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ABSTRACT: *Few healthcare organizations acknowledge, discuss, or provide interventions for assisting with compassion fatigue. Yet, it is an important concept due to its individual, professional, and financial costs. This article defines compassion fatigue, differentiates it from burnout, and offers system interventions for supporting nurses and reducing compassion fatigue.*
KEY WORDS: *burnout, compassion fatigue, nursing, workplace environments*

CE 2.5 contact hours

By Chelsia Harris and Mary T. Quinn Griffin

NURSING ON

Nurses are considered caring, compassionate professionals. Individuals, families, and entire communities seek nurses for support, healing, and encouragement during times of physical, emotional, and spiritual anguish. A nurse's innate capacity to nurture and embrace another's suffering as if it is his or her own can be conceptualized as compassion. But with the continuous giving of oneself, nurses are at risk for developing *compassion fatigue.* As nurses, we cannot give if we are fatigued and worn. Nurses and healthcare organizations must first clearly and comprehensively understand the concept of compassion fatigue to recognize when they are at risk or experiencing signs and symptoms of compassion fatigue. They also will be able to identify compassion fatigue and be in a position to offer support. Through having an understanding of the concept, organizations and individuals can develop interventions tailored to their particular situations that reduce compassion fatigue and allow them to continue giving and providing excellent care.

The purpose of this article is to analyze and define compassion fatigue, provide information on how to identify it, as well as offer potential protective mechanisms and alternatives to deal with compassion fatigue at the organizational level and from a Christian perspective.

"Caregivers may perform a number of concrete functions, but the essential product they deliver is themselves."

ORIGINS OF THE TERM

Compassion fatigue is a concept originally coined in the healthcare arena by Carla Joinson (1992), when she noticed that nurses dealing with frequent heartache had lost their "ability to nurture" (p. 116). Later, Figley (1995) took a different approach and attempted to redefine compassion fatigue as secondary traumatic stress disorder (STSD). Figley's definition seems somewhat antithetical to Joinson's original idea of compassion fatigue.

EMPTY: COMPASSION FATIGUE SIGNS, SYMPTOMS, AND SYSTEM INTERVENTIONS

Nevertheless, Joinson's informal conceptualization and Figley's medically inclined definition struggle to capture the comprehensive meaning of the term.

To comprehensively and accurately conceptualize compassion fatigue, one must deconstruct the whole into its parts: *compassion* and *fatigue*, and then develop a definition dovetailing the two. Despite the lapse of two decades since the identification of compassion fatigue within the profession of nursing, a shortage of research and a discord regarding the concept remain. For this analysis, the definitions of compassion and fatigue, individually, were explored via an integrated literature review.

The word *compassion* dates as far back as 1400-1500 BCE, when an Egyptian Pharaoh's daughter found baby Moses crying. Scripture notes, "And she had compassion on him." (Exodus 2:6, KJV). Later, God described himself to Moses as, "The LORD, the LORD, the compassionate and gracious God, slow to anger, abounding in love and faithfulness." (Exodus 34:6). Jesus was the ultimate portrayal of compassion as he hung, beaten beyond recognition, on a cross between two criminals, and spoke aloud the words: "Father, forgive them, for they do not know what they are doing" (Luke 23:34, NIV).

Today, compassion is considered as empathy or the deep awareness of another's suffering, coupled with a desire to alleviate it (Dictionary.com, 2014a; Merriam-Webster.com, 2014). Shelly and Miller (2006) discuss compassion as the ability to "*feel with* [emphasis added] another person" (p. 230). Note that compassion is more than just sympathy or pity; it involves wanting to do something to change the state of another. Nurses, ministerial workers, teachers, parents, and caregivers of all sorts are told to have, "compassionate hearts, kindness, humility, meekness, and patience, bearing with one another" (Colossians 3:12-13, ESV).

Whereas compassion has only one core meaning, fatigue carries many meanings. Dictionary definitions include menial work completed by military personnel; clothing worn by military personnel; the tendency of a material to break under repeated stress; or a complete depletion of physical and/or mental energy or strength (Dictionary.com, 2014b). With regard to nursing, a concept analysis by Tiesinga, Dassen, and Halfens (1996) revealed

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that, "fatigue is a multidimensional, subjective phenomenon lacking specificity that is resultant from prolonged physical and mental activity." Fatigue often is used synonymously with tiredness or weariness.

WHAT DEFINES COMPASSION FATIGUE?

Compassion fatigue has been noted to involve emotional, physical, and spiritual weariness or exhaustion related to chronic or prolonged exposure to trauma (emotional upset) or difficult situations and/or the continuous offering or giving of self (Coetzee & Klopper, 2010; Gilmore, 2012; Joinson, 1992; Stewart, 2009; Yoder, 2010). Rev. Stephen Wende stated: "Caregivers may perform a number of concrete functions, but the essential product they deliver is themselves" (as cited in Joinson, 1992, pp. 116-117). Compassion fatigue involves a decline in one's energy, desire, and/or ability to love, nurture, care for, or empathize with another's suffering (Coetzee & Klopper, 2010; Gilmore, 2012; Stewart, 2009). These critical defining attributes were used to develop a theoretical definition (Walker & Avant, 2005):

> *Compassion fatigue* is the physical, emotional, and spiritual result of chronic self-sacrifice and/or prolonged exposure to difficult situations that renders a person unable to love, nurture, care for, or empathize with another's suffering.

Exposure to specific examples or situations assists in further understanding a particular concept or phenomenon. The following *model case* (Walker & Avant, 2005) has been constructed to better perceive compassion fatigue.

"Hannah" had been a geriatric nurse in a long-term care facility for 12 years. At one time, Hannah's colleagues referred to her as an "angel of mercy," as she continuously served the residents. She arrived early and stayed late. She poured into residents' lives through quality time and service. She listened to the residents' stories of childhood, marriage, and eventual loss of parents, friends, and spouses. Hannah administered medications, consoled grieving families, rubbed backs, and washed feet. Nothing was too much for Hannah.

Over the past several months, many of the residents whom Hannah loved passed away. In what seemed like an unending valley of loss, Hannah became weary and exhausted. She started arriving late to work, due to frequent tension headaches and physical exhaustion. Her emotional and spiritual emptiness resulted in complacency and apathy toward residents. She began to yell at residents when they were incontinent or unable to participate in activities. Her desire to nurture the people she once loved and cared for was gone. Hannah was experiencing compassion fatigue.

WHAT COMPASSION FATIGUE IS NOT

Hannah was experiencing compassion fatigue, but one could potentially confuse other cases similar to Hannah's as the same. To ensure integral comprehension of a concept, one must present not only a model case, but various cases that are not representative of the concept under analysis. The following presents a *related case* with regard to compassion fatigue. "Related cases are instances of concepts that are related to the concept being studied but that do not contain all the defining attributes" (Walker & Avant, 2005, p. 71).

The phenomenon of nurse *burnout* is often mistaken as compassion fatigue, and vice versa. Like compassion fatigue, burnout has proposed physical and psychological components, coupled with a decrease in or loss of motivation. However, the triggers and many of the critical attributes differ. Combining the old and new schools of thought, burnout is believed to be triggered by increased workplace demands, increasing healthcare expectations in general, lack of resources, interpersonal stressors, and organizational policy leading to diminished caring, cynicism, and ineffectiveness (Bush, 2009; Maslach, 2001).

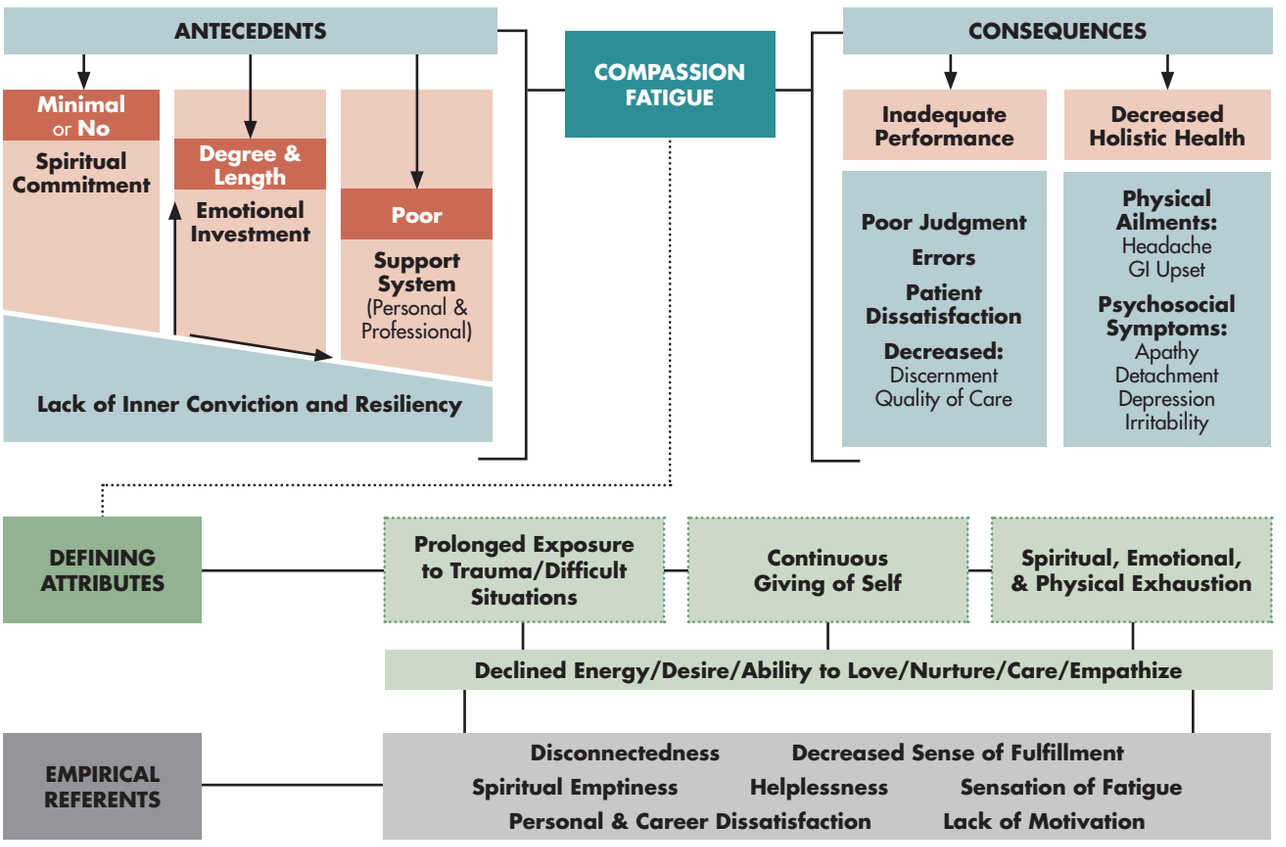
"Peter" had been a nurse for 20 years. During his career, he had worked in emergency, intensive care, and information technology. Most recently, he accepted a position on an adult medical-surgical unit in a large metropolitan hospital. Peter cared for patients with a multitude of diagnoses. His patient population ranged from wealthy senators' wives admitted for various plastic surgeries, to addicted, diabetic, destitute widowers.

Peter's first several months seemed to go well. Daily, he managed the care of five patients with ease. However, after a recent hospital merger yielded new policies, increased patient load, and budget cuts, Peter began to feel physically exhausted, overwhelmed, and incapable of caring. Additionally, he had been fighting with his wife for the past month over their financial difficulties. Sinking under the combined intrinsic and extrinsic stressors, Peter became cynical of everyone, including his patients. This led to depersonalization of care and a multitude of mistakes. On several occasions, he contemplated giving up nursing altogether. Peter was experiencing burnout.

Compassion fatigue and burnout are loosely related; however, they are also different as one can deduce from the previous cases. A significant variation is the idea of compassion. Nurses must possess compassion to experience the fatigue of it. In contrast, those experiencing burnout need not have the prerequisite of compassion.

Compassion fatigue is the physical, emotional, and spiritual result of chronic self-sacrifice and/or prolonged exposure to difficult situations

FIGURE 1. Compassion Fatigue Concept Map



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SIGNS, SYMPTOMS, CONSEQUENCES

Following recognition of the model and related cases, one can better identify and understand compassion fatigue. Nurses also need to know the antecedents and consequences of a phenomenon to better address the issue. Antecedents are circumstances or occurrences that must precede the occurrence of a concept, whereas the consequences are outcomes arising from the presence of the concept (Walker & Avant, 2005).

Authors disagree as to the antecedents to compassion fatigue, depending on their conceptualization of the concept. For this analysis, the determined antecedents for the nurse are as follows: the degree and length of emotional investment; poor or lack of personal and professional support systems (Abendroth & Flannery, 2006; Yoder, 2010); minimal or no spiritual commitment; and lack of inner conviction and resiliency (Bush, 2009).

The most overt and continually identified consequences of compassion fatigue are *inadequate performance* and *decline in holistic health* (Bush, 2009; Coetzee & Klopper, 2010; Potter et al., 2010; Stewart, 2009). Refer to Figure 1 for a concept map of the antecedents, consequences, attributes, and referents of compassion fatigue.

Familiarity with the theoretical definition of compassion fatigue helps nurses identify this concept in themselves and among colleagues. For example, nurse managers and administrators in particular must pay attention to the scheduling and patient acuity their staff is experiencing. Prolonged exposure to difficult situations, such as caring for terminally ill patients or those requiring intensive care, may lead to compassion fatigue. Managers need to observe their staff for manifestations of compassion fatigue that may present as spiritual emptiness, a decreased sense of fulfillment, disconnectedness to people, lack of motivation, sensation of fatigue, personal and career dissatisfaction, and feelings of helplessness related to the unrelenting sacrifice of self and/or prolonged exposure to trauma.

Nurses experiencing compassion fatigue often have a decline in personal health, leading to inadequate nursing performance, including medical errors related to poor judgment and decreased discernment, ineffective and decreased quality of patient care, and patient dissatisfaction (Bush, 2009; Coetzee & Klopper, 2010; Potter et al., 2010). In recent years, patient satisfaction has been at the forefront of hospital reimbursement. Compassion fatigue may also lead to nurses leaving the profession, as they experience career dissatisfaction, poor job satisfaction, and feelings of spiritual emptiness.

Interventions for compassion fatigue don't have to be expensive.

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a standardized national survey publicly presenting patients' perspectives of their hospital care (Agency for Healthcare Research and Quality, 2012). The survey allows patients to communicate how well their nurses communicated with them, the responsiveness to their needs, adequacy of their pain management, depth of communication regarding their medications, whether key information was provided at discharge, and whether or not they would recommend the facility to family and friends. Compassion fatigue among nurses can negatively affect patients' responses and induce financial instability of institutions, as well as lead to nurses' indifference or apathy toward patients, generate feelings of helplessness/hopelessness, produce headaches, sleeplessness, gastrointestinal symptoms, depression, and/or a desire to leave the profession (Bush, 2009; Coetzee & Klopper, 2010; Joinson, 1992; Maiden, Georges, & Connelly, 2011; Stewart, 2009).

With growing nursing shortages, leaving the profession could be devastating for the provision of excellent nursing care. Prevention, early recognition, and interventions aimed at reducing compassion fatigue will improve patient care and outcomes, as well as help keep nurses in the profession; therefore, the development of strategies to reduce compassion fatigue is imperative. Personal interventions nurses can employ to cope with compassion fatigue have been discussed elsewhere and include work/life balance and development of personal coping strategies (Boyle, 2011); adequate sleep; healthy, balanced nutrition; regular physical exercise; mini-vacations (Slatten, David Carson, & Carson, 2011); attention to spiritual needs through daily personal prayer, devotions, and scriptural readings; and engaging in enjoyable, creative pursuits (McHolm, 2006). McHolm points out that "The key to recovering from compassion fatigue is to focus on self in a healthy way so that you are appropriately sensitive to others' needs" (p. 16). However, no matter how much personal intervention a nurse employs, critical to combatting compassion fatigue is a supportive work environment that is nurturing, caring, and compassionate for nurses as well as for patients.

A NOURISHING WORKPLACE

A first critical step in reducing compassion fatigue is acknowledging that it exists, and to do so in a supportive fashion (Boyle, 2011). Nurses are notorious for trying to be brave and strong, putting up a front that says *I'm okay*. Acknowledging that compassion fatigue can be a normal response to caring in difficult situations helps one recognize and accept it. Talking about compassion fatigue and making it *okay* is critical to creating a nourishing workplace. In such an environment, when interventions and support are offered, nurses will be more likely to participate and/or accept help.

Interventions for compassion fatigue don't have to be expensive, although some of the following suggestions may involve some cost to the institution. Many of the following actions can be implemented on the unit level, although some will require broader organizational support. Table 1 summarizes system interventions for compassion fatigue.

Putting compassion fatigue on meeting agendas acknowledges and normalizes the phenomenon. Managers can take time in regular unit meetings to educate about compassion fatigue and teach interventions. Discussion can occur about patient care situations, as well as how staff members will implement interventions. Managers, clinical nurse specialists, and staff educators can develop a planned approach and present exemplars with appropriate outcomes, as well as lead discussions about ways to reduce compassion fatigue.

Acknowledging worker contributions to patients and to the organization gives energy to individuals and to nursing unit teams. When organizational leaders recognize and thank nurses for their compassionate caring, they help combat the sense of fatigue and feeling that efforts to care don't matter. Public recognition in newsletters or meetings, or private handwritten notes or emails sent to individuals can revitalize staff members.

Education is important for nurses at risk for or experiencing compassion fatigue. Healthcare organizations should include formal educational training regarding therapeutic communication, establishing boundaries, conflict resolution, ethical dilemmas, and self-care (Boyle, 2011). These topics address critical issues that can lead to compassion fatigue, such as unresolved problems in work relationships, inappropriate involvement

with patients and families, and not acknowledging or processing difficult care situations. Education can be included during orientation and periodically throughout the year. Administrators need to ensure there are multiple educational offerings accessible to all shifts.

Timeouts can be used when nurses are working in high acuity areas, or caring for patients during intense periods such as during labor and delivery, around the time of death, in intensive care units, or with any critically ill or challenging patient. A timeout is a period when the nurse can either be given a scheduled break or ask for a break when he or she feels an emptiness or inability to care or empathize with the patient and/or family. This timeout can be as short as 5 to 10 minutes or longer, depending on circumstances. A timeout gives the nurse the opportunity to step away, reflect, refresh, and be refilled. Timeouts are not to replace scheduled mealtime breaks; these are breaks for the mind and heart to refill beyond physical needs. It is important that timeouts are seen as an intervention to ensure patients receive high standards of care delivered by compassionate nurses, as opposed to regular, scheduled breaks. Managers can facilitate timeouts through rethinking patient allocation (Slatten et al., 2011). This can include scheduling a nurse with an expected intense period of caring with a nurse with a different patient mix so he or she can provide care while the fatigued nurse takes a timeout.

A related option to timeouts is *rotating care of difficult patients* when appropriate and feasible. This means one nurse does not care in the same challenging situation day-after-day, shift-after-shift, without a break. Giving nurses a break by rotating assignments can be a way to help nurses rejuvenate.

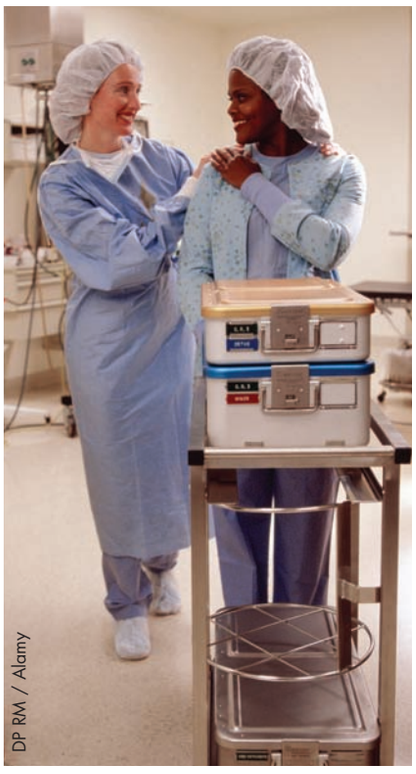
Hospital administrators can facilitate timeouts by *providing quiet rooms for staff.* These rooms should be conducive to reflection, meditation, and prayer, with subdued lighting and calming décor, including comfortable chairs and cushions. Nurses need to feel nurtured as they refill their giving and caring attributes. A variety of music could be available for individual use. Availability of reading materials such as poetry and religious materials suitable for all faith traditions are important. The hospital chapel, if it can offer private space, can be a place for nurses to take timeouts.

Debriefing is a useful intervention after any intense period of caring or prolonged difficult situations. Debriefing may occur on a regular basis, depending on the unit. Contributions from all staff members are welcome, such as speaking about the difficult experiences and asking for suggestions to reduce compassion fatigue. Talking about fatiguing experiences can help nurses cope with caring dilemmas as well as reframe difficult events and interactions. Rather than complaining, debriefing sessions should focus on events, actions, perceptions, feelings, and processing events.

To help new graduate nurses or staff new to a care area, nursing units can *develop a buddy system,* pairing novice and experienced nurses, or allow nurses to self-select their *buddy*. Debriefing sessions can be planned within the buddy system whenever needed.

TABLE 1: System Interventions for Compassion Fatigue

Acknowledge, openly discuss compassion fatigue
Acknowledge worker contributions to patients and the organization.
Formal education on compassion fatigue, contributing factors
Institute workplace Timeouts (Psalms 62:5; 91:1)
Rotate care of difficult patients
Provide quiet rooms for staff (Psalm 23:1-3)
Encourage debriefing (formal and informal)
Develop a buddy system (Ecclesiastes 4:9-12)
Encourage personal journaling
Offer collective ways to share difficult experiences
Provide support people for on-site counseling (Proverbs 27:9)
Provide healthy physical nourishment options 24/7
Encourage support groups and meeting outside of work (Hebrews 10:25)
Treat employees wholeheartedly (Ephesians 6:7-9)
Act justly, love mercy, walk humbly with God (Isaiah 57:15; Micah 6:8)
Rescue from oppression (Jeremiah 22:3).
Serve employees (Matthew 7:12, 20:25-28)



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Journaling is another helpful intervention to reduce compassion fatigue, particularly if coupled with debriefing and reflection. Managers can encourage staff nurses to privately journal about their experiences during prolonged, difficult caring situations or trauma. Journaling can assist the reflection process, as nurses gather their thoughts about experiences and transfer them to print.

Offering collective ways to share difficult experiences can assist in processing grief and expressing compassion fatigue. Sometimes simply talking, sharing emotions, experiences, and grief with other compassionate, understanding individuals is nourishing. A bulletin board where nurses can post notes, draw pictures, or make collages from magazine pictures or headlines can be a way to express feelings. Art materials in a break room or the timeout quiet room to engage in art therapy can be helpful. Attending memorial or funeral services after a patient death and/or sending a sympathy card signed with personal notes help staff share their grief and meaningfully support families.

Support people available for on-site counseling is a useful tool for staff members experiencing compassion fatigue. Making psychiatric advanced practice nurses, professional therapists, social workers, and pastoral care staff available to nursing staff can facilitate support (Boyle, 2011). Instead of nurses seeking out counsel, counseling staff can bring their support to the nurses as a compassionate service. Some ideas are: anointing and blessing nurses' hands for continued sacrificial giving, bringing food and treats, and offering a compassionate presence to allow discussion of frustrations, grief, and sadness (Aycock & Boyle, 2009). Counseling staff can attend debriefing sessions as well.

Physical nourishment is needed to achieve holistic rejuvenation. Healthy nutrition increases strength and resilience to stress. Nurses often skip meals or eat unhealthy snacks due to work schedules; this can lead to fatigue and poor health. Hospital administrators can encourage nurses to improve physical health by promoting healthy lifestyles in the workplace. Making sure that healthy foods, including snacks, are available to staff around the clock can promote physical health. The introduction of walking circuits in the workplace promotes physical fitness, as does taking the stairs and wearing a pedometer. Imagine how interesting (and fun!) it could be for hospitals to provide pedometers to nurses to record distances walked at work each day! All of these interventions assist in addressing the individual critical attributes of compassion fatigue.

It is important that timeouts are seen as an intervention to ensure patients receive high standards of care delivered by compassionate nurses, as opposed to regular scheduled breaks.

Nurse support groups and meeting outside of work can be extremely helpful in preventing and treating compassion fatigue. Coming together to share a meal and encourage one another helps nurses process work experiences, receive feedback and words of encouragement, and hear what others have done to deal with compassion fatigue. A special kind of support group is Nurses Christian Fellowship (NCF) meetings and events. Nurses meet together to study Scripture, pray, fellowship, and interpret nursing through a Christian biblical lens. In addition, Jesus joins in meetings as he said, "For where two or three come together in my name, there am I with them" (Matthew 18:20, NIV).

CHRISTIAN RESPONSES

Isaiah 54:8 refers to God's compassion as a phenomenon that emanates from everlasting love. Likewise, Christian nurses also provide compassionate care from a position of everlasting love. For Christians, compassion can be empowered through the Holy Spirit of God dwelling in them (Romans 5:5; Titus 3:5-6).

Holistic nourishment is needed to intentionally nourish one's personal emotional, spiritual, and physical well-being. The Bible illustrates how Elijah experienced tremendous emotional and physical fatigue, so much so that he requested God to take his life. However, God enabled Elijah to sleep and sent an angel to provide wise counsel and instruct him to "get up and eat." Elijah slept under a broom tree, ate some warm bread, and drank a jar of water. This nourished, refreshed, and strengthened him, enabling him to travel 40 days and nights to Horeb (1 Kings 19:3-8, NIV). Nurses can learn from the story of Elijah: listening to wise counsel, and finding refreshment and nourishment when fatigued.

There are protective mechanisms that Christ-followers can use to prevent and/or overcome compassion fatigue. McHolm (2006) describes in detail a number of biblical prescriptions for dealing with compassion fatigue on a personal level. These include removing, cleansing, physical renewal, filling, and serving in freedom and humility. A key principle is obtaining and extending forgiveness and being continually filled with the Holy Spirit of God.

On a systems level, Scripture encourages employers to treat employees *wholeheartedly* because both are actually serving God (Ephesians 6:7-9). Employers are to act justly, love mercy, and walk humbly with God (Isaiah 57:15; Micah 6:8), as they rescue from oppression (Jeremiah 22:3). The organization should not "lord it over" but serve employees (Matthew 20:25-28). Managers and organizations should treat nurses the way they themselves want to be treated (Matthew 7:12). Following biblical directions for caring for others will help counteract issues that contribute to compassion fatigue.

CONCLUSION

Sadly, few healthcare organizations acknowledge, discuss, or provide

interventions for assisting with compassion fatigue (Boyle, 2011). Compassion fatigue is an important concept for nurses and healthcare due to its professional and financial costs related to work days lost and the loss of nurses to the profession. Nurses and organizations must acknowledge the importance of compassion fatigue and have a thorough understanding of the concept to recognize when someone may be experiencing compassion fatigue, and intervene. Future direction lies in developing and testing interventions for compassion fatigue in different clinical sites among all nursing levels. Research results can be used to support the introduction of evidence-based best practices in the workplace to reduce compassion fatigue. Christian nurses can think about and praise "The Father of compassion and the God of all comfort who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves have received from God" (2 Corinthians 1:3-4, NIV).

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