy session. This demonstrates the value of having a therapy pet who can travel to the units instead of making the nurses leave their unit to find the

pet. Having to leave the unit during their shift is not always feasible for a nurse, and pet therapy is one program that would not require leaving the unit.

Theoretical Framework

Chapter 3 described three theories to support this research: servant leadership theory, moral distress theory, and human–animal bond theory. The theories are discussed in the following sections in relation to the literature and the data results.

Servant Leadership Theory. Servant leadership is a proposed leadership style where the leaders' main purpose is to serve (Northouse, 2016). Listening, hearing, empathy, healing, awareness, and stewardship are characteristics of a servant leader and a nurse. A nurse serves their patients in the form of medical care. One thing most nurses learn in school is to consider the whole patient, not just their presenting ailment or problem. Considering the whole patient entails listening and anticipating a patient's needs, incorporating family members or caregivers in their care, educating them on their plan of care, and serving them all with compassion. Participant 5 complained that compassion fatigue makes it difficult to provide holistic patient care due to the inability to provide enough emotional support to meet a patient's needs. Multiple participants mentioned having a difficult time focusing on patients and listening to everything that they had to say. A few also mentioned not being able to spend as much time with each patient as needed. Listening, hearing, and empathy are characteristics of servant leadership that are negatively affected by nurses experiencing compassion fatigue, which causes difficulty for nurses to adequately serve their patients, impairing their ability to be good servant leaders. Servant leaders make listening to their followers a priority so they can understand their abilities, needs, and goals, which allows these followers to achieve their full potential (Northouse, 2016). Part of

nursing is treating, supporting, and helping patients, so understanding a patient's abilities, needs, and goals is important. Moral distress can also impact servant leadership.

Moral Distress Theory. Moral distress involves the damaging feelings that occur when an individual knows the ethically correct action to take but does not have the power to take that action (Corley, 2002). The theory focuses on what happens when a nurse feels unable to advocate for a patient, leading to the experience of moral distress. Serving as a patient advocate is similar to stewardship, a characteristic of servant leadership. Moral distress causes difficulty in advocating for patients, which interferes with a nurse's ability to be a strong servant leader. The same factors that lead to moral distress can lead to compassion fatigue, but moral distress alone has also been found to lead to compassion fatigue (Fernandez-Parsons et al., 2013). Now, more than ever with the COVID-19 pandemic, nurses are likely experiencing moral distress. Restrictions such as isolation protocols, not allowing patient visitors to physically sit beside their loved ones, unavailable treatment options and medical equipment, and increased workloads resulting in less time available for patient care are all events outside of a nurse's control. They may feel powerless to take what they believe to be the correct ethical action.

Participant 6 described being burnt out because they did not feel they were helping anyone anymore but just keeping the patient as comfortable as possible while the virus ran its course. This feeling fit the criteria of moral distress and demonstrated how it contributes to their development of compassion fatigue. When nurses experience moral distress, it is important they feel supported. This support should come from both inside and outside the workplace. Corley (2002), who coined the moral distress theory, found that nurses sought support from others when resolving ethical dilemmas and related stress. Nurses need the opportunity to ponder their concerns in a safe and nonjudgmental space. Pet therapy can help. Animals can provide social

support through reducing loneliness, being constantly available, and providing support and unconditional love—conditions that are often not present in human relationships (O'Haire, 2010). Animals are used for therapeutic purposes because they remain free of prejudice and judgment when interacting with people (Calcaterra et al., 2015).

Human–Animal Bond Theory. HAB theory, which stems from attachment theory, involves the health benefits received from the unique bond between humans and animals (Beetz, 2017). Animals can provide the social support nurses need to manage their stress. As all the participants agreed, a pet therapy program could provide multiple benefits for nurses. It could allow nurses the opportunity to feel energized and recharged to finish their shift. It could change their mood by bringing a smile or moment of joy to their day. Even something as minor as providing a brief distraction could be enough to get them through their shift until they leave and can utilize their other stress management techniques. These benefits can improve a nurse's mental health and prevent or decrease the effects of compassion fatigue.

Limitations

Limitations in research are important because they include potential weaknesses in the data interpretation that could threaten the study's credibility and trustworthiness. In phenomenological research, ensuring trustworthiness involves the ability to assess the quality of the research (Alase, 2017). Credibility expresses the quality of the research, the rigor of the methodology, and if the research findings are believable from the perspective of the participant (Leavy, 2017; Terrell, 2016). Transferability is the ability to transfer research findings from one context to another. Both components contribute to a study's trustworthiness. This phenomenological study had limitations that may have affected the trustworthiness of the results.

At the start of this study, I was not currently practicing nursing at the bedside. I worked as a nurse in direct patient care for many years and was plagued with compassion fatigue. As a result, I left my bedside role for one that did not directly involve patient care. I am now again working at the bedside, participating in patient care daily, but am not currently experiencing compassion fatigue. In addition, I have a love for animals. Although I practiced bracketing and kept an open mind during my data collection and analysis, these experiences and opinions may have created personal biases that influenced the results and conclusions. Researcher bias is a concern of qualitative research, but a phenomenological research approach can minimize the effect researcher bias has on the results and enhance the credibility and trustworthiness of the findings (Creswell & Creswell, 2017; Saldaña & Omasta, 2018).

The COVID-19 pandemic forced multiple changes to this study and created new limitations. The pandemic made recruiting volunteers more challenging and even caused a change in my recruitment strategy. The strain it has placed on nurses may have lessened their desire to participate in a research study, therefore limiting my planned total number of participants. Nurses were experiencing a high level of fatigue due to the long-term events associated with the COVID-19 pandemic and may have been reluctant to continue thinking about and discussing aspects of their work on their days off. However, since I was able to reach data saturation with my 6 participants, I do not believe the reduced number of participants affected the interpretation of the results. Another impact of the COVID-19 pandemic was that it prevented the use of in-person interviews. With virtual interviews, it is possible to miss some nonverbal cues or body language usage since the researcher's view of the participant is limited. The long-term experiences working in a COVID-19 pandemic may have affected the participants' ProQOL scores, part of the inclusion criteria. The ProQOL scale measures

compassion satisfaction and compassion fatigue, both of which can change dramatically from the difficult working conditions most nurses are currently experiencing. The experiences the participants shared when responding to questions about occupational stress and compassion fatigue all included the COVID-19 pandemic, likely because these were their most recent experiences. I found it easy to get them to remember and share their experiences before the COVID-19 pandemic, so it did not appear that asking them to recall memories from before the COVID-19 pandemic affected the results.

Since my sample had to be changed, I was no longer limited to using only one facility to recruit nurses. However, this change created a different limitation. I was not able to target facilities that utilized a pet therapy program, which was one of the reasons I chose the hospital in my original research design. Although the participants in this study knew what pet therapy was, they had not participated in it or did not know what the programs entailed. Not having experience participating in a pet therapy program may have influenced their perceptions of pet therapy.

Implications

The findings in this study aligned with and extended the current literature. One finding even created new knowledge in an underresearched area. There were no surprise findings or results that differed from the literature. Compassion fatigue increases the level of distress experienced by nurses while serving their patients, making them less effective servant leaders. It also causes difficulty for nurses to assist their coworkers when needed. Compassion fatigue can manifest acutely or progressively (Henson, 2020). I believe there is an acute onset of compassion fatigue for most nurses now as a result of the COVID-19 pandemic. The radical changes nurses have been forced to adapt to, combined with an increase in patient volume, acuity level, and need

for emotional support, can quickly lead to developing compassion fatigue. Since many patients were not able to have their loved ones at their side as they struggled to fight their illness, the responsibility of providing additional emotional support landed on the nurse. However, the literature mostly describes prolonged, continuous contact with patients as leading to an exhaustion of resources for expressing empathy and compassion (Henson, 2017). Therefore, a progressive onset of compassion fatigue is more commonly studied and referenced in the literature. Whether it is acute or progressive, compassion fatigue decreases the effectiveness of servant leadership.

Putting others first is the defining characteristic of servant leadership because the leader places their followers' needs over their own self-interest (Northouse, 2016). Nurses tend to neglect their needs so they might serve others. But they also need emotional support so they can continue to support others. Existing literature reveals that nurses believe their self-care and well-being are not priorities because they do not recognize how setting aside their own needs may risk their ability to help others (Andrews et al., 2020; Couser, 2020; Halm, 2017). Not taking care of oneself can raise stress levels and worsen compassion fatigue (Keesler & Troxel, 2020). One way to improve self-care and compassion is through the support of others. Another way to improve self-care and compassion is through education to prepare future nurses for the stressors they will likely face and the importance of taking care of themselves.

It appears that nursing schools offer little to no education on coping with occupational stress or compassion fatigue, therefore not properly preparing future nurses in their role as servant leaders. As mentioned earlier, it is recommended that compassion fatigue be a part of the nursing curriculum. The literature also revealed that there is a lack of stress reduction techniques being introduced to undergraduate students (Jafari, 2017). Nursing schools have a need for

specific curriculum to teach positive coping strategies to better prepare new graduates to engage with the complex, demanding, and constantly changing work environment involved in nursing (He et al., 2018). Several studies revealed that compassion fatigue was found more often in novice nurses than in experienced ones (Kolthoff & Hickman, 2017; Mattioli et al., 2018). They may not have had the opportunity to learn what activities can decrease their stress levels or the skills needed to cope with their new work experiences. Making future nurses aware of the emotional demands facing today's nurses is essential so they might be better prepared to manage the stressors that come their way and become servant leaders. As mentioned earlier, it is also important that new and future nurses develop a support system as a method for taking care of themselves.

The nurses in my study believed pet therapy could help them manage their occupational stress and combat compassion fatigue. Pets can serve as a form of social and emotional support for humans (Bert et al., 2016). The evidence of benefits that animals can have on stress relief and mental and physical health in humans is extensive (Bert et al., 2016; González-Ramírez et al., 2013; González-Ramírez & Hernandez, 2014; Levine et al., 2013; Polheber & Matchock, 2014; Utz, 2014). However, these studies usually focus on helping patients with their illnesses, not on health care workers. Animal intervention can help nurses because of the stress buffering effect that can occur while interacting with an animal, causing a period of relaxation (O'Haire, 2010). This would (a) help nurses unwind after their shift or on days off if they had a family pet at home and (b) allow for a moment of stress relief during their shift if their facility had a pet therapy program.

Recommendations

As shown in the literature and this study's results, compassion fatigue is a problem for nurses. Compassion fatigue can also cause a challenge for others who work in the health care field and any profession that requires caring for others. Despite this being a documented problem, there is a lack of research regarding prevention techniques or ways to combat compassion fatigue. Multiple recommendations were drawn from the results of the IPA of qualitative interview data. The following recommendations for practical application and future research are based on the findings.

Recommendations for Practical Application

Given the current state of health care because of the COVID-19 pandemic and the effect it has had on the nursing field, helping nurses with compassion fatigue is crucial. As stated previously, compassion fatigue can lead to nurses leaving their role in patient care, further contributing to the nursing shortage (Hersch et al., 2016). The world needs even more nurses now as patient volumes increase; however, nurses have become mentally and emotionally exhausted from the strain of battling the virus. As a result, morale has plummeted, causing nurses to leave the profession (Gaffney, 2022). As evidenced by the results of this study and the existing literature, education on compassion fatigue and the importance of managing occupational stress is severely lacking in nursing school. Curriculums should allow for dedicated time spent on compassion fatigue, including signs and symptoms, causes, consequences, how to recognize it in oneself and coworkers, and what to do about it. As indicated by the themes that emerged from the results, not only was there a lack of education, but there also was no perceived disadvantage to this education in nursing school. Education on why nurses need to manage their occupational stress should also be a focus. As revealed by the data, real-world scenarios of nursing could help

demonstrate what future nurses can expect to find once they enter the field. The current COVID-19 pandemic would be an excellent example of something unexpected that forced nurses to learn how to adapt, manage their self-care, and avoid compassion fatigue and burnout. Included in the education about compassion fatigue should be the terms “burnout” and “compassion satisfaction.” As described in Chapter 2, burnout and compassion satisfaction are linked to compassion fatigue and can affect the professional quality of life of a nurse (Durkin et al., 2016).

Education on compassion fatigue should not stop after nursing school. It needs to be a topic in nurse residency or new-nurse training programs. This education could include even more of an introduction to the real world of nursing with guest speakers from the hospital who do not mind sharing their personal experiences and how compassion fatigue has affected or changed them, or videos of a similar nature. Another option could be to make new nurse residents find and share research articles on compassion fatigue so they can learn about this topic themselves and teach their peers. Continuing education on compassion fatigue provided by the workplace, especially hospitals, and other nursing entities such as nursing journals and professional conferences where nurses earn continuing education credits should all be sources of information that cover this subject.

In addition to providing education, hospitals should provide support for nurses. One resource could be in the form of a mentorship program. Mentoring has been found to decrease stress and loneliness and increase self-efficacy (Raymond & Sheppard, 2018). These results could increase compassion satisfaction, therefore decreasing the risk of developing compassion fatigue (Sacco & Copel, 2018). A mentorship program could benefit both the mentor and mentee. Another way hospitals could support their nursing staff is by being proactive. Special training for nursing leadership, specifically supervisors and managers, to teach them how to

recognize the signs and symptoms of compassion fatigue and burnout in their staff could help with early recognition and prevent them from losing their staff. Managers and supervisors typically interact with their nurses frequently when they hold staff meetings, perform evaluations, and do rounding on their units. Hospitals should also consider taking advice from their frontline workers. Every participant had ideas on how to improve their current position and working conditions, so including employees in brainstorming ways to improve their working conditions could be a helpful concept.

Support could also come in the form of a pet therapy program. Hospitals that already have pet therapy programs need to include health care staff in their rounds instead of solely focusing on patients. The effect of pet therapy on health care staff is underresearched, but the perceived benefits as noted in this study's results, as well as the documented benefit pet therapy has on a person's physical, mental, and emotional health, make it reasonable to assume pet therapy could help nurses manage their stress (Bert et al., 2016; González-Ramírez et al., 2013). Hospitals that have a high turnover rate or know burnout or compassion fatigue is a common complaint among nursing staff could investigate investing in a pet therapy program. The cost of having a pet therapy program may be considerably lower than the cost of nurse turnover rates (Adams et al., 2019).

Recommendations for Future Research

In this study, I presented findings that demonstrate to nurses the importance of managing their occupational stress and may show nursing schools the need to add to their curriculum and health care facilities why they need to support their staff. To address the limitations of this research, I recommend that researchers replicate the study in a different context or multiple contexts to determine whether the data are transferable and to further validate the results. This

study could be replicated when there is not a pandemic that has been exhausting nurses and health care resources for a long period. This research concept would add to the nursing literature and provide a better understanding of one possible stress management technique that could decrease the risk of developing compassion fatigue.

Experimental research can be conducted in which nurses participate in pet therapy sessions while their stress levels are measured. A control group—no pet therapy—can be compared to the experimental group—participation in pet therapy sessions during their shift—while stress levels are measured before and after each shift. This could discover if pet therapy can help with long-term stress management for nurses. There is minimal literature on how pet therapy affects nurses. Based on the perceived benefits pet therapy can have, as portrayed in this study, I believe experimental research is a viable next phase in research related to this topic.

Research studies that explore different prevention techniques or ways to combat compassion fatigue is another underresearched avenue that should be explored. The present study revealed that education on compassion fatigue and the importance of managing occupational stress is lacking in nursing schools and the perceived benefits it could have. Future research could compare nurses who received education on these topics to those who did not. The study could uncover the effect education has on a nurse's ability to cope with and manage their stress, as well as whether it changes their risk for developing compassion fatigue.

Summary

The purpose of this phenomenological study was to discover if nurses were prepared to cope with occupational stress and compassion fatigue. A secondary purpose was to examine the perceived benefit that pet therapy can have as a possible stress reduction technique to decrease the effects of compassion fatigue. Specifically, I investigated nurses at moderate to high risk of

developing compassion fatigue and ones who were currently experiencing it and their lived experiences with compassion fatigue and managing their occupational stress, the education they had received on these topics, and their perception of pet therapy. Given this aim, I used a phenomenological approach to collect data.

Through this research, I presented thick and realistic descriptions of the experiences shared by the participants. I developed themes and condensed codes that emerged from the data. I presented my interpretation of the findings in relation to the literature. Given the amount of data collected in this research, the ability to reach data saturation after 6 participants, and the results developed from IPA, I found the negative effect that compassion fatigue has on a nurse's ability to serve their patients and coworkers was significant. To recap, the goal of this study was to discover possible ways for nurses to manage their occupational stress and cope with compassion fatigue to improve their mental health and career longevity and find one possible way to slow the increasing nursing shortage. Through this research, I achieved my purpose and goals in three ways. It appears as though compassion fatigue elevated the level of distress nurses experienced while caring for patients. Further, there was a perceived lack of education to prepare nurses for the real challenges they will likely face during their career. Finally, there was a perceived benefit that pet therapy can have on a nurse's ability to manage their occupational stress and possibly decrease the effects of or the ability to cope with compassion fatigue.

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Appendix A: Professional Quality of Life Scale

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)

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)

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

Compassion Satisfaction Scale

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

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

Total: ____

The sum of my Compassion Satisfaction questions is	And my Compassion Satisfaction level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Burnout Scale

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

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

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

Total: ____

The sum of my Burnout Questions is	And my Burnout level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Secondary Traumatic Stress Scale

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

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

Total: ____

The sum of my Secondary Trauma questions is	And my Secondary Traumatic Stress level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Appendix B: Interview Protocol

Opening script: Thank you for agreeing to participate in this research study. I want to ensure you understand the purpose of this study, and the potential risks and benefits to you as a participant that were listed on the consent form you signed. Please let me know if you have any questions now. As a reminder, I will be recording this interview so I can review it later as part of the data analysis process. It will not be viewed by anyone else, and I will not share your name with anyone else. Please be aware that I will also be taking notes during your interview, so I apologize if there are any moments of silence as I write. This interview should take approximately one hour. If you don't have any questions at this time, let's get started!

Intro Questions

How long have you been a nurse?

In what unit/area of nursing do you currently work?

What shift do you work (days, nights, prn, weekends, etc.)?

How satisfied are you with your current position?

- Subquestion: What could make you more satisfied?

Occupational Stress

How has your education prepared you for occupational stress, specific to nursing?

How often do you experience stress specific to your job while at work?

How does this affect you outside of work?

What are some of your methods for stress reduction?

How often do you find yourself needing to utilize these stress reduction techniques after working a shift vs on your days off?

Compassion Fatigue

What does the term "compassion fatigue" mean to you (thoughts and feelings)?

What is your personal experience with compassion fatigue?

What is your secondhand experience with compassion fatigue, if any?

How does compassion fatigue affect your ability to help your patients and coworkers?

How were you exposed to the topic of compassion fatigue?

Would you find education about compassion fatigue useful?

- Subquestion: How could education on compassion fatigue help you?

What are some benefits (or disadvantages) for education about compassion fatigue during nursing school?

Pet Therapy

How familiar are you with pet therapy (animal-assisted therapy, animal-facilitated therapy)?

How often do you see a therapy pet come to the hospital?

How often to your unit?

- Subquestion: How often do you get a chance to interact with them?

How do you think you as a nurse could benefit from pet therapy?

What are some benefits (or disadvantages) for having a therapy pet program specifically for health care workers at your facility?

- Subquestion: How many of your coworkers do you think would be interested in participating in pet therapy sessions either before, during, or after their shifts?

Closing script: Thank you again so much for your time and for participating in this study. Your contributions are greatly appreciated. I hope through your shared experiences and perceptions I can demonstrate the need for education during nursing school on compassion fatigue and the importance of stress management, as well as the need for an intervention that can help with these phenomena. Can I contact you in the future if any follow up is needed?

Appendix C: Institutional Review Board Approval Letter

ABILENE CHRISTIAN UNIVERSITY
Educating Students for Christian Service and Leadership Throughout the World

Office of Research and Sponsored Programs
320 Hardin Administration Building, ACU Box 29103, Abilene, Texas 79699-9103
325-674-2885

January 14, 2021

Katie Clark
Department of Graduate and Professional Studies
Abilene Christian University

Dear Katie,

On behalf of the Institutional Review Board, I am pleased to inform you that your project titled
"How Early Education and Pet Therapy May Help Nurses With Compassion Fatigue",

(IRB# 21-006)is exempt from review under Federal Policy for the Protection of Human Subjects.

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable.

I wish you well with your work.

Sincerely,

Megan Roth

Megan Roth, Ph.D.
Director of Research and Sponsored Programs