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Abstract

Background: Compassion fatigue is a term used to describe the unique stressors affecting people in caregiving professions. **Purpose:** For nurses and other direct care providers, the impact of compassion fatigue may result in stress-related symptoms, job dissatisfaction, decreased productivity, decreased patient satisfaction scores, safety issues, and job turnover. Those who care for seriously ill children and their families are at increased risk for compassion fatigue. Constant exposure to children who are suffering, in combination with work place stressors and personal issues, may contribute to the development of compassion fatigue. **Methods:** The Professional Quality of Life Scale Version 5 was used to determine the risk for compassion fatigue among 296 direct care providers at St. Louis Children's Hospital. **Results:** Compassion satisfaction, burnout, and secondary traumatic stress scores did not differ by age, work category, level of education, or work experience. There were, however, significant differences in scores as a function of nursing unit. Nurses who work in the pediatric intensive care unit reported lower compassion satisfaction scores, and higher burnout and secondary traumatic stress scores. **Clinical Implications:** Results demonstrated the risk for compassion fatigue and provided data necessary to support development of a compassion fatigue program for direct care providers.

Key words: Compassion fatigue; Intervention; Pediatric nurse; Work environment.

COMPASSION FATIGUE AMONG PEDIATRIC HEALTHCARE PROVIDERS

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A number of recent studies have clearly demonstrated that an enriched work environment promotes improved patient outcomes and better patient satisfaction (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Boev, 2012; Weinberg, Avgar, Sugrue, & Cooney-Miner, 2013). Leaders in hospitals today realize that a positive work environment is a significant contributor to efforts to retain a competent and caring professional staff who are then able to provide excellent patient care. A supportive environment for caregivers is necessary to provide a supportive environment for parents and children.

Pediatric healthcare involves unique challenges for the direct care provider who is continually exposed to both children who are seriously ill, in pain, and possibly facing death, and to their families who are also suffering (Zadeh, Gamba, Hudson, & Wiener, 2012). Constant exposure to children who are suffering, along with work place stressors such as increased patient assignments, staff shortages, perceived lack of management support, and a paucity of resources to perform their job well, eventually affects nurses' emotional and personal health. In turn, these factors ultimately have an impact on the nurse's ability to provide safe, competent nursing care to patients (Zadeh et al.).

Pediatric healthcare providers are at particular risk for developing burnout and compassion fatigue (Robins, Meltzer, & Zelikovsky, 2009). Compassion fatigue, the traumatization of healthcare providers occurring as a consequence of their commitment to helping others, is a relational source of stress that has an impact on pediatric direct care providers. Working with children who may have experienced trauma or may be facing death has been shown to increase the risk for experiencing secondary traumatic stress and eventually compassion fatigue (Robins et al.). Providers may have uncomfortable feelings if their patients are similar in age or gender to their own children. Circumstances surrounding the child's disease or family may be similar to the healthcare professional's personal experiences, which may also contribute to the development of compassion fatigue (Meadors & Lamson, 2008).

Nurse administrators identified the need to explore the concept of "compassion fatigue" as one strategy to ensure a nurturing practice environment that would translate into improved patient and family care. This study was designed to identify risk for compassion fatigue among pediatric healthcare providers at St. Louis Children's Hospital, a large academic pediatric medical center affiliated with Washington University in St. Louis, MO. Addressing compassion fatigue is recognized as a major step in retaining staff, preventing turnover, and improving quality of care (McHolm, 2006; Potter et al., 2010; White, 2006).

Literature Review

Caring for others can be very rewarding and fulfilling, yet a review of the literature leaves little doubt that this work can also take a toll on the psychosocial and physical health of the healthcare provider. There is a cost to caring (Figley, 1995). Many direct care providers are secondary witnesses to trauma and serious illness experienced by others (Figley, 1995; Stamm, 2010). Few of these caring professionals anticipate the emotional implications and sequelae that come from close interpersonal relationships with patients and families. Compassion, a feeling of empathy for the distress of another, commonly gives rise to an active desire to alleviate another's suffering and is considered a cornerstone of the healthcare professions. However, the continuing stress of meeting the often overwhelming needs of patients and families can result in what is termed "compassion fatigue." Research over the past 2 decades indicates compassion fatigue is an ongoing and common problem (Showalter, 2010).

The concept of compassion fatigue was introduced in the healthcare literature over 2 decades ago. Joinson (1992) first used the term to describe "the loss of the ability to nurture" in a study of emergency department nurses. Figley (1995) later formally defined compassion fatigue as a secondary traumatic stress reaction resulting from helping or desiring to help a person suffering from traumatic events. Empathic caregivers indirectly experience the trauma of their patients, and their efforts to empathize and show compassion often lead to inadequate self-care behaviors and increased self-sacrifice (Boyle, 2011; Figley, 1995; Lombardo & Eyre, 2011; Sabo, 2011; Yoder, 2010).

Figley (1995) described compassion fatigue as comprised of two main elements: burnout and secondary traumatic stress. Burnout consists of feelings such as frustration, anger, and depression with the work environment. Secondary traumatic stress encompasses behaviors and emotions that develop in an individual caring for a patient who has experienced a traumatic event. Compassion fatigue occurs unexpectedly and encompasses a sense of powerlessness and uncertainty (Gentry, Baranowsky, & Dunning, 2002). It can be the result of efforts to consistently deliver compassionate patient care over a prolonged period without always experiencing the positive outcome of seeing improvement (McHolm, 2006). Nurses' risk for compassion fatigue is unique in that nurses function as both first responders and as sustained responders providing nursing care to patients and families on a continual basis (Bush, 2009).

The concept of "compassion satisfaction" in determining the risk for compassion fatigue was introduced by Stamm in 1988 as one of the aspects of the professional's quality of life that should be considered when determining the risk for compassion fatigue. Stamm (2010) defines professional quality of life as "the quality one feels in relation to their work as a helper" and is composed of three factors: the work environment, the client environment (the person being helped), and the personal environment (characteristics of the worker) (p. 8). Professional quality of life is the combination of both the positive quality (compassion satisfaction) and the negative quality (compassion fatigue). Caring for patients allows nurses and other healthcare professionals to feel a sense of well-being and fulfillment that energizes them and leads to retaining a high morale, thriving in the workplace, and the enthusiasm to continually meet patients' needs (Coetzee & Klopper, 2010). Compassion satisfaction is the motivation that a healthcare provider receives from using his or her skills, knowledge, and available resources to provide care to patients. The reward for the provider is to see the patient improve both physically and emotionally (Coetzee & Klopper). However,

although caring for others can be rewarding, there is also a toll on the healthcare worker from repeated exposure to patients' pain and suffering. This negative aspect of providing direct care is now known as compassion fatigue.

Compassion fatigue can also lead to increased accidents and poor quality of care (Slatten, David Carson, & Carson, 2011). Quality and effectiveness of an organization's work can be compromised when its providers are suffering from stress and secondary traumatization. Providers who do not manage their stress are more likely to struggle with empathy toward their patients and thus reduce effectiveness of care. If problems are not addressed, the subsequent culture in the organization can have a depressing effect that will inevitably contribute to reduction in the quality of care and an increase in medical errors (Meadors & Lamson, 2008).

Experts in the field of compassion fatigue have begun to advocate for interventions to prevent compassion fatigue (Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2004; Gentry, Baranowsky, & Dunning, 1997; Potter et al., 2010). Potter et al. (2013) described success of specific approaches for developing coping and stress management skills. They reported development and implementation of a hospital-wide program to provide hospital personnel with self-care measures to prevent compassion fatigue, as well as information necessary to recognize signs and symptoms of compassion fatigue. Slatten et al. (2011) suggest that healthcare systems consider incorporating opportunities to manage effects of compassion fatigue on direct caregivers. On-site counseling, support groups, debriefing sessions, art therapy, and assisting healthcare providers to integrate self-care plans into goal setting in conjunction with annual performance appraisals have all been suggested interventions (Slatten et al.). Compassion fatigue has become an increasingly important issue across the healthcare continuum. Potter et al. (2010) stresses that an essential first step for organizations that wish to implement programs that address compassion fatigue and establish a positive work environment is to assess the prevalence of compassion fatigue within the organization.

A supportive environment for staff is necessary to provide a supportive environment for parents and children.

Study Design and Methods

This descriptive, cross-sectional survey using electronic distribution for data collection was conducted to identify prevalence of compassion fatigue among staff nurses, advanced practice nurses, social workers, respiratory therapists, physical therapists, occupational therapists, psychologists, child life therapists, and patient care associates. We sought to determine the relationship between demographic variables (age, work category, level of education, work experience) and risk for compassion fatigue. Following approval by the Institutional Review Board of the affiliating university, the survey was distributed to registered nurses (RNs) and other direct care providers in the emergency unit (EU), pediatric intensive care unit (PICU), cardiovascular intensive care unit (CICU), and the hematology-oncology and cardiology units.

Compassion fatigue was measured with the Professional Quality of Life Scale Version 5 (Pro-QOL) (Stamm, 2010). This instrument was originally developed by Figley in 1995 and then modified by Stamm in 2005 and 2010. It has been used frequently in research and clinical settings to identify risk for compassion fatigue (Stamm, 2010; Young, Derr, Cicchillo, & Bressler, 2011). The ProQOL includes three 10-item subscales: compassion satisfaction, burnout, and secondary traumatic stress. Respondents rate how frequently they experienced each issue in the last 30 days using a scale from one (never) to five (very often). Reliability for the compassion satisfaction and burnout scales is high, with an alpha of 0.80 or better (Stamm, 2010), whereas reliability for secondary traumatic stress tends to be a bit lower but still acceptable with a reported alpha of 0.70

or better (Stamm, 2010). Most studies found support for the three-factor structure of the survey, although there is some overlap between scores on the burnout and secondary traumatic stress scales (Stamm, 2010).

For each subscale, raw scores are summed (after several items are reverse scored) and converted into *T* scores, so each scale has a mean of 50 and standard deviation of 10. Higher scores on the compassion satisfaction score are believed to indicate higher professional satisfaction at work. Higher scores on the burnout scale are associated with increased feelings of hopelessness and difficulties feeling effective at work. Higher scores for secondary traumatic stress are associated with increasing severity of a constellation of symptoms that include difficulties with sleep and intrusive images that result from being exposed to the life traumas of patients at work.

For each scale we also recoded *T* scores into a dichotomous variable indicating whether the respondent was at risk for low compassion satisfaction, high burnout, or high secondary traumatic stress. We used Stamm's (2010) definition of "high risk," which is those who scored in the lowest quartile for compassion satisfaction (a *T* score below 43) or the highest quartile for burnout and secondary traumatic stress (*T* scores above 57).

A meeting with each department manager was scheduled to fully explain the purpose of the study and amount of time needed to complete the survey. Managers were informed if the study identified a need, the survey results would be used to develop a program to address compassion fatigue for all hospital caregivers. We sent eligible participants an informational e-mail fully explaining the purpose of the study and a link to the electronic survey. Nurses and allied health staff could choose to access the survey from the privacy of their homes or they could complete the survey in their work environment. Participants reported that it took less than 15 minutes to complete the survey.

Descriptive statistics were computed for demographic variables. For each demographic variable, we compared mean scale scores using multivariate analyses of variance (MANOVA), entering all three scale scores in the same model but running separate models for each demographic variable. For the MANOVA with primary department, we used the Fisher's least significant difference test for post-hoc analyses to identify which pairs of values were significantly different. In addition, we compared the percentage of those at risk for poor outcomes with those not at risk for each demographic variable using the chi-square test. Alpha was set at .05 for all tests.

Results

The survey was sent to 502 eligible participants and was completed by 296 respondents for a response rate of 60%. A final sample of 274 participants with complete data, 179 nurses and 92 allied healthcare professionals, was used for analysis (Table 1). Most participants were 41 years old or younger (66.5%), female (86.9%), worked as an RN or advanced practice nurse (65.1%), held a baccalaureate degree (79.6%), and had 10 or less years of experience (58.5%).

TABLE 1. Demographic Characteristics of Respondents (*N* = 274)

Variable	*N*	(%)
Age		
≤40	183	(66.5)
≥41	91	(33.1)
Gender		
Male	33	(12.0)
Female	239	(86.9)
Job category		
RN	179	(65.1)
Not RN	92	(33.5)
Highest level of education		
Diploma	7	(3.2)
Associate degree	38	(17.2)
Bachelor's degree	176	(79.6)
≥Master's degree	50	(18.2)
Years of healthcare experience		
≤10 years	161	(58.5)
≥11 years	112	(40.7)
Primary department		
Pediatric ICU	73	(26.5)
Cardiovascular ICU	32	(11.6)
Emergency unit	69	(25.1)
Cardiology	38	(13.8)
Hematology/oncology unit	43	(15.6)
ProQOL scores: n/% at high risk		
Compassion satisfaction	69	(25.1)
Burnout	85	(30.9)
Secondary traumatic stress	74	(26.9)

Differences in ProQOL5 subscale *T* scores by background variables are presented in Table 2. The overall MANOVA for gender was significant ($F[3,268] = 2.67$; $p < .05$), but none of the univariate tests were significant. There was a trend for men to score lower than women on secondary traumatic stress, although the difference wasn't statistically significant (Table 2).

There were, however, significant differences in ProQOL scores as a function of clinical unit. For compassion satisfaction, post-hoc analyses revealed that staff who worked on the cardiology unit scored higher than staff who worked on either PICU, CICU, EU, or hematology/oncology unit. These results indicate that nursing staff in the cardiology unit feel more positively about their work in general than those who work in the other units. This finding may be a result of the nurses on this unit successfully selecting a nursing unit that matches their personal style and interest (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). The nurses on the cardiology unit have had long periods of stability with minimal staff and management turnover.

On the burnout scale, staff who worked in the PICU scored significantly higher than staff who worked in any other unit. Previous studies (Hooper et al., 2010; Meadors

TABLE 2. *T* Scores by Subscale for Each Demographic Variable

	CS *T* score		BO *T* score		STS *T* score	
Variable (MANOVA test statistic)	***M* (SD)**	**Univariate *F* value (df)**	***M* *F* value (df)**	**Univariate**	***M* *F* value (df)**	**Univariate**
Age; F(3,270) = 1.10						
≤ 40	50.6	1.81	49.5	1.81	50.1	0
	(9.9)	(1,272)	(9.7)	(1,272)	(9.6)	(1,272)
≥ 41	48.9		51.2		50.1	
	(10.1)		(9.8)		(10.3)	
Gender; F(3,268) = 2.67*						
Male	48.1	1.38	50.7	0.13	47.2	3.27 ($p < .08$)
	(12.4)	(1,270)	(9.0)	(1,270)	(8.7)	(1,270)
Female	50.3		50.1		50.5	
	(9.6)		(9.9)		(9.8)	
Job category; F(3,267) = 0.16						
Nurse	50.3	0.09	49.7	0.42	50.0	0.06
	(9.7)	(1,269)	(9.6)	(1,269)	(10.0)	(1,269)
Not a nurse	49.9		50.6		50.3	
	(10.3)		(9.9)		(9.1)	
Highest level of education; F(3,267) = 0.57						
≤ Bachelor's degree	50.1	0	49.9	0.19	50.2	0.35
	(10.1)	(1,269)	(9.8)	(1,269)	(10.0)	(1,269)
≥ Master's degree	50.2		50.6		49.3	
	(9.4)		(9.8)		(8.0)	
Years of healthcare experience: F(3,269) = 1.88						
≤ 10 years	50.9	2.30	49.2	3.31	50.2	0
	(9.5)	(1,271)	(9.2)	(1,271)	(9.2)	(1,271)
≥ 11 years	49.0		51.4		50.1	
	(10.6)		(10.4)		(10.4)	
Primary department; *F*(12,750) = 1.96*						
Pediatric ICU	48.2[1]	2.08	52.3[3,4]	2.19	53.0[5,6]	3.62*
	(10.0)	(5,250)	(9.7)	(5,250)	(9.7)	(5,250)
Cardiovascular ICU	50.1		50.5		50.1	
	(8.0)		(8.6)		(8.7)	
Emergency unit	49.5[2]		48.1[3]		47.6[5,7]	
	(11.4)		(10.2)		(10.2)	
Cardiology	53.8[1,2]		47.9[4]		48.0[6]	
	(8.0)		(9.3)		(9.0)	
Hematology/oncology	50.9		50.4		51.9	
	(10.2)		(9.9)		(9.5)	

Notes: df = degrees of freedom; for Primary Department, numbers in superscripts are used to indicate pairs of values that were significantly different based on post-hoc tests.

** $p < .05$*

& Lamson, 2008) have shown that nurses working in the PICU, EU, and those that work with chronically ill children may be at greater risk to develop compassion fatigue. Overall, the PICU nurses reported lower compassion satisfaction scores, and higher burnout and secondary traumatic stress scores. Stamm (2010) identifies high secondary traumatic stress and high burnout scores in combination with low compassion satisfaction scores as the most worrisome combination of scores. Studies have shown nurses working in the intensive care unit have a high risk of developing compassion fatigue (Jenkins & Warren, 2012; Maiden, Georges, & Connelly, 2011; Young et al., 2011). Healthcare providers that work in the PICU are constantly exposed to trauma, death, and grieving families.

Nurses on the hematology-oncology unit had higher compassion satisfaction scores and lower secondary traumatic

stress scores than the other units. Numerous stressors have been identified by Potter et al. (2010) as specific to the oncology workplace. These findings seem to support a "protective mechanism" against developing compassion fatigue among nurses that work on the hematology-oncology unit. Perry (2008) suggested that some oncology nurses were able to avoid compassion fatigue by connecting with patients through "meaningful interactions."

In our study, the EU nurses' secondary traumatic stress scores were lower than those of the PICU staff. The findings from our study are similar to those by Hooper et al. (2010), which showed EU nurses were at less risk than nurses working on inpatient units to develop compassion fatigue. The staff in the EU experiences the initial trauma and suffering of the patient and family; however, the exposure is brief as the patient is stabilized and then transferred to the nursing unit for further medical management and care (Hooper et al.).

There are several limitations to our study. The units surveyed have higher acuity patients than patients on the general medical-surgical units, which may lead to higher burnout and secondary traumatic stress scores in nurses that participated in the survey. The instrument used is a self-report measure, which may produce a response bias. Also, we measured presence of burnout, secondary traumatic stress, and compassion satisfaction at a single point in time. Participants' perceptions may change over time due to changes in the individual and work place environment. However, the study did identify the presence of compassion fatigue among healthcare professionals and provide the support needed for program development.

Clinical Nursing. Implications

Compassion fatigue may be responsible for development of stress-related symptoms and job dissatisfaction among caregivers. It leads to decreased productivity, increased sick days, and job turnover within the healthcare system resulting in negative consequences for patients and employers (Meadors & Lamson, 2008). Nurse caring is one of the most influential measurements of patients' willingness to return to that healthcare system and is prognostic of patient satisfaction (Burston & Stichler, 2010). Healthcare systems must balance providing competent, safe, and compassionate care for patients with the financial viability of the healthcare system. Nurse leaders must understand the effects of caring for critically ill pediatric patients on professional healthcare providers. Since there are many factors that contribute to the workplace environment, it is vital to recognize the impact of compassion fatigue.

One of the goals of this study was to determine prevalence of risk for compassion fatigue in the work environment to support development of a program for direct care providers. Based on these results, a resiliency program has been developed and tested in the emergency department with 10 social workers and on the hematology/oncology unit with 10 staff nurses. The 4-hour program is offered at the hospital. It is based on the work of Gentry et al. (1997) and focuses on recognition of signs of compassion fatigue and the harmful effects of chronic stress. Participants learn about the impact of chronic sympathetic stimulation on behavioral and cognitive function to more fully understand the need for stress management as a healthcare provider. Using seven specific exercises that are completed either individually or in small groups, the program content to address prevention of compassion fatigue is presented. These resiliency strategies encompass self-regulation, intentionality, perceptual maturation and self-validation, social connection, and self-care. The program is being offered quarterly to all healthcare providers and an evaluation of the program is ongoing. ✣

Suggested Clinical Nursing Interventions

- Nurse leaders are responsible for understanding effects of caring for ill children and their families on nurses.
- Compassion fatigue may be present in all clinical settings and nurses need to be aware of signs and symptoms for themselves and their colleagues.
- Prevention of compassion fatigue can contribute to increased nursing satisfaction, decreased burnout, and increased productivity.
- Providing information about the contributing factors and harmful effects of chronic stress may help nurses develop preventative self-help strategies.

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