



# Compassion Fatigue in Palliative Care Nursing

## *A Concept Analysis*

Lisa A. Cross, MSN, BA, CRRN, CHPN

The purpose of this review was to define compassion fatigue in the context of palliative care nursing. Compassion fatigue was first introduced as a description for nursing burnout; however, it was not fully described. An initial concept analysis within nursing placed it in terms of a psychological model for secondary traumatic stress disorder, with continual revisions of this application. Palliative care nurses are routinely exposed to pain, trauma, and the suffering they witness by nature of ongoing symptom management and end-of-life care delivery; however, the focus of care is on healthy end-of-life management rather than preservation of life. The literature was reviewed to provide clarification of compassion fatigue for palliative care nurses to assist in future identification and direction in the profession. CINAHL, EBSCO, Journals@Ovid, MEDLINE, PsycINFO, PubMed, and ScienceDirect databases were queried for peer-reviewed literature, and dictionaries were examined for subject-specific definitions. The method that was used was a concept analysis in the tradition of Walker and Avant. A concept definition was proposed for the discipline of palliative care nursing. Identification of compassion fatigue for this profession helps facilitate the recognition of symptoms for a group that deals with patient suffering on a regular basis.

patients and caregivers who are suffering. The prolonged contact with these individuals during times that they are at end stages of serious illnesses predisposes palliative care nurses to physical, emotional, spiritual, and psychological distress, possibly limiting their ability to provide compassionate care.<sup>1</sup> Compassion fatigue has been used to describe the distress that results from work-related stressors and has been defined as “a state of exhaustion and dysfunction—biologically, physically, and socially—as a result of prolonged exposure to compassion stress and all that it evokes.”<sup>2</sup>

Compassion fatigue in nurses can impact job satisfaction and patient outcomes and can lead to nurses leaving a profession already plagued by staffing shortages.<sup>3-5</sup> Of significance, compassion fatigue has been seen in diverse nursing settings and has been associated with stemming from caring, a foundational component to nursing.<sup>6</sup> Identification of symptoms is important for reducing occurrences of compassion fatigue, improving patient care, and retaining nurses.<sup>3</sup> Palliative care nurses are predisposed to distress, because they are surrounded by seriously ill or dying patients on a regular basis.<sup>1,7</sup> The focus of this concept analysis is to define compassion fatigue for palliative care nursing to assist in recognition of occurrences and future implications for this discipline.

### KEY WORDS

compassion fatigue, compassion satisfaction, concept analysis, hospice, palliative care nursing

Nurses are challenged with maintaining the balance between everyday stressors and work stressors. Palliative care nursing is a demanding nursing subspecialty, requiring time and continual contact with

### BACKGROUND

Compassion fatigue emerged as a concept in health care by Joinson<sup>8</sup> in 1992, when it was introduced as a synonym for burnout. Figley,<sup>9</sup> a psychologist, originally introduced the new concept of secondary catastrophic stress reactions as synonymous with the phenomena of secondary traumatic stress disorder (STSD) and later clarified STSD as compassion fatigue in 1995.<sup>2</sup> After years when compassion fatigue, STSD, and burnout became interchangeable terms, Coetzee and Klopper<sup>10</sup> defined compassion fatigue in terms of nursing practice in 2010.

Compassion fatigue is complex, because its consequences affect nurses, organizations, and patients. The multiple levels of stress that are experienced place nurses who have symptoms in a state of vulnerability.<sup>11</sup> These nurses may find the duties of their jobs in direct competition with their distress and find difficulties in providing compassionate care.<sup>11,12</sup> This places patients at risk for circumstances that include low staffing, errors, abuse, and neglect, as well as poor caring relationships.<sup>11</sup> Health

Lisa A. Cross, MSN, BA, CRRN, CHPN, is doctoral nursing student, University of Massachusetts, Lowell; and is clinical nursing instructor, North Shore Community College, Danvers, MA.

Address correspondence to Lisa A. Cross, MSN, BA, CRRN, CHPN, 10 Silas Meriam Way, Middleton, MA 01949 (lacross1@comcast.net).

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care organizations face the challenges of retaining nurses and maintaining safety outcomes by preventing, identifying, and relieving the symptoms of compassion fatigue.<sup>11</sup>

Palliative nurses care for sick and suffering patients on a continuum. Palliative care is a type of care that encompasses the patients and the caregivers through a holistic approach to manage the symptoms of serious illnesses, while addressing pain, symptoms, psychosocial issues, spirituality, and quality of life.<sup>13</sup> The World Health Organization identifies palliative care as “an approach that improves quality of life of patients and their families facing the problem associated with life-threatening illness.”<sup>14</sup> Because the focus of care is comprehensive, palliative nurses bear witness to patient and caregiver suffering on multiple levels that include physical, psychological, social, emotional, and spiritual.

Hospice and palliative nursing are frequently used as interchangeable terms, programs, or types of nursing care. However, hospice care is a type of palliative care where the care delivery is intensified, because the disease is identified as terminal or end-stage, with a prognosis of 6 months or less.<sup>13</sup> The movement for end-of-life care and bereavement services began with Dame Cicely Saunders, a registered nurse from the United Kingdom.<sup>15</sup> She saw the need for extended support during the dying process and opened the first hospice in England in 1967.<sup>15</sup> As recognition for services spread, the hospice philosophy eventually came to the United States, with hospice also becoming a Medicare benefit during the 1980s.<sup>15</sup> In the United States, the terminology may be confusing, because the hospice Medicare benefit provides coverage that includes nursing care, medications, equipment, and psychosocial support for patients who are determined eligible by physicians.<sup>15</sup>

Hospice and palliative care nurses are focused on delivering quality health care to their patients and caregivers as they approach the end of life, and it is imperative that they maintain quality and health in their own lives.<sup>16</sup> Palliative care nurses may experience three stressors unique to this discipline.<sup>17</sup> The first stressor arises from personal factors from the palliative nurse and includes the nurse’s discomfort with the patient’s illness or treatment plan, inadequate preparation or training to manage the illness, or external distractions from outside life. The second stressor is derived from the patient or caregiver and includes patient health decline or noncompliance with the treatment plan. The third stressor is related to the work environment and includes practice issues such as poor staffing and resources. These stressors are distinct to the palliative care discipline and are associated with the struggles in finding a balance between intimacy and empathy in the working relationship.<sup>7,18</sup> The identification of predisposing stressors has become critical to providing future support for palliative care nurses. As palliative care nurses experience an intense relationship with their patients and their caregivers, there is a greater risk for compassion fatigue, placing emphasis on the need to define compassion fatigue for the discipline of palliative care nursing.

## Data Sources

English-language dictionaries and nursing and medical dictionaries were reviewed for the terms “compassion fatigue,” “compassion,” “fatigue,” “palliative,” and “hospice.” Compassion fatigue was a newer term; however, it appeared in nursing and medical dictionaries as well as in the online dictionaries reviewed. The databases that were searched were CINAHL, EBSCO, Journals@Ovid, MEDLINE, PsycINFO, PubMed, and ScienceDirect for the time frame of 2010 to 2018 and were limited to those items that were in the English language. “Compassion fatigue,” “palliative care,” and “hospice” were used as search terms or keywords and then were narrowed down to subject-specific terms to eliminate nonrelevant data. A second search was conducted with the search terms “concept analysis” and “compassion fatigue” in the same manner. Abstracts, reviews, and commentaries were excluded from this search. Studies that involved compassion fatigue outside nursing or helping professions were excluded. Duplicate results were eliminated.

Seventy-one articles within the identified time frame were found. Six concept analyses related to compassion fatigue were found. There were two analyses for other nursing subspecialties other than palliative care; however, the search did not yield one for palliative care nursing. Twenty-eight studies were identified, with four specifically related to palliative care or hospice nurses and compassion fatigue. The other disciplines that were studied were oncology nurses, student nurses, intensive care nurses, critical care nurses, general nurses, pediatric nurses, military nurses, mental health nurses, social workers, and genetic counselors.

Two dissertations in palliative care nursing were found. Three recent literature reviews within the search years were found, reviewing compassion fatigue across all nursing care. Articles that were used outside the search parameters were those by the original developers,<sup>2,8,9</sup> as several other articles referenced preliminary work in the area of compassion fatigue concept development. Two books were found to be relevant to the time frame and to the search terms.<sup>13,15,16</sup>

## RESULTS

### Concept Selection

This concept analysis was guided by the method of Walker and Avant.<sup>19</sup> The method included eight stages: choose the concept, outline the purpose, determine uses of the concept, describe its attributes, examine a model case, illustrate any additional situations, identify antecedents and consequences, and establish empirical indicators.<sup>19</sup> The stages are described hereinafter.

### Aim of the Analysis

This analysis will separate compassion fatigue from the similar terms “burnout,” “secondary traumatic stress,”



and “vicarious traumatization” and define the concept on its own. The purpose of this concept analysis was to further define compassion fatigue within the discipline of palliative care nursing to make it relevant for those nursing caregivers who have routine exposure to the suffering of their patients and their caregivers while providing quality end-of-life care. Past research has defined the concept as STSD, burnout, or vicarious traumatization. However, palliative care is delivered over a continuum, focusing on compassionate care delivery rather than preservation of life as in other nursing disciplines.<sup>13</sup> This analysis will provide a separate identity for compassion fatigue and place it within the context of palliative care nursing.

### Use of the Concept

The terms for the concept were identified in and out of the nursing literature to explore other uses of concept language.<sup>19</sup> *Palliative* is identified as relieving care without curing or an individual who relieves an uncomfortable condition.<sup>20</sup> The word *hospice* has origins in Latin that means “guests” or “hosts,” and its current use is as a care model or a location for care.<sup>15</sup> *Taber's Cyclopedic Medical Dictionary* defined it slightly differently than other sources; here, it was described as a program derived from palliative and supportive services, interdisciplinary in nature, that focused on the “physical, spiritual, social, and economic needs” of terminally ill patients and their caregivers.<sup>20</sup>

*Compassion* is defined as having pity or the urgent desire to help or aid someone.<sup>21</sup> It is also identified as a synonym for sympathy.<sup>20</sup> *Fatigue* is defined in different contexts that include manual work; an exhaustion from labor, stress, or exertion; or a “loss of power induced by a sensory receptor.”<sup>22</sup> It can also be defined in military terms as a unit or a uniform worn.<sup>22</sup> The medical definition of fatigue placed it in the context of a diminished capacity for work in the mental and physical domains and also identified acute, alert, chronic, muscle, and volitional fatigue in addition to compassion fatigue.<sup>20</sup>

Compassion fatigue is medically defined as “cynicism, emotional exhaustion, or self-centeredness occurring in a health care professional previously dedicated to his or her work and clients.”<sup>20</sup> Compassion fatigue is described as a form of exhaustion resulting from prolonged exposure to caring for sick or traumatized patients.<sup>23</sup> Compassion fatigue is also defined as “fatigue, emotional distress, or apathy resulting from the constant demands of caring for others or from constant appeals from charities.”<sup>24</sup> This definition of disinterest is fairly consistent with a 1983 public policy application by *The New York Times*<sup>25</sup> that described the United States’ detachment in helping refugees after the Soviet occupation of Afghanistan.

Almost a decade later, Joinson<sup>8</sup> was the first to refer to compassion fatigue in nursing literature as a type of burnout, specifically linking it to caring professions such

as nursing, ministry, and counseling. Nurses were identified as prone to the phenomena because of the nature of their work. Later work by Figley<sup>2</sup> portrayed compassion fatigue as a state of exhaustion and biological, psychological, and social dysfunction that resulted from prolonged exposure to compassion stress. Burnout was identified as a process that existed simultaneously with compassion fatigue or its synonymous concept, STSD, that developed gradually as physical, emotional, behavioral, professional, and interpersonal symptoms progressively worsened.<sup>2</sup> Although Figley<sup>2</sup> applied compassion fatigue and STSD to nurses, he used the same concepts and definitions for psychotherapists and other disciplines. He continues to develop his work with STSD in formulating a theory with resilience, stress, and trauma victims.<sup>26</sup>

Coetzee and Klopper's<sup>10</sup> development of a compassion fatigue concept analysis in 2010 was heavily influenced by Figley's work with STSD. This was the first concept analysis in relation to nursing care, and despite numerous nursing articles and nursing studies examining compassion fatigue, several years had passed before this analysis clarified what was a relatively new concept during that time.<sup>10</sup> Their concept analysis indicated that compassion fatigue resulted from a cumulative process where compassion discomfort led to compassion stress and, if not managed, led to compassion fatigue through prolonged and intense contact with patients, exposure to stress, and self-involvement in care.<sup>10</sup> The authors differentiated the concept of compassion fatigue as separate from STSD, with compassion fatigue resulting specifically from exposure to direct care of patients and STSD resulting from exposure to traumatic events or stories of traumatic events of others.<sup>10</sup> However, the definition that was used was slightly different from that proposed in a previous work by Figley<sup>2</sup> in that it did not identify distress in the psychological domain. Psychological responses could be a causative or resulting factor associated with stress and are important elements for compassion fatigue concept definition.<sup>6,17</sup>

Sorenson et al<sup>27</sup> provided an updated concept analysis of compassion fatigue using Rodgers' evolutionary model to guide the analysis in relation to nursing care. The definition was identified as interchangeable with STSD and indicated that compassion fatigue was the emotional cost of caring related to caring for those suffering individuals and, as a result, emotional, physical, and spiritual exhaustion occurred.<sup>27</sup> Effects in the social and professional domains were not addressed in this definition. This analysis also identified a similar concept, vicarious traumatization, or results from caring for those with STSD.<sup>27</sup>

### Defining Attributes

Walker and Avant<sup>19</sup> indicated that attributes were those characteristics that were frequently associated with the concept. Compassion fatigue develops over time. There are five



domains identified as elements of compassion fatigue upon pertinent literature review: emotional and psychological, intellectual and professional, physical, social, and spiritual. These are listed in the Table and will be reviewed in this section.

**Empathy Imbalance**

Palliative care nurses are involved in the end-of-life process for all of their patients. Some have indicated that they “compartmentalize” their feelings from their everyday life to avoid feeling the stress of multiple deaths.<sup>28</sup> However, as they separate their feelings, these feelings can become inappropriate, leading to excessive empathy. Empathy is present when nurses are actively aware of feeling or experiencing the concerns of patients without having the thoughts or feelings described or communicated to them.<sup>29</sup> Excessive empathy can create role confusion or blurred boundaries, just as not enough empathy can create a poor connection between the nurse and the patient. When nurses dwell on their feelings and roles, other emotions such as self-doubt set in and they become overwhelmed. Anxiety, depression, and irritation with patients can result from this process.

**Diminished Performance**

The nurse experiencing compassion fatigue has difficulty concentrating on his/her job. There is diminished performance as compared with the previous level of ability. As this becomes out of control, it may be evidenced by behavior that is out of character for the nurse such as disorderly appearance, making mistakes, or calling out.

**Increased Complaints**

Palliative care nurses often neglect their own physical needs as they attend to the needs of their chronically suffering patients.<sup>28</sup> This poor self-care manifests as exhaustion, lack of sleep, increased physical complaints, and poor endurance. Nurses have described physical exhaustion as being “sucked in” or “wrung out.”<sup>11</sup> Physical symptoms vary from each person but may include headaches, gastrointestinal symptoms, chest pain, and malaise.<sup>27</sup>

**Inability to Share in Suffering**

The palliative care nurse with compassion fatigue experiences greater difficulty enjoying outside life as exposure to stress and suffering at work combined with the energy expenditure to maintain productivity makes it difficult to maintain personal relationships. Family members or loved ones may have unrealistic expectations, finding it difficult to identify with the nurse’s feelings of suffering or inability to share or acknowledge pain or feelings.<sup>11</sup> This contributes to the nurse’s difficulties in working through his/her feelings and further exacerbates feelings of anxiety and self-doubt.

**Poor Judgment**

A normal function of the palliative care nurse is to provide spiritual assistance to his/her patient and caregiver.<sup>15</sup> However, the nurse feeling the pressures of compassion fatigue has a spiritual disconnect and lacks the ability to provide judgment on a spiritual level.<sup>10</sup> This also makes it difficult to perform normal duties.

<b>TABLE Compassion Fatigue in Palliative Care Nursing</b>			
<b>Antecedents<sup>a</sup></b>	<b>Consequences<sup>b</sup></b>	<b>Attributes<sup>c</sup></b>	<b>Empirical Referents<sup>d</sup></b>
Ability to experience compassion and empathy	Loss of ability to feel compassion and empathy	Emotional/psychological: empathy imbalance	Emotional/psychological: irritation, depression, anxiety, and self-doubt
Exposure to suffering	Burnout	Intellectual/professional: diminished performance	Intellectual/professional: poor performance, calling out, mistakes, and inability to concentrate
Repeated exposure to stressors	Breakdown	Physical: increased complaints	Physical: headache, nausea, chest pain, exhaustion, sleep loss, malaise, and poor endurance
	Disinterest	Social: inability to share in suffering	Social: difficulty in maintaining interpersonal relationships
	Moral distress	Spiritual: poor judgment	Spiritual: inability to provide judgment, lacks awareness

<sup>a</sup>The events that exist before the compassion fatigue.<sup>19</sup>  
<sup>b</sup>The outcomes of the compassion fatigue.<sup>19</sup>  
<sup>c</sup>Those characteristics that were frequently associated with the compassion fatigue.<sup>19</sup>  
<sup>d</sup>The real-world instances that help determine the existence of the compassion fatigue.<sup>19</sup>





## Cases

### Model Case

A model case is a use of the concept as a pure example.<sup>19</sup> The following is a model case with the defining attributes identified.

M.D. is a 27-year-old man who has been a home palliative and hospice nurse for 3 years. He loved his job and the connection he had with his patients, being able to identify with them on a personal level. Having lost his sister during his teens to a congenital heart defect, he always wanted to be a hospice nurse. He has recently experienced an increase in his caseload due to covering another nurse's maternity leave. Not long ago, his wife had their second child. He has found himself becoming anxious about the number of death pronouncements he has had recently, having experienced incredible loss in a short amount of time, and has been afraid to get close to his new patients. He has not been sleeping and has been arguing with his wife about child care. The other day, he drew up the wrong amount of morphine for a patient, and the week before, he went to the wrong house on the wrong day. It was okay, as neither patient really noticed, so he did not mention it to his supervisor, J.S. He stopped going to the bereavement groups after interdisciplinary team meetings to save time to schedule his nursing visits. He is frustrated and is starting to resent the drive to work and to the homes of the patients who live in the area that he is covering. "Why do I have to go to those towns, anyway?", he wonders. "They aren't even my patients."

### Borderline Case

A borderline case is one that has most of the defining characteristics of the concept, but not all of them.<sup>19</sup> The following case is of STSD. Secondary traumatic stress disorder is a situation that develops when the caregiver experiences stress from providing support to a traumatized individual and usually occurs when the caregiver imagines himself/herself as integral to the individual's support system.<sup>27</sup> It is similar to compassion fatigue, but it occurs from caring for patients who have experienced trauma and is usually observed in different settings.

T.F. is a 38-year-old critical care nurse who has been practicing for 13 years. For the past week, she has been caring for two young boys who were brought in as shooting victims of a homicide-suicide committed by their father with their mother as the homicide victim. Before their mother was killed, they were held hostage in their apartment with her for 3 hours before being rescued. Their father killed himself before law enforcement came in. Social service members have been in to see the boys on the unit. T.F. has become very protective of them and has trouble leaving her shift in the evening. She has been calling on her off-hours to check on their progress and is concerned

about what will happen to them when they are ready to discharge. She has found herself unable to stop thinking about the shock on their young faces when they were brought in and has been crying at night. She is starting to have difficulty sleeping and does not want to go to work but is worried if she does not go in, "Who will take care of the boys?"

### Related Case

A related case is a scenario that is close to the concept but does not have all of the defining attributes.<sup>19</sup> The following related case is that of vicarious traumatization. Vicarious traumatization is similar to compassion fatigue, but it is the stress that results from caring for traumatized patients who are experiencing STSD.<sup>27</sup> It can occur from hearing about the trauma that patients have experienced and empathizing with those experiences and usually occurs in settings different than palliative care.

R.T. is a 58-year-old woman working on an inpatient rehabilitation floor treating military veterans with complex injuries. She has been at her nursing job for 6 years and initially enjoyed coming to work because of the longer-term relationships she established with her patients. She recently has been caring for a young man of similar age to her son, and she has developed a special bond with him. She began to spend longer time on the unit to stay and talk to him about his injuries, and gave him her number so that he could call her when he had bad thoughts. She has become so preoccupied with caring for him and thinking about his war experiences that she has been having nightmares and making mistakes at work. She cannot reach out to her husband and son, who do not understand her work, and she has been thinking about talking to another colleague to discuss these frustrations.

### Contrary Case

A contrary case demonstrates the opposite of the model case.<sup>19</sup> The opposite of compassion fatigue is compassion satisfaction. Compassion satisfaction was presented in a concept analysis by Sacco and Copel,<sup>29</sup> where it was defined as occurring when empathy drives altruism and results in alleviation of suffering, which further results in a positive work experience for the nurse. The following is based on this concept.

J.D. is a 34-year-old nurse with 8 years of experience in an inpatient hospice unit. She has always wanted to be a hospice nurse, finding joy in her connection with patients and families. Although she is sad at losing patients, she finds support through colleagues and through formal and informal meetings with the interdisciplinary team. She leads the unit bereavement group and is a mentor to new nurses at the unit, helping them cope with their stress management skills. During her recreation time from work, she enjoys being part of a book club, cooking, volunteering



at her children's school, hiking, and vacationing with her family. When her friends and acquaintances ask, "Why hospice nursing?", she tells them that she likes what she does and finds it satisfying, still looking forward to her work.

### Antecedents and Consequences

Antecedents are events that exist before the concept development.<sup>19</sup> Antecedents for compassion fatigue are the ability to experience compassion and empathy, exposure to suffering, and repeated exposure to stressors. To lose something, one must first have it. The ability to feel empathy and compassion is a requisite to compassion fatigue. If the nurse does not have the ability to feel these two emotions, there will not be a loss. The nurse who is continually exposed to stress will react with a change in ability to empathize.<sup>27</sup> With exposure to suffering combined with the stress and empathy for the patient, the nurse does not have the ability to focus on himself/herself, creating a risk for compassion fatigue.

Consequences are the outcomes of the concept.<sup>19</sup> The consequences of compassion fatigue are the loss of ability to feel compassion and empathy, burnout, breakdown, disinterest, and moral distress. The loss of the ability to feel compassion and empathy results from prolonged exposure to the stressors and suffering. One of the most important roles of the palliative care nurse is that of care facilitator as well as case manager of the interdisciplinary team.<sup>13</sup> When the nurse is disinterested and no longer able to be concerned, he/she is no longer able to care, which is the basic function of nursing.<sup>6</sup> Moral distress occurs when the palliative care nurse conducts himself/herself in ways that contradict his/her personal values and beliefs.<sup>30</sup> This is a result of not performing professional nursing duties as to normal capabilities, including disinterest or poor performance. The nurse no longer has control over the situation, and burnout can occur. This has been described as similar to compassion fatigue; however, burnout has been identified as occurring over a longer period.<sup>12</sup> It can occur from similar stressors as compassion fatigue, and it can emerge before compassion fatigue symptoms and may also be a contributing stressor. Emotional and physical breakdown is a consequence of compassion fatigue occurring when other consequences exist unattended by the palliative care nurse's loved ones, peers, or managers.<sup>10</sup>

### Empirical Referents

Empirical referents are the real-world instances that help determine the existence of the concept.<sup>19</sup> It is important that managers and coworkers recognize these situations for the safety of the palliative care nurse and the patients under care.

Examples for the emotional and psychological realm include outward irritation, verbalizations that indicate lack of empathy or excessive empathy, indications that the

nurse is having doubt of ability, or anxiety regarding work. Callouts due to illness, visualization or verbalization of exhaustion by the nurse, poor endurance, poor hygiene or professional appearance, and frequent mistakes in paperwork, medication administration, or skills are examples for the professional or intellectual domain.

Physical complaints of nausea, chest pain, headache, poor sleeping habits, and overall exhaustion may be signs of compassion fatigue. The nurse who closes himself/herself off from coworkers and family, refuses to assist others, or is having relationship issues may be demonstrating signs of compassion fatigue. The palliative care nurse who previously was willing to participate spiritually and now is unable to focus or demonstrate judgment or clarity in this realm may be at risk for compassion fatigue.

### Proposed Definition of Compassion Fatigue

The proposed definition of compassion fatigue in the context of palliative care nursing is the result of compassion and empathy in the palliative care provider with chronic professional exposure to suffering and repeated exposure to stressors. It is the state where compassion and empathy are lost, demonstrated by emotional and psychological, intellectual and professional, physical, social, and spiritual characteristics that, if left unattended, result in disinterest, moral distress, burnout, and breakdown.

## DISCUSSION

### Strengths

This analysis separates compassion fatigue from its similar concepts of vicarious traumatization, STSD, and burnout, providing a definition for palliative care nursing. Compassion fatigue has not been defined in the context of palliative care nursing in previous literature. Palliative care nurses are routinely exposed to suffering and death of the patient population they care for, and the caring leads to compassion fatigue.<sup>1</sup>

### Limitations

One limitation of the data search was its restriction to the English language. Compassion fatigue is a concept that has not been limited to English-speaking countries, so there may have been relevant data excluded.<sup>11,31,32</sup> Another limitation is that, by not exploring dictionaries outside the traditional, medical, or nursing dictionaries, ideas may have been excluded through definitions that could have impacted this concept. Sources were obtained primarily from helping profession databases, including nursing, medicine, social work, and psychology, and the literature search was refined based on the search terms. However, using these databases and not expanding the initial search may have been a limitation.



## Implications for Nursing

Future implications include recognition of compassion fatigue with the goal of promoting strategies for compassion satisfaction. The concept analysis of compassion satisfaction by Sacco and Copel<sup>29</sup> identified three antecedents similar to this model: empathy connection, negative impact of exposure to suffering, and influence of stressors in the environment. The authors expanded their model to include three more antecedents for the development of compassion satisfaction that are not present in compassion fatigue: the nurse's desire for a beneficial, caring relationship; meeting patients' needs resulting in positive behaviors; and the existence of positive aspects among negative aspects of caring.<sup>29</sup> Recognition and incorporation of those additional factors in the palliative care setting could help prevent the detrimental effects of compassion fatigue. Research in the area of identification of compassion fatigue empirical indicators could help prevent manifestation of its attributes. Educational awareness of beneficial behaviors and practices for palliative care nurses could reduce compassion fatigue risk factors and symptoms and help with coping strategies in the wake of stressors.

## CONCLUSION

Nurses who are satisfied and engaged are likely to provide better care for themselves and their patients.<sup>33,34</sup> Ongoing assessment of staff and development of programs that encourage appropriate engagement activities are some ways to support palliative care nurses.<sup>7</sup> Offering specialized education, self-care resources, and individualized staff bereavement programs may decrease professional stressors.<sup>35</sup> Compassion fatigue is a concept that is inversely related to compassion satisfaction. Currently, there is a gap in the literature regarding the theoretical connection that future research might explore and bridge in the discipline of palliative nursing. Developing a better understanding of the relationship between these two concepts could provide more insight for palliative nursing care.

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