A brief "quiet ego" workplace intervention to reduce compassion fatigue and improve health in hospital healthcare workers

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1. Introduction

Nurses and healthcare professionals are at risk for stress-related impairment due to the nature of their work in which they provide direct and indirect care for the ill and suffering, work long hours, and make important decisions in an increasingly complex work environment with changing and competing priorities (Aycock & Boyle, 2009). Of particular concern are the adverse effects resulting from what is known as *compassion fatigue*, a type of occupational burnout that associated with caregiver stress resulting from providing ongoing empathy and compassion to others at the expense of one's own self-care (Figley, 1995). Relatedly, compassion fatigue can be exacerbated by vicarious traumatization and secondary traumatic stress brought on by working in settings where exposure to traumatic events or situations is common (Mealer, Jones, & Moss, 2012). Compassion fatigue symptoms can be varied but may include many forms of distress, emotional exhaustion, poor work performance, decreased work commitment, and reduced self-worth (Maslach, Schaufeli, & Leiter, 2011). Successful healthcare organizations desire to reduce compassion fatigue for the benefit of employees and patients (e.g., Hunt, Denieffe, & Gooney, 2017) and to battle employee shortages (Toh, Ang, & Devi, 2012). As such, reducing compassion fatigue may serve to both improve patient outcomes via better care and reduce occupational hazards for those individuals who have dedicated their lives to servicing the needs of others. Yet, interventions that teach skills to reduce workplace related stress (i.e., compassion fatigue) could be improved to reach a broader audience, increase efficacy, and to be more broadly accessible to diverse caregivers.

Various interventions have been implemented to reduce compassion fatigue, including those aimed at managing stress and increasing self-care skills (e.g., Anderson & Gustavson, 2016; Houck, 2014). However, interventions that strengthen compassion-based skills and *compassion satisfaction* (i.e., the positive outcomes associated with approaching one's work with compassion and empathy; Stamm, 2012) hold the most promise as compassion satisfaction has been positively related to higher self-efficacy beliefs, a sense of community, positive coping, and strengthening nurses' resilience in the face of work stress (Mealer et al.,

2012).

The most well-known interventions are mindfulness-based stress reduction programs (e.g., Kabat-Zinn, 2003; Neff & Germer, 2013). These programs have been successful in ameliorating compassion fatigue, strengthening compassion satisfaction, and increasing psychological skills in mindfulness, self-compassion, and psychological flexibility (Burton, Burgess, Dean, Koutsopoulou, & Hugh-Jones, 2017; Duarte & Pinto-Gouveia, 2016; Grossman, Niemann, Schmidt, & Walach, 2004; Raab, 2014). Mindfulness stress reduction strategies are most effective in combination with compassion-based content, especially for compassion fatigue related outcomes (e.g., stress, distress, quality of life, burnout; Khoury, Sharma, Rush, & Fournier, 2015). Despite their efficacy, these programs have features that may limit their appeal or effectiveness more broadly (Van Dam et al., 2018). For example, mindfulness is associated with spirituality (cf., Smith, 2014), and misinformation and expectations associated with mindfulness may lead to disappointment, non-adherence, and lack of results for public consumers of these stress reduction methods (Van Dam et al., 2018). Moreover, mindfulness interventions often require significant financial and time investment and can add to the time pressures and demands facing employees in work contexts (Huffman, Irving, & Wayment, 2015).

To address these potential limitations, our research focused on a cognitive and non-spiritual approach to reducing psychological defensiveness and excessive self-focus. This quiet ego theoretical approach driving our intervention was based on two observations. First, compassion fatigue is characterized by *imbalance*: being too distant or too close, having too much emotional distance, or being overwhelmed by taking on and identifying with patients' distress. In a study of compassion fatigue and satisfaction in oncology nurses, Perry (2008) argued that the resilience needed to combat compassion fatigue was fostered by an ability to take the client's *perspective*, which created meaningful moments of connection. Second, the need to protect the self is so fundamental that situations that challenge self-worth are inherently stressful (Sherman & Cohen, 2006). However, these defensive responses to everyday threats to self-integrity are exactly the types of cognitive adaptations that can be minimized. A very brief cognitive intervention

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can reduce defensiveness, help individuals engage in more balanced information processing and utilization of working memory, break ruminative cycles, and reduce physiological correlates of stress (cf. Cohen & Sherman, 2014, for review).

Accordingly, the purpose of the current study was to offer a brief, 4-session workshop to teach healthcare providers an easy-to-learn self-management skill that could be implemented easily and effectively. To do so, the intervention addressed defensive, cognitive adaptations and used cues to remind individuals of their ability to engage in self-awareness, perspective-taking, and empathy, as well as, to balance self- and other-concerns. Furthermore, this ability minimizes defensiveness and facilitates growth. Our approach is amenable for use in workplace settings due to the broad applicability and ease of adaptation (Huffman et al., 2015). In the next sections, we introduce the concept of quiet ego, the theorized mechanisms by which quiet ego reduces stress and improves a sense of balance and compassion, and how it has been used to date in stress reduction interventions.

1.1. Quiet ego

Borrowing heavily from long-standing psychological and philosophical traditions, Wayment and Bauer (2008) coined the term "quiet ego" to reflect four specific compassion-based values adapted from eudaimonic and humanistic perspectives: perspective-taking, detached awareness, inclusive identity, and growth-mindedness. These characteristics are quite similar to those recommended by Perry (2008) and Watson (2010) as useful for facilitating compassion satisfaction. Wayment and Bauer (2017a, 2017b) explain that quiet ego, as a mid-level construct, fundamentally indicates balance and growth values. The quiet ego reflects a *balanced* self-identity that is neither excessively self-focused nor excessively other-focused. The quiet ego also reflects eudaimonic motivation, the willingness to initiate actions toward personal excellence and *growth* as well as universal values such as wisdom, kindness, and gratitude (Kaczmarek, 2017). As such, those high in quiet ego characteristics (or those who develop them) are likely to reap a myriad of positive benefits.

As an example, the self-report measure of quiet ego (Wayment, Bauer, & Sylaska, 2015) has been associated with reduced perceptions of stress, partly explained by several psychological mechanisms including increased self-compassion and self-control, and a balance of self-focused and other-focused values (Wayment & Bauer, 2017a; Wayment, West, & Craddock, 2016). Quiet ego characteristics have also been reliably and positively associated with several indices of well-being such as, heightened self-esteem, greater life satisfaction, increased resilience, reduced anger and hostility, increased sense of inclusiveness, lower depressed mood, and better self-reported physical health (Wayment, Bauer, & Sylaska, 2015).

Experimental research has shown it is possible to strengthen the salience of quiet ego characteristics using a brief cognitive intervention called the quiet ego contemplation (Wayment, Collier, Birkett, Traustadottir, & Till, 2015). The quiet ego contemplation offers a novel approach to strengthen compassion-related values, which can supplement and facilitate other types of stress-reduction methods available to healthcare workers. Preliminary findings suggest the quiet ego method may disrupt the physiological process that adversely impact health and well-being. For example, Wayment, Collier, et al. (2015) showed that a minimal exposure to quiet ego cues among first year college students was associated with reductions in oxidative stress over a nine-week period. In another study, a single exposure to a quiet ego recording muted a salivary IL-1β (i.e., physiological stress) response to a distressing event (Collier, Wayment, & Birkett, 2016). Other naturalistic studies have shown an association between quiet ego characteristics and coping with the stressors related to autism spectrum disorder, after a collective loss, and in response to unemployment (see review in Wayment & Bauer, 2017b). Thus, the quiet ego approach offers a robust, evidence-based, and efficacious method for addressing compassion fatigue and reducing stress.

The goal of the current study was to adapt the quiet ego contemplation ideas into a workshop format and assess its effectiveness in a sample of healthcare providers. Prior use of the quiet ego contemplation has been in extremely brief, experimental settings which used cues to remind individuals of the four quiet ego dimensions (e.g., Wayment et al., 2016; Wayment, Collier, et al., 2015). We reasoned that this brief intervention could be enhanced and tailored to a workshop format via three key changes: 1) additional explication of the quiet ego values/dimensions, 2) opportunities to question and discuss the concepts with peers, and 3) weekly practice and feedback on the implementation of the quiet ego concepts to real-world workplace stressors. Thus, the workshop format implemented these types of changes (see Method for more detail). We argue that the quiet ego intervention would strengthen important compassion-related constructs associated with key wellbeing and work outcomes, as measured over time (pre- to post-intervention). We hypothesized that the workshop would strengthen quiet ego characteristics (H1a) and emotion regulation skills (H1b). Second, we ventured that the quiet ego intervention would have a direct effect on three key work outcomes. Specifically, we hypothesized improvements in self-rated health (H2a), compassion fatigue (H2b), and compassion satisfaction (H2c).

2. Method

2.1. Sample and procedures

Participants were employees of a hospital in a large town in the southwestern United States. Prior to securing study approval (hospital and university IRB) we shared our ideas with wellness program directors and piloted the ideas in a small group of hospital employees. Beginning in Fall 2017, hospital employees enrolled in the wellness program were sent emails inviting them to participate in a workshop entitled "Quiet Ego Skills" which was briefly described "as a workshop to strengthen resilience in health care via cultivating a 'compassionate self-identity' and learning positive coping strategies." Participants who attended three out of the four sessions received "Life points" that could partially pay for medical plan premiums or be deposited into a health savings account. Employees provided written Informed Consent prior to participating. The initial sample consisted of 49 individuals. We report data from a final sample of 37, for whom we had complete data at both time points. The average age of the sample was just under 50 years ($SD = 12.19$), with an average time of employment at the hospital of 6.58 years ($SD = 7.38$). The sample was primarily female ($n = 34$), white ($n = 31$), with other ethnicities represented (i.e., Latina/Latino, $n = 5$, and $n = 1$ for American Indian). Just under half (43%) of the sample was married ($n = 19$), while the rest were not (9 single, 7 divorced, 1 widowed, and 2 other). Seventy-three percent of the sample had children and 41% were still caring for children at home ($n = 15$). Participants came from a variety of healthcare occupations (nurses, pharmacists, office and administrative coordinators, dietitians, patient access representatives, and others; 61.8% had direct contact with patients in their role).

The workshop was divided into 4-sessions, conducted bi-weekly, and lasting 45–60 min. Participants met in a large auditorium on the hospital campus. The general format of each meeting was nearly identical. First, participants were greeted, and their activity sheets (collected at sessions 2, 3, and 4) were collected outside the conference room by research assistants. Next, the workshop coordinator (a graduate student intern working at the hospital) addressed any logistical concerns and answered questions. Third, a seminar-style lecture and discussion were presented by the first author. Finally, participants were able to interact with each other and the facilitators informally. The overarching goal of the training was to educate participants on the quiet ego concept, train participants on how to use the strategy in work and nonwork settings, and finally, practice using the strategy in work

and nonwork settings. A description of the training procedures and components is provided in the Supplementary Materials. Survey data were collected via an online questionnaire emailed directly to participants, which was completed within one-week of the first/last workshop session. All study procedures were implemented between January and March 2018.

2.2. Instrumentation

2.2.1. Demographic information

Background information was collected on pertinent demographics (e.g., age, gender, race, length of employment, position in hospital).

2.2.2. Quiet ego

We used the 14-item *Quiet Ego Scale* (QES; Wayment, Collier, et al., 2015). All items were rated on a 5-point scale (1 = strongly disagree to 5 = strongly agree) with higher scores reflecting stronger endorsement of quiet ego characteristics ($\alpha_{T1} = 0.88$; $\alpha_{T2} = 0.71$). Item examples included "I feel a connection to all living things." and "I have the sense that I have developed a lot as a person over time."

2.2.3. Cognitive reappraisal

We used four items from the Cognitive Reappraisal subscale (Gross & John, 2003). The items were rated on a 7-point scale (1 = strongly disagree to 7 = strongly agree). One sample item was "When I want to feel more positive emotion (such as joy or amusement), I change what I'm thinking about." Higher scores on this variable reflected greater ability to regulate emotion ($\alpha_{T1} = 0.88$, $\alpha_{T2} = 0.88$).

2.2.4. Compassion fatigue

Three subscales were combined to measure compassion fatigue. Two subscales from the Professional Quality of Life Scale (ProQOL; Stamm, 2012), *burnout* (10 items; $\alpha = 0.86$) and *secondary traumatic stress* (10 items; $\alpha = 0.84$). The ProQOL instrument assesses feelings in the past 30 days and is a commonly used measure of the negative effects of helping others who have experienced suffering and trauma. All items were rated on a 5-point scale (1 = strongly disagree to 5 = strongly agree). Respondents were asked to read a list of problems and complaints that healthcare employees sometimes have in response to stressful life experiences and used a 5-point scale (1 = not at all to 5 = extremely; $\alpha = 0.95$) to rate how much they had been bothered by that problem in previous 30 days. Item examples included "Repeated, disturbing memories, thoughts, or images of a stressful experience from the past," and "Feeling jumpy or easily startled." These three scales were highly correlated in each sample (T_1 range: 0.58 to 0.68; T_2 range: 0.53 to 0.63). Coefficient alphas were acceptable ($\alpha_{T1} = 0.83$ and $\alpha_{T2} = 0.82$). Higher scores on this measure indicated higher levels of compassion fatigue.

2.2.5. Compassion satisfaction

We used the compassion satisfaction subscale from the Professional Quality of Life Scale (ProQOL; Stamm & Figley, 2009). The ProQOL instrument assesses the positive effects (past 30 days) of helping others who experience suffering and trauma. All items were rated on a 5-point scale (1 = strongly disagree to 5 = strongly agree; $\alpha = 84$). One sample item was "I get satisfaction from being able to help people." Coefficient alphas was adequate ($\alpha_{T1} = 0.84$, $\alpha_{T2} = 0.81$).

2.2.6. Self-rated health

We adapted the 1-item self-rated health measure "How would you rate your overall health at the present time?" (Sargent-Cox, Anstey, & Luszcz, 2008) to be rated on a 7-point scale (1 = poor, 7 = excellent). This single-item measure is considered a robust measure of health, used universally in health-related research, sensitive to health changes, able to predict important health outcomes across socioeconomic status levels, and central to health surveillance efforts around the world (SRH;

Idler & Benyamini, 1997).

2.2.7. Perceived usefulness of workshop

Participants completed weekly worksheets.[1] As part of those exercises (which also asked about stressors) they rated the usefulness of the quiet ego cues to help them cope with defensive emotions, with "self-criticism," and with dealing with criticism from others. Each item was rated on 4-point scale (1 = not at all, to 4 = I thought about it a lot). Participants were also asked three single item questions regarding their use of the quiet ego workshop overall, rated on a 7-point scaled (1 = strongly disagree to 7 = strongly agree). Questions included: "I found the quiet ego intervention to be a useful tool," "I used the quiet ego intervention during times of stress," and "I would use the quiet ego intervention in the future."

3. Results

3.1. Perceived usefulness of quiet ego cues

Participants' rated the usefulness of the quiet ego cues for dealing with negative emotions ($M = 2.80$, $SD = 0.90$), dealing with self-criticism ($M = 2.88$, $SD = 0.90$), and dealing other criticism ($M = 2.92$, $SD = 0.85$). The average usefulness ratings were well above the scale mean. Overall, participants employed quiet ego cues 88.1% of the time they experienced a stressor to help alleviate stress associated with the individual situation. Participants rated the workshop highly on all three single item measures: usefulness of the intervention as a tool ($M = 5.55$, $SD = 0.96$), use of the quiet ego intervention in times of stress ($M = 5.45$, $SD = 0.88$), and future intentions ($M = 5.63$, $SD = 1.1$).

3.2. Correlational results

Correlations among the study variables at both time points are presented in Table 1. In both samples, compassion fatigue and compassion satisfaction were inversely correlated. QES was positively associated with cognitive appraisal and compassion satisfaction, and less compassion fatigue. In the T_1 sample, 1) compassion fatigue was related to lower self-rated health, and 2) self-rated health was positively related to QES, cognitive appraisal, and compassion satisfaction. Cognitive appraisal was positively related to compassion satisfaction and negatively related to compassion fatigue. The remaining T_2 correlations were similar in direction as in the T_1 sample, but smaller and non-significant.

3.3. Hypothesis testing

We examined whether participants in the workshop reported improvement on six measures. We utilized paired *t*-tests with bootstrapped estimates (1000 samples) to assess change from T_1 to T_2. Results are presented in Table 2. First, since the workshop was designed to teach quiet ego skills, we examined and found that QES scores

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[1] At the first workshop session, participants were given a folder with information about the workshop as well as six worksheets. During the first session, participants were asked to complete two worksheets (one a week) for the subsequent two weeks and return to the second session which was held two weeks later. The same procedure was repeated for sessions 3 and 4. Thus, over the course of the workshop, participants could return up to six worksheets. Worksheets asked participants to identify weekly goals, if they recalled any situations that made them feel defensive, or critical of themselves or others, and, if so, what types of emotions they experienced. Participants were also asked a series of questions about whether and how often they used the quiet ego cues to deal with these situations. A total of 109 worksheets were collected throughout the workshop across all participants at all times. On average, participants returned an average of three worksheets.

Table 1
Variable correlations for time one and time two (N = 37).

	Quiet ego	Cognitive appraisal	Compassion fatigue	Compassion satisfaction	Self-rated health
Quiet ego	0.80***	0.55***	−0.33	0.57***	0.24
Cognitive appraisal	0.70***	0.66***	−0.29+	0.21	0.22
Compassion fatigue	−0.52***	−0.44***	0.91***	−0.53***	0.14
Compassion satisfaction	0.65***	0.53**	−0.61***	0.62***	0.15
Self-rated health	0.47***	0.43**	−0.35**	0.37**	0.75***

Note: Correlations for T_1 sample are in bottom left portion of table; T_2 sample in upper right portion of table. + $p < .07$ * $p < .05$, ** $p < .01$, *** $p < .001$. Correlations on the diagonal are correlations of variable at both time points (T1 & T2).

Table 2
Study variable means for time one and time two (N = 37).

	Time one			Time two					
	Mean	SD	95% CI	Mean	SD	95% CI	$T_{\text{paired (36)}}$	p	d
Quiet ego	3.67	0.56	[3.52, 3.83]	3.82	0.35	[5.35, 5.94]	−1.81	0.079	0.43
Cognitive appraisal	5.17	0.97	[4.90, 5.42]	5.68	0.90	[4.49, 5.46]	−3.65	0.001	0.66
Compassion fatigue	2.37	0.62	[2.21, 2.56]	2.15	0.56	[3.90, 4.15]	3.56	0.001	0.86
Compassion satisfaction	3.92	0.45	[3.80, 4.05]	4.03	0.40	[3.71, 3.92]	−1.21	0.234	0.30
Self-rated health	4.55	1.73	[4.05, 5.04]	5.00	1.64	[1.97, 2.33]	−2.02	0.051	0.38

improved over time, $t(37) = −1.81$, $p = .039$, one-tailed (H1a). Cognitive appraisal skills also significantly improved, $t(37) = −3.65$, $p = .001$ (H1b; see Table 2 for means, CIs, and mean differences). We also expected positive changes in self-rated health and compassion fatigue (burnout, secondary stress, and PTS symptoms). As expected, self-rated health improved from T_1 to T_2 $t(37) = −2.02$, $p = .051$ (H2a) and compassion fatigue significantly decreased, $t(37) = 3.56$, $p = .001$ (H2b). There were no changes in compassion satisfaction, $t(37) = −1.21$, $p = .234$ (H2c). Effect sizes ranged from 0.30 (compassion satisfaction, ns) to 0.86 (compassion fatigue).

4. Discussion

Today's healthcare professionals are exposed to extreme work-place stressors such as caring for the ill, working long hours, and making important, and in many cases, life-saving decisions (Aycock & Boyle, 2009). These stressors contribute to compassion fatigue, and ultimately to the well-being of healthcare providers and the organization. The current study was designed to reduce compassion fatigue and increase self-reported health in a sample of healthcare employees. We found that compassion fatigue was related to lower self-rated health, a robust measure of health and vitality (Idler & Benyamini, 1997). Thus, our sample of healthcare employees reported similar patterns found in previous studies on healthcare employees.

We examined the effectiveness of a brief, cognitive-focused intervention to reduce compassion fatigue and increase self-reported health. The premise of our intervention was based on the idea that the use of brief quiet ego cues could interrupt maladaptive reactions to stress: excessive self-focus, defensiveness, and other noisy ego characteristics, and, in so doing, strengthen compassion-based values. At both time points, our self-report measure of quiet ego was strongly correlated with compassion satisfaction (and lower compassion fatigue). Furthermore, over time, quiet ego increased, and compassion fatigue decreased. Compassion-based resources (i.e., quiet ego, compassion satisfaction) were also positively related to self-rated health, and importantly, self-rated health improved over time. Our findings concerning self-rated health are important because this one-item measure has been shown to be a robust predictor of health (Idler & Benyamini, 1997). Interestingly, healthcare providers did not report higher levels of compassion satisfaction. It could be that there was a ceiling effect on compassion satisfaction with scores being high (3.92 out of 5) before the intervention, leaving little room to increase. Taken together, our

results support the idea that self-care interventions that strengthen compassion-based psychosocial resources may be effective in reducing compassion fatigue and associated health-related issues.

Results from this study also extend prior research on the utility of a brief quiet ego intervention by examining these processes in a population of employees facing significant stressors. The positive impact of quiet ego has been demonstrated in cross-sectional studies (cf. Wayment, Huffman, & Irving, 2018; Wayment & Silver, 2018) and in limited experimental research (e.g., Collier et al., 2016; Wayment, Collier, et al., 2015). In previous studies, the link between quiet ego and stress has been found to be at least partly explained by an increase in self-compassion and self-control (Wayment et al., 2016, 2018). This study examined another potential explanatory mechanism: cognitive reappraisal, an emotion regulation strategy that involves an ability to reinterpret the meaning of an emotional stimulus (cf., Hunt et al., 2017). Previous work has demonstrated quiet ego to strengthen cognitive focus (Wayment, Collier, et al., 2015), and quiet ego has been shown to be associated with problem-focused coping (Wayment, Bauer, & Sylaska, 2015). However, this is the first examination of cognitive reappraisal in an applied setting.

4.1. Limitations

Although the study showed great promise in introducing the utility of quiet ego cues as a cognitive intervention in healthcare settings, we cannot ignore the limitations of our study. Our study employed a pre-post, non-randomized, non-control, design. Although not an uncommon approach in naturalistic studies implemented in workplace settings, there was no control group to ensure that changes in key variables were not attributable to other factors. For example, flyers advertising the workshop emphasized stress reduction, which may have led to participant expectancy effects. Another limitation was our small sample size. We recruited a limited number of participants in order to keep the workshop atmosphere manageable (approximately 20–25 individuals in each session). Unfortunately, this sample size reduced our ability to assess whether different aspects of the training were more favored by employees of different roles within the hospital or the types of emotion regulation strategies utilized by participants in stressful situations. Future research would benefit from larger samples and utilization of other methods to better understand how cues can be used most effectively. One idea for future research is the deployment of smartphone-based quiet ego cues that could not only track cue use but also send

random or pre-scheduled pop-up quiet ego reminders.

4.2. Implications

We propose several suggestions for healthcare organizations interested in developing a quiet ego intervention. First, although we used a large group format to deliver the material, we propose that small group sessions might also work. Allen, Watt, Jansen, Coghlan, and Nathan (2017) found that once-a-month group-based discussions, led by a staff psychiatrist, helped reduce secondary traumatic stress, burnout, and increased rates of compassion satisfaction in a sample of 25 physicians. We argue that the quiet ego intervention would have similar success and could be moderated by a trained health professional (e.g., social worker; see supplemental material for full description of intervention). Second, the intervention delivery is quite flexible and can be tailored to specific organizational units. For example, if healthcare organizations wanted to focus on a specific group (e.g., critical care nursing units), the training material could be adapted to issues most germane to their job and integrated and expanded into existing organizational structures (e.g., delivery at required staff meetings, charge nurse training for reminders). A recent article in a nursing development journal described how a set of six very brief mindfulness cues (e.g., "pause", "breathe", "identify emotion") were successfully utilized to enhance nursing responses in a simulation training exercise to reduce interpersonal frustration, misunderstandings, and resentment (Holtschneider & Park, 2018). Relatedly, the quiet ego intervention is modular, and can be embedded into existing programs, including educational training sessions. In a recent experimental study, it was demonstrated that the inclusion of an audio reminder of the quiet ego dimensions (4-minute recording) prior to art-making instructions improved outcomes for distressed college students (Collier & Wayment, 2019). Third, even for organizations that have time or financial constraints, a workshop presenting cognitive methods may be appealing to employees who are less interested in spiritual, meditative, or mindfulness-based programs. As most expenses associated with traditional stress-reduction programs training programs are material and personnel costs, one strength of our workshop approach was the brevity and informality of the required sessions (i.e., cost-effectiveness). Moreover, our results provide additional evidence supporting the idea that brief interventions can be effective, especially for healthcare workers (e.g., Farina, Minerva, Glunt, & Bernardo, 2018; Hevezi, 2016). Furthermore, there were minimal requirements asked of participants—that they try to use a quiet ego cue before or after stressful events. Finally, and importantly, the quiet ego concept resonates with healthcare employees. Quiet ego characteristics have been likened to a "compassionate self-identity" (Wayment, Collier, et al., 2015) and reflect the compassion-based values and concepts that healthcare professionals share.

5. Conclusion

In summary, we implemented a novel, inexpensive workshop that appealed to hospital employees serving a variety of roles in a regional Trauma I hospital. The workshop introduced 1) the theoretical underpinnings of the quiet ego (Wayment & Bauer, 2008) through presentations about how threat tends to engage our tendencies toward defensiveness, and 2) cues for employees to briefly remind themselves of their quiet ego as a way to interrupt defensive tendencies. In so doing, our work conceptually replicates research on the stress-reducing benefits of affirming self-expansive values and extends the broader literature on the benefits of putting the "self" in perspective (Sherman & Cohen, 2006). Our results also provide an example of an applied solution for healthcare organizations that strive to provide employees with a diverse set of skills to decrease compassion fatigue and improve health. The quiet ego intervention is a method that has been designed to assist healthcare employees think, feel, and act in accordance with their compassion-based values as they pursue their important role as

caretakers and colleagues.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.apnr.2019.05.002.

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