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Countering Compassion Fatigue: A Requisite Nursing Agenda

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Abstract

Nurses have a longstanding history of witnessing the tragedy experienced by patients and families; however, their own reactions to profound loss and premature death have not been systematically addressed. There is a paucity of research describing interventions to prevent or minimize the ramifications of repeated exposure to traumatic events in the clinical workplace. Compassion fatigue is a contemporary label affixed to the concept of personal vicarious exposure to trauma on a regular basis. Yet this phenomenon of compassion fatigue lacks clarity. In this article, the author begins by describing compassion fatigue and distinguishing compassion fatigue from burnout. Next she discusses risk factors for, and the assessment of compassion fatigue. The need to support nurses who witness tragedy and workplace interventions to confront compassion fatigue are described.

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Nurses care for ill, wounded, traumatized, and vulnerable patients in their charge. This exposes them to considerable pain, trauma, and suffering on a routine basis (Coetzee & Klopper, 2010; Hooper, Craig, Janvrin, Wetzel, & Reimels, 2010). While many nurses perceive their work as a calling, few anticipate the emotional implications and sequelae that come from their close interpersonal relationships with patients and families (Aycock & Boyle, 2009; Walton & Alvarez, 2010). Compassion, or the feeling of emotion which ensues when a person is moved by the distress or suffering of another, is foundational to nursing practice (Hooper, et al., 2010; Schantz, 2007). A requisite competency is the repeated generation of compassion energy to foster connectedness and offer nurturance to those requiring nursing care (Dunn, 2009).

The term compassion fatigue was first used in the context of the study of burnout in nurses nearly two decades ago. At that time, Joinson (1992) coined the term to describe the 'loss of the ability to nurture' that was noted in some nurses in emergency department settings. Multiple environmental stressors, such as expanding workload and long hours, coupled with the need to respond to complex patient needs, including pain, traumatic injury, and emotional distress, resulted in nurses feeling tired, depressed, angry, ineffective, apathetic, and detached. Somatic complaints in nurses were also noted. These complaints often included headaches, insomnia, and gastrointestinal distress. This phenomenon appeared to escalate gradually over time as a result of cumulative stress, particularly when nurses ignored their symptoms and did not attend to their own emotional needs (Bush, 2009).

Figley (1995) subsequently identified compassion fatigue as a more user-friendly term to describe secondary traumatic stress disorder (STSD), an outcome of counter-transference whereby empathic caregivers indirectly experience the trauma of their patients (Kanter, 2007; Quinal, Harford, & Rutledge, 2009). As Figley (1995) continued to observe this phenomenon in mental health workers, he explained:

> *There is a cost to caring. Professionals who listen to clients' stories of fear, pain and suffering may feel similar fear, pain and suffering because they care. Sometimes we feel we are losing our own sense of self to the clients we serve (p.1).*

Compassion fatigue historically has been studied in professional populations other than nursing (Yoder, 2010). Over the past two decades the dynamics of compassion fatigue have received more attention within the realm of caregiving stress, considering a wider array of health professionals. As the field of traumatology has grown, so has an interest in the nature and emotional complexity of professional caregiver reactions specific to the helping process (Thomas & Wilson, 2004).

A Contemporary Description of Compassion Fatigue

If compassion fatigue is not addressed in its earliest phases, it can permanently alter the ability of a caregiver to provide compassionate care.

While compassion fatigue has been observed in professional caregivers and discussed in the literature over the past two decades, a specific definition of its characteristics and corollaries has not been uniformly embraced (Coetzee & Klopper, 2010; Najjar, Davis, Beck-Coon, & Doebbeling, 2009). As a result multiple terms have been used synonymously to describe the phenomenon. A list of compassion fatigue descriptions used by the various authors referenced in this article is provided in Table 1. The use of multiple terms to describe compassion fatigue, and the absence of a distinct and accepted definition has hindered the study and identification of interventions related to this important problem seen in clinical care settings (Najjar et al., 2009; Yoder, 2010).

In its simplest form, compassion fatigue implies a state of psychic exhaustion. Sabo (2006) described it as a severe malaise resulting from caring for patients experiencing varying aspects of pain (i.e., physical, emotional, social). Compassion fatigue is associated with the 'cost of caring' and refers to the resultant strain and weariness that evolves over time (Showalter, 2010; Thomas & Wilson, 2004). Implicit in its nature is a preoccupation with the trauma experienced by patients (Figley, 2002). Compassion fatigue characterizes a progressive state of emotional unease. It evolves from compassion discomfort, to compassion stress, and finally to compassion fatigue, a state where the compassion energy that is expended by nurses (and others) surpasses their ability to recover from this energy expenditure, resulting in significant negative psychological and physical consequences. Table 2 describes the many manifestations of compassion fatigue. If compassion fatigue is not addressed in its earliest phases, it can permanently alter the ability of a caregiver to provide compassionate care.

Nurses are particularly vulnerable to compassion fatigue.

For health professionals, compassion fatigue arises when providers have close interpersonal contact with a suffering patient and their emotional boundaries become blurred to the point that the caregiver unconsciously assimilates the distress experienced by the patient (Bush, 2009). The internalization of patients' adversity may result in the healthcare professionals' feelings of self-blame, futility, or impotence, especially if these scenarios occur repeatedly over time. Physicians, social workers, and counselors have been identified as health professionals at risk for compassion fatigue (Adams, Boscarino, & Figley, 2006; Kearney, Weininger, Vachon, Harrison, & Mount, 2009; Levy, 2004; Pfifferling & Gilley, 2000; Simon, Pryce, Roff, & Klemmack, 2005).

Nurses are particularly vulnerable to compassion fatigue. They often enter the lives of others at very critical junctures and become partners, rather than observers, in patients' healthcare journeys. Acute care nurses in particular often develop empathic engagement with patients and families. This, coupled with their experience of cumulative grief, positions them at the epicenter of an environment often characterized by sadness and loss (Boyle, 2006). Nurses are frequently enmeshed in existential issues surrounding life and death. Yet the consequences of caring work, such as compassion fatigue, have historically been under-recognized and under-researched in nursing (Sabo, 2006). Coetzee and Klopper (2010) have suggested that because compassion fatigue has not formally been defined within nursing practice, the phenomenon has not been explored, described, or explained in a manner that would allow nurses to identify and combat compassion fatigue effectively.

Distinguishing Compassion Fatigue From Burnout

The impetus for burnout stems from conflict within the work setting... [Compassion fatigue] stems from emotional engagement and

While burnout and compassion fatigue are separate concepts, they share similarities (Najjar et al., 2009; Yoder, 2010). They both impose added coping and adaptational demands upon nurses. Valent (2002) has postulated that failed survival strategies generate both responses and result from failure to achieve desired goals. Burnout arises when assertiveness-goal achievement intentions are not met. Compassion fatigue evolves when rescue-caretaking strategies are unsuccessful, leading to caregiver feelings of distress and guilt. With both burnout and

interpersonal intensity associated with witnessing tragedy within the work setting.	compassion fatigue, feelings of frustration, powerlessness, and diminished morale ensue.

Compassion fatigue is distinguished from burnout by three variables: triggers or etiologies, chronology, and outcomes as summarized in Table 3. The impetus for burnout stems from conflict within the work setting (Alcock & Boyle, 2009; Alkema, Linton, & Davies, 2008; Bush, 2009; Kash, Holland, Breitbart, Berenson, Dougherty, Ouellette-Kobasa, & Lesko, 2000; Potter, Deshields, Divanbeigi, Berger, Cipriano, Norris, & Olsen, 2010). Conflicts can include disagreements with managers or co-workers, dissatisfaction with salary, or inadequate working conditions. Compassion fatigue, on the other hand, emanates from relational connections nurses have with their patients or the patient's family. It stems from emotional engagement and interpersonal intensity associated with witnessing tragedy within the work setting. Burnout usually evolves over time. Compassion fatigue may have a more acute onset. While the 'burnt out' nurse gradually withdraws, the 'compassionately fatigued' nurse tries harder to give even more to patients in need. Both outcomes, however, are associated with a sense of depletion within the nurse, a 'running on empty' feeling. Investigation into the relationships between these phenomena is needed for an enhanced understanding of how to support nursing staff in the workplace.

Risk Factors for Compassion Fatigue

Compassion fatigue usually evolves in caring professionals who absorb the traumatic stress of those they help (Najjar et al., 2009). These include 'first responders,' those in the helping professions who are on the front lines witnessing the tragedies of others. These professionals include fire fighters, police, and paramedics. This term has also been used in the military to depict individual units of soldiers who hold the responsibility to be first on the scene of major combat. Acknowledging the potentially severe emotional sequelae of witnessing tragedy, these groups frequently have well-established support mechanisms in place, such as counselors, psychologists, chaplains, and time-off allowance to deal with the negative ramifications of their work-related stress. Compassion fatigue has also been noted in caring professionals whose personal identity is closely associated with their professional role. Hence nurses can be considered 'first responders' based on their obligation to meet patient needs in a timely, 'moment-to-moment,' comprehensive manner. On a daily basis, nurses respond to urgent and life-threatening emergencies that require complex, cognitive work in tandem with the provision of emotional counsel (Ebright, 2010). Yet, they frequently have little or no formal supports in place to counter the potentially negative emotional sequelae of their work (Aycock & Boyle, 2009; Potter et al., 2010). One exception is palliative and hospice nursing where the affective implications of working with the dying is formally addressed with provision of preventive and therapeutic interventions (Alkema et al., 2008; Abendroth & Flannery, 2006; Keidel, 2002; Payne, 2001; Qaseem, Shea, Connor, & Casarett, 2007).

Assessment of Compassion Fatigue

The identification of compassion fatigue requires assessment of various helper characteristics germane to counter-transference reactions. Five characteristics that may contribute to compassion fatigue include:

- affective states in the helper
- cognitive expectations and individual capacities to process information
- ego-defensive processes
- stress effects on the helper's self-capacities, ideological beliefs, and systems of meaning
- coping abilities and techniques of stress management (**Thomas & Wilson, 2004**)

Available instruments that measure the presence of compassion fatigue are limited in scope and appropriateness for use with nurses (Najjar et al., 2009). Their domains fail to capture unique aspects of the nurses' role and target only select populations (e.g., trauma). To date, the following three tools have been used most frequently to measure compassion fatigue:

- The Compassion Fatigue Scale (**Adams et al., 2006**; **Adams, Figley, & Boscarino, 2008**)
- The Secondary Traumatic Stress Scale (**Bride, 2007**; **Bride, Robinson, Yegidis, & Figley, 2004**; **Dominquez-Gomez & Rutledge, 2009**; **Ting, Jacobson, Sanders, Bride, & Harrington, 2005**)
- The Professional Quality of Life Scale (**Stamm, 2009**; **Stamm, 2002**)

Need for Support for Nurses Who Witness Tragedy and Death

Nursing is distinguished from other human service disciplines in two prominent ways. First, there is no global recognition of the potentially negative implications of nurses' work (Aycock & Boyle, 2009). Hence there are few systematic supports in place to help nurses deal with their emotional responses to witnessing the tragedy of others and experiencing associated sadness, grief, and loss. Second, nurses' risk for heightened intensity of emotional responses is unique in that nurses are not only 'first responders,' but are also 'sustained responders,' who are expected to provide ongoing (vs. time-limited, episodic) support and interventions to highly vulnerable patients and families (Bush, 2009).

It is an expected component of nursing work that nurses witness trauma on a regular basis (Showalter, 2010; Yoder, 2010). Yet, unlike firefighters, police, and even the military, nurses' interactions with patients are maintained over time in both acute and ambulatory settings, and most certainly in home care. Nurses become part of a mosaic of caring within a family framework that may be fraught with anticipatory loss, tension, disbelief, and physical disfigurement. In the acute care setting they are responsible 24/7 for the patient's care and the family's response to the illness trajectory. Often, they cannot leave the situation after bad news is shared or a death has occurred. It is this extended time, and the placement of the nurse at the center of the interchange that makes nursing's role unique. Fagin and Diers (1983) described:

> *Nursing is a metaphor for intimacy. Nurses are involved in the most private aspects of patients' lives and they cannot hide behind technology or a veil of omniscience as other practitioners in hospitals do. Nurses do for others publicly what healthy persons do for themselves behind closed doors. Nurses, as trusted peers, are there to hear secrets, especially the ones born of vulnerability (p.116).*

Hence, strategies to assess and manage compassion fatigue need to be integrated into clinical practice settings.

Interventions

The management of compassion fatigue must be multifaceted and include prevention, assessment, and consequence minimization (Figley, 2002). Central to any discussion of interventions to manage compassion fatigue is the need to acknowledge its presence in a proactive manner. Remen (1996) noted:

A central irony in nursing is that the majority of nurses perceive themselves as giving, caring people but find it hard to nurture themselves.

> *The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk on water without getting wet. This sort of denial is no small matter (p. 52).*

It is important to consider three categories of interventions that can be used to ameliorate the intensity of compassion fatigue in nursing. They include work/life balance, education, and work-setting programs.

Work/Life Balance

Work/life balance enables nurses to invest time and energy into nurturing the self, in order to nurture others.

A central irony in nursing is that the majority of nurses perceive themselves as giving, caring people but find it hard to nurture themselves. As Hooper and colleagues (2010) identified, nurses often wait until a crisis ensues to address their needs. This has definitive implications for the phenomenon of nurse grief (Boyle, 2000). The cumulative impact of witnessing death in tandem with the professionally unsanctioned response of mourning numerous losses may coalesce to prompt pathologic grief responses in nurses.

Work/life balance enables nurses to invest time and energy into nurturing the self, in order to nurture others. It involves establishing a self-care plan that is relentlessly carried out in an attempt to enhance a calm state (Jones, 2005). Welsh (1999) termed this practicing responsible selfishness. Larson and Bush (2006) identified it as rendering compassionate care for the self. The use of exercise and attention to diet are central to work/life balance, as is focusing attention on pleasurable, non-work-related activities that promote pacing and personal planning. Journaling and meditation are other self-care strategies (Radziewicz, 2001). The identification of personal stressors (e.g., marital discord) and recognition of the demands of caregiving for young children or

elderly parents may transfer to the work setting and require attention (Graham & Ramirez, 2002). Because nurses may find it difficult to 'leave problems at home,' personal stress may be displaced into the work setting. Counsel and support are necessary when this occurs. Becoming aware of danger-signal responses, such as blaming others, complaining, utilizing self-medication with alcohol, or other addictive behaviors, is necessary. Work/life balance requires both introspection and action that is ongoing and perceived as necessary to ensure professional longevity.

Education

Problems with compassion fatigue often emanate from a lack of basic communication skills. Strategies for talking with and supporting patients and families under stress, or for dealing with complex family scenarios, are seldom taught in basic nursing programs (Boyle, 2000). Perceived lack of communication competency may lead nurses to feel sad and depressed about their inability to support patients and their loved ones. Examples of basic communication and self-care skills include the ability to:

Becoming aware of danger-signal responses...is necessary.

- Identify personal coping strategies
- Develop caring communication styles
- Establish boundaries in relationships with patients and families
- Understand family systems theory and identify family norms
- Re-frame 'difficult' interactions with individual patients and families
- Resolve interpersonal relationship problems in the work setting
- Cope with ethical conflict and dilemmas
- Utilize self-care strategies such as meditation and mindfulness

Continuing education programs that augment basic emotional-support competencies in the practice setting, patient rounds, and interdisciplinary team meetings that integrate the humanistic perspective into healthcare are excellent modalities for developing these skills. Specialty education programs, such as those focusing on end-of-life training, also augment both knowledge and skill in an emotionally laden context of nursing care. It is important for the phenomenon of compassion fatigue to be integrated into every undergraduate and graduate nursing curriculum, as well as nursing-orientation programs. In general, an increased awareness of the emotional demands facing today's nursing workforce is of utmost importance (Erickson & Grove, 2007).

Work Setting Interventions

On-site workplace interventions that address the emotional strain on nurses can be very effective in reducing compassion fatigue. Stichler (2009) stated that the literature is replete with the positive effects of workplace interventions on reducing job conflict and turnover and increasing interdisciplinary collaboration and satisfaction. Future attention to the healing focus within healthcare settings will increase in the coming years.

Work settings that offer staff a menu of opportunities to manage the emotional sequelae of nursing practice will most likely become work destinations of choice. However, few facilities or healthcare systems currently integrate these options into daily operations. Various authors have described these options (Aycock & Boyle, 2009; Brown-Saltzman, 1994; Chan, Mok, Po-ying, & Man-chun, 2009; Hinds et al., 1994; Italia et al., 2008; Lucette, 2005; Kash et.al., 2000; Mackereth et al., 2005; Medland et al; Raphael & Wooding, 2004; Walton & Alvarez, 2010). Following is a 'menu' of options that can be offered in practice settings:

- **On-site counseling** by a psychiatric advanced practice nurse, therapist, counselor, social worker, or chaplain trained in the provision of emotional support for healthcare providers experiencing real or potential compassion fatigue. These resources must be visible, accessible, and offer practical solutions for staff. Employee assistance programs can also provide support.
- **Support groups for staff.** Although it is difficult for staff to participate in these groups during their working hours, the benefits of peer support and consultant guidance in addressing emotional issues cannot be underestimated. Groups and/or workshops offered during evening or weekend hours, or in retreat settings may have better attendance by staff.
- **De-briefing sessions** can serve to identify helpful and non-helpful approaches to pivotal events in clinical practice. These sessions should be viewed not as critical reviews but rather as instructive, to help staff nurses mature and develop new skill competencies in their work settings.
- **Art therapy** integrated during the work day can offer a brief outlet from the intensity of caring work.
- **Massage sessions** also provide both mental and physical breaks from the stress of caregiving.
- **Bereavement interventions**, for example funeral attendance, memorial service participation, and the sending of sympathy cards to families, can help with grief resolution. This is especially true when the nurse has formed a special bond with the patient and/or family.
- **Attention to spiritual needs** is paramount as so much of the tragedy, sadness, and sense of futility that nurses may experience is associated with life and death issues.

Assisting nurses to integrate self-care plans into goal setting in conjunction with annual performance appraisals may assist in addressing the need for, and expectation of countering compassion fatigue.

Gentry, Baranowsky, and Dunning (2000) have described a five-session treatment protocol, called the Accelerated Recovery Program (ARP), for distressed helpers. It augments professional caregivers' ability to minimize compassion fatigue by addressing nine interventional domains, which include:

- Identify, understand, and develop a hierarchy of what triggers symptoms of compassion fatigue
- Review present methods for addressing difficulties in practice
- Develop caregiver plans for self-treatment
- Identify resources for addressing compassion fatigue
- Teach effective self soothing
- Teach grounding and containment skills
- Enhance proficiency in self-care and boundary setting
- Teach video-dialog techniques for internal conflict resolution and self-supervision
- Facilitate development of self-administered, self-care planning

Workplace leaders are encouraged to develop and customize formal interventions such as the ARP program for nurses (Potter et al., 2010). Inherent in these programs is significant personal introspection, a much needed strategy to counter individual compassion fatigue. With this self-analysis may come a re-definition of success, and an invaluable opportunity to counter caregiver stress (Welsh, 1999).

Enabling caregivers to decrease compassion fatigue benefits not only individual caregivers but also the institutions in which these caregivers work.

Research targeting compassion fatigue should be a priority for all nursing specialties. Investigations of personal qualities, such as resiliency, hardiness, and social support, could shift the focus from pathology to effective adaptation in those engaged in caring work with patients experiencing pain, suffering, and trauma (Sabo, 2006). An enhanced understanding of other characteristics that can predict, minimize, or buffer the consequences of compassion fatigue, such as age, gender, coping style, spiritual orientation, tenure/longevity, peer cohesion, and the role of nurse managers, is direly needed (Abendroth & Flannery, 2006; Erickson & Grove, 2007; Najjar et al., 2009; Newsom, 2010; Perry, 2008). Investigation of opportunities to promote compassion satisfaction are also of value (Alkema et al., 2008; Coetzee & Klopper, 2010).

Enabling caregivers to decrease compassion fatigue benefits not only individual caregivers but also the institutions in which these caregivers work. These benefits for the institution can include, but are not limited to, increased staff morale and productivity, engagement in facility initiatives, reduced sick time, lower turnover rates, and higher patient and family satisfaction (Aycock & Boyle, 2009; Coetzee & Klopper, 2010; Najjar et al., 2009).

Conclusion

Compassion fatigue is commonplace in healthcare today (Showalter, 2010). For nurses, compassion fatigue is a relational phenomenon stemming from therapeutic connectedness with patients and families in need (Potter et al., 2010; Sabo, 2008). Fatigue, stress, sadness, and the associated decrease in morale and work performance, are all influenced by psychosocial factors that have traditionally been ignored in nursing. These conditions not only impact retention of staff but also may influence patient satisfaction and patient safety (Potter et al., 2010; Yang & Huang, 2005). Addressing the real but unrecognized phenomenon of compassion fatigue in nursing has the potential to influence both the recruitment and retention of highly effective nurses. Encouraging self-care strategies and offering workplace interventions address a key distinction of nursing practice, namely that of holistic care.

Addressing the real but unrecognized phenomenon of compassion fatigue in nursing has the potential to influence both the recruitment and retention of highly effective nurses.

Compassion fatigue requires more deliberative attention from managers, educators, researchers, and nurses themselves. Until the consequences and ramifications of compassion fatigue can be linked to more concrete outcomes, it will remain an elusive aspect of nurses' work. Evolving consumer expectations for highly personalized care and changes in the responsibility matrix of nurses in this regard will increase attention focusing on nurse compassion fatigue in the coming years.

Table 1. Descriptors of Compassion Fatigue
▪ Borrowed stress

- Compulsive sensitivity
- Disabled resiliency
- Emotional contagion
- Empathic distress
- Empathic strain
- Empathy fatigue
- Empathy overload
- Existential suffering
- Fatal availability
- Indirect trauma
- Secondary victimization
- Soul pain
- Vicarious trauma
- Wounded healer

Table 2. Manifestations of Compassion Fatigue

Emotional:

- Anger
- Apathy
- Breakdown
- Cynicism
- Desensitization
- Discouragement
- Dreams, flashbacks, preoccupation (r/t patient experiences)
- Feelings of being overwhelmed
- Attitude of hopelessness
- Irritability
- Lessened enthusiasm
- Sarcasm

Intellectual:

- Boredom
- Concentration impairment
- Disorderliness
- Weakened attention to detail

Physical:

- Increased somatic complaints
- Lack of energy
- Loss of endurance
- Loss of strength
- Proneness to accidents
- Weariness, sense of fatigue, exhaustion

Social:

- Callousness
- Feelings of alienation, estrangement, isolation
- Inability to share in or alleviate suffering
- Indifference
- Loss of interest in activities once enjoyed
- Unresponsiveness
- Withdrawal from family or friends

Spiritual:

- Decrease in discernment
- Disinterest in introspection
- Lack of spiritual awareness
- Poor judgment r/t existential issues

Work:

- Absenteeism
- Avoidance of intense patient situations
- Desire to quit
- Diminished performance ability (i.e., medication errors, decreased documentation accuracy/record-keeping
- Stereotypical/impersonal communications
- Tardiness

Sources: Aycock & Boyle, 2009; Coetzee & Klopper, 2010; Showalter, 2010

Table 3. Characteristics Differentiating Burnout From Compassion Fatigue

Variable	Burnout	Compassion Fatigue
Etiology	Reactional: response to work or environmental stressors (i.e., staffing, workload, managerial decision making, inadequate supplies or resources)	Relational: consequences of caring for those who are suffering (i.e., inability to change course of painful scenario or trajectory)
Chronology	Gradual, over time	Sudden, acute onset
Outcomes	Decreased empathic responses, withdrawal; may leave position or transfer	Continued endurance or 'giving' results in an imbalance of empathy and objectivity; may ultimately leave position

Sources: Alkema et al., 2008; Bush, 2009; Coetzee & Klopper, 2010; Figley, 1995; Najjar et al., 2009; Pfifferling & Gilley, 2000; Sabo, 2006; Sabo, 2008; Showalter, 2000; Yoder, 2010

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