Compassion Fatigue: The Experience of Nurses

Wendy Austin, Erika Goble, Brendan Leier and Paul Byrne

The term compassion fatigue has come to be applied to a disengagement or lack of empathy on the part of care-giving professionals. Empathy and emotional investment have been seen as potentially costing the caregiver and putting them at risk. Compassion fatigue has been equated with burnout, secondary traumatic stress disorder, vicarious traumatization, secondary victimization or co-victimization, compassion stress, emotional contagion, and counter-transference. The results of a Canadian qualitative research project on nurses’ experience of compassion fatigue are presented. Nurses, self-identified as having compassion fatigue, described a change in their practice by which they began to shield and distance themselves from the suffering of patients and families. Time to help patients and families cope with suffering seemed unavailable, and many felt they were running on empty and, ultimately, impotent as nurses. Feelings of irritability, anger, and negativity arose, though participants described denying or ignoring these emotions as a way to try to survive their work day. Difficulties with work carried over into the nurses’ personal lives, affecting their relationships with family and friends. Such experiences invariably called into question the participants’ identity, causing them to reflect on the kind of nurse they were. The participants’ compassion fatigue created a sense of hopelessness regarding positive change, although some nurses described strategies that seemed to help alleviate their compassion fatigue.

Keywords Compassion Fatigue; Compassion; Nurses; Ethical Practice; Canadian

I haven’t enough feeling left for human beings to do anything for them out of pity.
Graham Greene, A Burnt-out Case (1960)

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Within health care, the relationship created between patient and healthcare professionals shapes the moral space within which ethical action occurs. Without a genuine connection with those giving care, without real engagement, patients are alone no matter how many professionals surround them (Gadow 1995). And without being genuinely available to their patients, professionals cannot fulfil their fiduciary promise to them (Liaschenko 1994; Reynolds et al. 2000). In fact, it has been argued that lack of engagement is the source of maleficence in health care (Schultz & Carnevale 1996). So one wonders what happens when engagement, the intentional action of moving close to those in one’s care, is deemed a source of trauma to the professional. Can it be that the shared space between professional and patient is a dangerous place?

The term compassion fatigue was initially used to describe the cultural phenomenon of public weariness that reduced empathy towards social problems and crises. Starting in the early 1990s, however, it began to be used to describe a disengagement or lack of empathy occurring in care-giving professions, a condition of health professionals that involves a lack of empathy, compassion, and connection towards patients. Compassion fatigue has been called a type of burnout and a cost of caring. It appears, then, that being empathic and emotionally connected to one’s patients can put health professionals at risk.

To understand this contradiction and its implications for ethical practice, the experience of compassion fatigue is explored. In this article, the authors briefly review the compassion fatigue literature before reporting the results of a qualitative study of nurses’ experience of compassion fatigue, a study conducted as a pilot project in advance of a broader interdisciplinary study that is now underway. As these findings reveal, the term ‘compassion fatigue’ speaks to a unique experience: one of impotence, isolation, and meaninglessness, one that has been inadequately conceived of thus far within the health literature and, therefore, calls for further, more comprehensive exploration within health research.

The Literature

The term ‘compassion fatigue’ was first used to describe an apparent growing indifference to public appeals for aid. However, in 1992, it appeared in a professional development article for nurses describing a specific and newly apparent phenomenon in health care. The author, Carla Joinson (1992), described compassion fatigue as a type of burnout; nurses were ‘burned out and burned up’ by caring for others (p. 116). Caring, empathy, and emotional investment were thus identified as putting health professionals at risk (Figley 2002a). Since then, the literature regarding compassion fatigue has been divided between two approaches. The predominant approach, largely in the field of psychology, addresses compassion fatigue at an individual level, as a condition resulting from the psychological make-up of the person affected, the nature of the work s/he performs, and his/her ability to manage the process of engaging with others.
The less common approach, emerging from the fields of media studies and sociology, addresses compassion fatigue at a macro level, as a widespread phenomenon brought about by specific conditions within an environment.

Compassion Fatigue as a Psychological Phenomenon

Predominating the compassion fatigue literature is the study of compassion fatigue as an individual psychological phenomenon. However, in this literature the term has been inconsistently applied to a wide expanse of phenomena and, to date, no standard, working definition has been established. Compassion fatigue has been equated with secondary traumatic stress disorder, vicarious traumatization, secondary victimization or co-victimization, secondary survival, emotional contagion, counter-transference, and burnout (Collins & Long 2003a; Figley 1995, 2002b, 2005; Fox & Carey 1999; Henry & Henry 2004; Huggard 2003; Joslyn 2002; Nelson-Gardell & Harris 2003; Salston & Figley 2003; Sexton 1999), despite the marked differences between each of these concepts. Charles Figley, the most cited source in this literature, defines compassion fatigue as ‘identical to secondary traumatic stress disorder (STSD) and is the equivalent of PTSD’ (1995, p. xv), assuming a causal link from it to psychological problems. He defines compassion fatigue as ‘a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders, persistent arousal (e.g., anxiety) associated with the patient’ (Figley 2002a, p. 1435). Freely interchanging compassion fatigue and secondary traumatic stress, Figley (1995) uses the terms as different names for the same condition, enabling sufferers to choose whichever name they find least stigmatizing. While most scholars build on Figley’s work, compassion fatigue has also been described more complexly as a form of ‘collusive resistance’ to genuine engagement (Fox & Carey 1999) and a ‘related variable’ or ‘convergence’ of secondary traumatic stress, vicarious traumatization, and burnout (Becvar 2003; Gentry et al. 1997; Salston & Figley 2003).

Like its definition, the characteristics of compassion fatigue are defined broadly and inconsistently. Gentry et al. (1997, and cited in Becvar 2003) have provided the most complete list, cautioning, however, that any single symptom

1. PTSD is post traumatic stress disorder, classified in the Diagnostic and Statistical Manual of the American Psychiatric Association (APA), which can develop after a traumatic event (i.e. personal experience of threatened death or injury or witnessing the event). Core symptoms are re-experiencing, avoidance and heightened arousal (APA 2000).

2. Compassion fatigue is marked by: ‘increased negative arousal; intrusive thoughts/images of clients’ situations/traumas (or clinicians’ own historical traumas); difficulty separating work life from personal life; lowered frustration tolerance/outbursts of anger or rage; dread of working with certain clients; marked or increasing transference/countertransference issues with certain clients; depression; perceptive/"assumptive world" disturbances; increase in ineffective and/or self-destructive self-soothing behaviors; hypervigilance; feelings of therapeutic impotence or de-skilled with certain clients; diminished sense of purpose/enjoyment with career; diminished ego-functioning (time, identity, volition); decreased functioning in non-professional situations; and loss of hope' (Gentry et al. 1997, p. 2 of 12).
could indicate compassion fatigue (Gentry et al. 1997, p. 2 of 12). Factors found to increase the risk of developing compassion fatigue include: continued exposure to patients’ stories and heightened emotions of family members; burnout and stress; failure to maintain self-care; and practitioners’ empathy levels (Collins & Long 2003a,b, Fox & Carey 1999; Figley 1995, 2002a). A study of secondary trauma in sexual assault counsellors in a northern area of Canada also found location (isolation, community attitudes, lack of privacy) as the dominant theme (Coholic & Blackford 2005).

Conversely, factors which protect against compassion fatigue include: seeing patients recover; compassion satisfaction; professional support—in particular a supportive healthcare team and professional resources—and personal support (Collins & Long 2003a,b; Clark & Gioro 1998; Gentry et al. 1997). While self-care is important in maintaining a personal–professional balance, it does not, in itself, protect against compassion fatigue (Kraus 2005, p. 86). Kadambi and Truscott (2004) argue that research indicates most professionals working with traumatized individuals are not at risk of profoundly negative effects. However, research to date, overall, fails to capture fully the source of compassion fatigue and the personal, professional, and organizational factors that influence its development.

Compassion Fatigue as an Environmental and Cultural Phenomenon

Coinciding with the discussion of the psychological nature of compassion fatigue is a smaller, and at times oppositional, investigation of compassion fatigue as a cultural phenomenon brought about by specific environmental conditions, in particular globalization, corporate rationalizations, and the media. While scholars most often link compassion fatigue with the public’s overexposure to media coverage of social problems such as homelessness, poverty, war and HIV/AIDS (Höijer 2004; Kinnick et al. 1996; Link et al. 1995), others, most notably sociologist Stjepan Meštrović, describe compassion fatigue as the predominant state of people in Western societies. Meštrović (1997) argues that due to recent technological, social, and global changes, Western societies have become postemotional: a state marked by a general cynicism and disconnect from community, where the public only experiences pre-synthesized emotions (promoted through mass media and used for manipulation), and the experience of any emotions has been disconnected from a desire to act. Within a postemotional society, compassion is negated and compassion fatigue moves from being an individual phenomenon to affecting the public at large, an inherent result of the social environment in which we live.

According to this conceptualization, as the postemotional society emerges, the same phenomenon of compassion fatigue manifests in smaller social institutions, such as the healthcare system, and mimics larger cultural changes. Applying Meštrović’s social analysis to contemporary nursing practice, Elizabeth Herdman (2004) notes the difficulty of retaining individualized care within a healthcare system that has undergone massive commodification and market
rationalization, also called *McDonaldization*. This transformation results in changes to how work is done (cost-effective routinization, quantitative measurement, evidence-based research and practice, and prescribed modes of engagement) and alienates genuine emotions from practice (Herdman 2004; Peters & Liaschenko 2004). Such conditions directly impact ethical nursing practice. As Herdman notes: ‘implicit in the postemotional outlook is disengagement or lack of empathy’ (2004, p. 97).

**Negating the Nature of Engagement**

Whether conceived within a psychological or cultural paradigm, the cause of compassion fatigue is frequently described as a prolonged exposure to another’s experiences—whether one’s patients (Collins & Long 2003a; Schwan 1998) or individuals who are homeless or victims of war (Link *et al.* 1995; Kinnick *et al.* 1996; Höijer 2004)—combined with one’s own empathic response (Collins & Long 2003a; Fox & Carey 1999). ‘The concept “compassion fatigue” seems to imply an earlier stage with some compassion’ (Höijer 2004, p. 529) that has been lost. Central, then, to understanding compassion fatigue is understanding the ‘empathic response’, compassion, as well as its diminishment.

*Compassion.* In much of the healthcare literature, the experience of compassion is often assumed to be an unquestioned good unless it evolves to compassion fatigue, when it becomes hazardous. One of the difficulties with conceptualizing compassion fatigue is the absence of a discourse characterizing compassion itself. The contribution of moral philosophy to health ethics has traditionally been in the realm of moral rationalism, the application of abstract principles to particular actions (Taylor 1989). With rare exceptions, there is nearly a two millennium gap in the philosophical literature surrounding compassion, from the Hellenistic era to well within the twentieth century. Feminist and clinical critiques of principle-based moral theory (see Bergum & Dossetor 2005; Gilligan 1982; Noddings 1984) stimulated a renewed interest in the role of emotion in moral life. Questions raised, for the most part, concern the nature and origin of compassion (whether it is a reconstructive, cognitive, and imaginative process or it is a pre-cognitive, instinctual and intuitive response to suffering) or are pedagogical and normative questions (can compassion be taught? Is compassion, or lack thereof, a determined and unchanging aspect of character?) (Blum 1994; Nussbaum 2001; Snow 1991). Without reiterating the details of these discussions, for the purposes of clarity, two uncontroversial claims towards a working definition of compassion can be made. First, compassion is an emotion, more particularly a pro-social emotion that emerges in human development as early as 18 months, and, as such, must be understood as a natural human capacity (Nichols 2004). Second, compassion has two necessary criteria: the experience of recognizing the suffering of another combined with the desire or motivation to alleviate that suffering (Nichols 2004). With such a definition, the phenomenon
of compassion fatigue may be the bifurcation of these necessary emotive constituents, where a person, unable to alleviate the suffering of another, actively withdraws from similar emotive stimuli.

At-risk groups. According to the literature, both the cause and the exacerbating conditions of compassion fatigue put certain groups at greater risk of developing it than others. While Joinson (1992) in her foundational article describes compassion fatigue as a phenomenon common, but not exclusive, to those in the care-giving professions, nurses and therapists have been identified as particularly vulnerable to developing compassion fatigue due to the nature of their roles and activities (Fox & Carey 1999; Joinson 1992). It is, in fact, due to their proximity to patients that nurses may develop moral distress or moral ambiguity, according to Peters and Liaschenko (2004). Far beyond other groups, to use a phrase by Höijer (2004), they ‘become bearers of inner pictures of human suffering’ (Höijer 2004, p. 520).

Nurses currently face unprecedented stresses, resources shortages, and marginalization, with recent reforms having altered the health care to such a degree that the environment itself may place professionals at greater risk (Caulfield 2002). In their study of the moral habitability of nursing work environments, Peters et al. (2004) note that nurses described their ‘work environments as oppressive across multiple dimensions, describing situation of powerlessness, exploitation, marginalization, and physical and interpersonal violence … dominated by medical or business values where nursing perspectives were marginalized’ (Peters et al. 2004, p. 359). Such environments undermine the foundation of the nursing role, a meaningful engagement between nurse and patient, and the ability of nurses to act ethically, thereby inducing a state of moral suffering (Peters et al. 2004). Moral distress is the distress experienced when one believes one knows the correct course of action but is unable to act upon it due to constraints (Austin et al. 2005a; Nathaniel 2002), and potentially compassion fatigue does not appear to lag far behind. ‘Proximity is paradoxical … because, while it propels nurses to act, it can also propel nurses to ignore or abandon’ (Peters & Liaschenko 2004, p. 218).

It should not surprise then, despite its ambiguity, that health professionals find the term compassion fatigue compelling. It seems as if professionals are searching for words to name the frustration, fatigue, and distress they feel on the frontlines of health care. Such feelings must not be dismissed. Attention needs to be paid to the idea of compassion fatigue as it names something of a common experience. Perhaps it is the basic meaning of the words, compassion (with suffering) and fatigue (weariness) that calls to health professionals. It may be that compassion fatigue is what Bernard Williams (1985) terms ‘a thick concept’, one that embraces both fact and value, whose application is ‘determined by what the world is like’ (Williams 1985, p. 129), and which reveals social realities related to human interaction (Levering 2002). Exploring the nature of compassion fatigue may help researchers and health professionals to come closer to the meaning of engagement and, in turn, gain better understanding of how to support ethical practice. To this end, compassion fatigue as an experience closely linked to everyday practice and
directly influenced by the healthcare environment is being studied. An initial (pilot) study of nurses’ experience of compassion fatigue within a hospital setting is described below.

**A Study of Nurses’ Experience of Compassion Fatigue**

**Method**

The study of nurses’ experience of compassion fatigue used interpretive description, a human science research model developed by nurse/theorist Sally Thorne to reflect the unique aspects of nursing research and directly influence clinical nursing practice (Thorne et al. 1997, 2004). A ‘non-categorical’ approach to qualitative research, interpretive description is appropriate for small-scale qualitative research projects that seek to understand a phenomenon ‘for the purpose of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding’ (Thorne et al. 2004, p. 5). Specifically, researchers using interpretive description attempt to create a ‘description that has explanatory power for understanding what might be shared or common within a phenomenon’ (Thorne et al. 1997, p. 174). They also attempt to link the experience—both commonalities and unique individual experiences—to a broader, predefined structure: the healthcare environment and the practice of nursing. This involves ‘struggling to apprehend the overall picture’ (Thorne et al. 1997, p. 174). To such an end, the research questions of our study were oriented to ‘What is the experience of compassion fatigue like?’ and ‘What is happening here?’ Specific interview questions included: ‘Have you ever experienced compassion fatigue? Can you tell me about it?’ and ‘Please describe a situation which you felt or still feel, to be emotionally draining.’ Funding for the research was provided by the Caritas Health Group (2006–07) and ethical approval was granted by the Health Research Ethics Board, Panel B, at the University of Alberta, Canada.

**Participants**

Registered nurses and registered psychiatric nurses who self-identified as currently having or having had compassion fatigue and who were currently practising within a local healthcare organization were invited to take part in a one-to-one unstructured research interview. The interviews focused on their experience of compassion fatigue and those care situations that they believed led to compassion fatigue. In the recruitment posters, it was noted that compassion fatigue might feel like burnout, distress, or emotional exhaustion. Our five volunteer nurse participants came from various service areas. It must be noted that, while five nurses were interviewed, four other nurses expressed interest in being interviewed but either became too ill or were too overwhelmed with work to be interviewed.
Data Collection and Analysis

Interviews were conducted at a place chosen by the participant (e.g. their home, workplace, or the relational ethics research centre at the university), and were carried out by the registered nurse member of the research team. During the interviews, the interviewer explored the nurse’s experience of working in situations that brought about the experience of compassion fatigue. Concrete, specific descriptions of situations which lead to the experience of compassion fatigue were elicited. Participants were asked to describe care situations which aroused feelings associated with compassion fatigue (e.g. emotional exhaustion, distress, ‘shutting down’ or a sense of ‘burnout’). All interviews were audio-taped and transcribed. Participants were given pseudonyms and information that might potentially identify the participants was removed from the transcripts during transcription. Additional materials (such as newspaper articles, health system guidelines and regulations, literature, stories, poetry, artwork, etc.) relevant to the research topic were also collected.

Following transcription of the interviews, the research team read and reflected upon the transcripts and identified themes. Collected materials were used to clarify questions of institutional procedures, augment and elucidate thematic descriptions of the experience of compassion fatigue, and link it to the contemporary healthcare system and the practice of nursing. In the process of analysis, the research team became involved with the transcripts, discerning configurations of meaning, of parts and wholes and their interrelatedness (von Eckartsberg 1986).

Findings

Six interconnected themes were identified from the interview data: running on empty; shielding myself; being impotent as a nurse; losing balance: it overwhelms everything; the kind of nurse I was; and trying to survive. In this Findings section, the words of the participants are presented as inset quotations with the pseudonyms given to each participant used to identify them.

Running on Empty

My emotional tank is empty. (Inga)

Nurses with compassion fatigue described feeling so fatigued that they are empty, having nothing to give emotionally to their patients. (This would eventually feel true in regard to their families, as well.) They gave sound explanations for their initial tiredness. Erin noted:

I’m working this weekend, which will be 12 days in a row. Because they’re 10 short in Emergency ... And I’m not the only one ...
Likewise, Beth commented:

Recently there haven’t been any ‘quiet’ shifts. I can remember a few years ago that once in a while there would be a quiet shift.

However, their tiredness soon transitioned into fatigue. Leslie found:

I can see the difference in how I bounced back from [situations] years ago and now.

Whereas previously Leslie could bounce back from a particularly exhausting shift—‘refuel’ so to speak—and be able to perform to her expected level the next day, now it takes much longer. Even so, she tries to continue. Beth’s description echoes Leslie’s:

I used to be able to do nights very well and be able to sleep and I am noticing how, more and more, I just can’t sleep well. Just feeling very, very tired ... and physically having more aches and pains. [This] kind of makes you less able to cope.

Sleep is disrupted by thoughts of work, denying the opportunity for gaining rest. Pia described her nights:

I feel tired. You start waking up often at night and thinking about the work. Sure you can think about it driving home or getting home, but then you have to try to push it aside and deal with your family and your house cleaning and whatever else there is. But when you sleep for two or three hours and then wake up and you start thinking, you can’t fall back asleep because of the anger of ‘I didn’t get this done,’ ‘There should be time to check the chart,’ and ‘Why don’t they realize that he also has got depression and just pouring a lot of stool softeners is not the answer?’ Whatever I am thinking about.

Not being able to do one’s job and the ineffectiveness of other staff were not the only things that keep the nurses awake at night:

I am going to give an example probably most nurses have done, but not admit to: You hear the call bell; it’s not your patient; you should respond but you got so many things to do with your own patients that you somehow block it out and walk right past. (Pia)

Such examples are only further cause for sleeplessness.

There is a striking similarity between the nurse participants’ descriptions of fatigue and those of cancer patients. Like the nurses, cancer patients describe pushing on despite decrease in stamina, difficulty sleeping, anxiety, feelings of being off balance, and the limiting of social interactions (Olson 2007). Fatigue researchers view the antecedents of fatigue as a non-adaptive response to tiredness. They note a distinguishing feature between tiredness and fatigue: fatigue occurs when one does not ‘bounce back’ from tiredness.
Shielding Myself

I just started feeling like I couldn’t give or open myself up to interact with the patients and their families. It was like I had to kind of shield myself because I was getting involved with them and I just didn’t feel like I could give them anything. (Beth)

The nurse participants described *distancing* themselves from patients and families, focusing more on their technical skills or providing *just the basics*. This ‘withdrawal’, as one nurse described it (I *kind of withdraw*), was achieved by focusing on the technical aspects of care and limiting genuine engagement with patients and families. Descriptions of similar withdrawal can be found in the findings of qualitative studies with neonatal and paediatric intensive care nurses as a strategy they use to cope with (i.e. avoid) the suffering of their patients (Hefferman & Heilig 1999). One nurse in the pilot study called it: *the silence that you have*.

Study participants also described how they avoid small talk and try not to get into conversations with families of patients. Pia, a palliative care nurse, spoke of how she came to this point: as the only RN for 14 patients on her evening shift, she could not respond to the families as she once did because there were always more pressing demands—like a patient in the midst of dying whom she could not abandon.

While it is used as a coping mechanism, shielding oneself from emotional connection with patients and their families, not pausing to engage with them in a meaningful way as people, can dehumanize the nurse her/himself. Beth put it this way:

> You must feel like you’re a robot. You’re going through the motions but there is some disconnection ... [you’re] not really feeling their suffering.

Such dehumanization can have serious immediate and longer term consequences. Most immediately, sensing nurse stress, patients likewise respond. The nurse participants spoke of how they were aware that their patients picked up the stress their nurses feel. Patients, the nurses said, would say things like ‘Oh, you seem so busy tonight’ and then withdraw or hold back themselves. This further diminished the likelihood of engagement between patient and nurse. Without this engagement, the nature of their work changes from meaningful interaction to mere activity: ‘I have to produce: it’s just a production line of chaos’ (Leslie). Over the longer term, such disengagement can result in the ultimate disengagement: leaving the job when voicing concerns proves futile, as was found in Nathaniel’s (2002) study of professionals’ moral distress.

However, it is noteworthy that it was not only the nurses and their patients who were aware that something was amiss. The nurse participants spoke of seeing colleagues with compassion fatigue. Researchers asked participants how they would recognize compassion fatigue in another nurse. One answered:
I sort of see them as isolated. Like, they’re just kind of doing their own thing, and ... not looking very happy. You can just sort of see it. Even in their conversation, I think you can hear it ... *They’re completely shut down ... zoned out ...*

The isolation felt filtered into the nurses’ personal lives. Beth spoke of how she started ‘pulling away’:

I started pulling back from friends. I did not feel like I wanted to have any conversation with anybody.

Not only did she pull away from people but she also started pulling away from even the things that had previously helped her cope, such as her crafts:

I just tried to push out everything, and just watch more TV and not be productive. I didn’t have any energy to do my crafts or anything like that. It’s a good thing I don’t drink or smoke. (Beth)

Likewise, Pia described her reluctance to engage with people, in particular people in her community who were suffering, such as a family at her church in which the young father has cancer. She does not feel like speaking to them:

You don’t want to share [even though] you feel, feel their grief.

**Being Impotent as a Nurse**

There’s a little piece of me now, that’s sort of like, ‘Okay [sighs], don’t give me any more. I can’t. I don’t have anything left. Too much already.’ I don’t have the physical time, I don’t have the ... I just can’t imagine making it happen. I don’t know how to do it ... (Erin)

The sense of impotence was captured by Erin, an Emergency Room (ER) nurse, when she described how she felt coming across a patient in a very ‘bad state’ wandering around the ER waiting room, overlooked by the ER staff. It is the way ‘those kinds of experiences over and over again ... makes you feel’ (Erin). This feeling feels wrong and yet the nurses cannot prevent it:

When you go home and you feel you haven’t given the care that you wanted to give, that you became a nurse to give, due to the stress of the unit, having too many things to do in a time span, and it ends up leaving you feeling inadequate. (Pia)

Even when a nurse succeeds in giving the care s/he wants to give you are juggling everything. You are juggling ins and outs and IV’s and you are just a juggler, and sometimes you drop a ball. (Pia)

Hopelessness regarding meaningful change permeated the participants’ descriptions. The sentiments of Tory’s comment, ‘There are things going on that
I thought should have stopped a long time ago’, were common. They had given up hoping that things would, or even could, get better. Leslie, a mental health nurse said: ‘My job is to build hope and I am the most hopeless person in the room.’ She described how she had regained hope for a while because of the leadership of a new unit manager. The manager was now leaving, having given up herself. Hopelessness was joined by expressions of feeling invalidated or disregarded by management. In Leslie’s words:

[There are] signs all over about vision and values, respecting all—written by the same people who break them. It’s become a joke, and I feel like I am being treated as a joke and not somebody that you need to treat seriously or with dignity or with respect.

She described a situation in her practice related to limited resources:

It’s about the system; the system is letting people down. ... I find [it] very discouraging. I feel like I’m constantly getting problems instead of solutions.

Despite their despair, two of the participants spoke of beginning to feel a glimmer of hope: Pia, because a Licensed Practical Nurse had been hired to work with her, and Erin, because she felt that she had more control of her practice in her new outpatient nursing position.

Losing Balance: It Overwhelms Everything

For the nurses interviewed, one identifying feature of compassion fatigue is its overwhelming nature, consuming all of their energy and being felt in every aspect of their lives. Having compassion fatigue was overwhelming and it caused the nurses to lose balance in their lives, a balance that they knew they desperately needed.

Part of the thing I’ve come up with is, I can’t get everything at work. I can’t expect to ... I just have to take work for what it is. I’m trying to find that balance in life ... I can’t— I can’t figure this stuff out, I can’t ... I don’t know, I cannot explain it; I’m just trying to find some balance ... I don’t want it to make me feel unhappy ... to change me ... (Erin)

In her interview, Tory paused and reflected on the recent suicides of two nurses whom she knew. She noted that a colleague had commented that ‘it is so bad that we do care for others but we can’t care for ourselves’. Pia has felt this first hand. She described being brought to a moment of despair, feeling so frustrated that she was crying on the bus going home. And screaming. Standing on the street while waiting for the bus and screaming and dropping the groceries that I had bought and breaking the jam or the juice or whatever was in the bag and having a big mess.
Being unable to ‘let go’ of work and losing their professional–personal life balance, wasn’t sensed only by the nurses. It was also felt by their families. Erin quoted her husband as telling her:

You’re tired; you’re working too much. You’re unhappy. Take care of yourself. Go do something that makes you happy ... You don’t have to save the world ...

He expressed some resentment at Erin’s lack of presence to her family because of her job:

You are willing to stay long hours and work, and you’re willing to give so much to the people you work for and for your patients. What about us at home? You’re willing to give that up. And you’re willing to come home at six or seven at night, and the kids have been home with me.

Though trying to give her some perspective of how things had gone out of balance, some awareness of what was needed to regain it, his comments did not help. Erin was only too acutely aware of how she could not balance her personal and professional lives:

It is the family [that suffers] ... you’re prepared to let them not have their needs met ... But there’s no way that you’re going to let that happen to your patients.

The participants struggled with a sense of failure to live happy, healthy lives, to be open and available to their families. It seemed to be another failure of energy, on top of and directly related to that of their nursing practice.

The Kind of Nurse I was

During the interviews, participants would refer to the way they used to be as nurses. Formerly, they were able to engage with patients, to be empathic, ‘to see through their eyes’. Erin said:

I get teary if I am in a family meeting and I see a husband who is sad because his wife is going to need to be placed [in a long-term care facility] because of her dementia or something. I feel sad about it. I was told many years ago, ‘You’re going to need to be a little tougher.’ It’s part of my personality. It’s not something I see as positive, but it is who I am. I can’t change it. I do feel deeply; I do care.

They had felt competent, committed. Erin described how she aspired to be a nurse whose patients ‘woke up in the morning knowing they would be well looked after’. She could never, in the past, have thought ‘that’s it, the shift is over, so I’m going home. I couldn’t go to work like that ... ’ But things have changed; she has changed: ‘And now, we just do what we can and then we just have to pass it on to the next group.’ Pia has likewise changed: ‘I went into nursing because I wanted to work with people but I wouldn’t do it over again.’
Being a nurse seemed to be a significant component of each nurse participant’s self-identity. ‘I couldn’t imagine ever saying “I used to be a nurse,” because, to me, I’ll always be a nurse’ (Erin). They said that they had ‘loved nursing’. The love of nursing, however, was expressed in the past tense.

Trying to Survive

The nurse participants in this study no longer felt they were living up to their expectations of being nurses. They felt disengaged, impotent, ineffectual, and often hopeless; they spoke of ‘trying to survive’. However, though their experiences were terrible, even heartbreaking, they hadn’t given up. They hadn’t quit nursing, though each had seriously considered it. Rather, they had developed means of surviving. Coping mechanisms included making changes within their professional practice, obtaining further training or skills, remembering when they have made a difference, and striving to regain balance.

Changing jobs and/or decreasing hours of practice were common attempts at addressing their compassion fatigue. The change in the type of job was usually to something where patient suffering might be less severe or the circumstances were ‘happier’, such as in health promotion, or rehabilitation or outpatient clinics. By seeing less pain, the nurses sought to ease their own. For instance, Leslie, the mental health nurse, opened a small practice to help ‘the worried well’ to offset her reduced hospital work with people living with severe, persistent mental illness. Erin decided to move from the bedside where

the contact with patients and family was more constant; it was more difficult just because you didn’t feel you had the time or the resources to give people what they needed ... The job I’m doing now, I have more of an office job where I see outpatients who aren’t usually as ill.

Likewise, positions in which there was no shift work or only night shifts were seen as more manageable. Decreasing one’s practice hours was a strategy, even if it required a move to a part-time position: Pia reduced her hours in palliative care and Beth spoke of how:

I am doing casual on a subacute unit, so that kind of gives me that avenue where these people are in rehab and they are moving towards going home and being able to manage at home better, and I think that a little bit of a more happier outlook.

Attending workshops and seeking out continuing educational opportunities were other common coping strategies. Tory said: ‘I want to learn more. I’m constantly going to courses.’ Another nurse revealed:

Part of the solution that I have had is taking courses that maybe will help me to deal with changes and deal with difficult people. Courses that [help me be] more introspective about how I can handle things better. (Beth)
In searching out these opportunities, the nurses were searching for ways of addressing their inability to practise the way they felt they ought within the realities of the healthcare system, repeatedly trying to figure out a better way to practise:

I went to every workshop and so there are hardly any workshops for me to go to.
(Tory)

In addition to attempting to improve their present situation by changing their practice and gaining knowledge and skill in ways to improve their practice, the nurse participants also spoke of reflecting on the past. They said that actively trying to remember the ‘big moments’ in their practice, the moments when they knew they had made a positive difference in the lives of their patients and families, was one way to keep trying to survive as a nurse. As bad as the present would appear, the past could show them when they had made a difference. This strategy was very similar to the one described by psychologists in a study of moral distress (Austin et al. 2005b).

Each of these activities played a part in the nurses’ attempt to regain balance in their lives. On the personal level, the nurses all noted that they were also consciously making attempts to reconnect with their family and friends and to revisit previous pleasures and activities. For example, they would agree to go to a movie (whether they wanted to or not) or spend Sunday afternoon going for a walk or picking up the half-knitted sweater. That such attempts had to be done consciously suggests the amount of effort that it took to do this. They said, in the words of one participant: ‘I’m taking time for myself, and replenishing myself’ (Beth).

Conclusion: What is Happening Here?

The descriptions provided show that the nurses can describe their sense of having compassion fatigue. Likewise, the themes above suggest that the common features of their experience can be known. But the question remains: what is happening here? Can we still ask: are these nurses empty from caring too much? Are they exhausted from trying to relieve the suffering of those in their care? Has their compassion made them suffer, in turn?

From their descriptions, we readily see the distress that compassion fatigue creates in the nurses or vice versa. The participants express how being unable to enact their moral responsibility to patients causes disengagement and distress. Practitioner distress, whether it manifests as moral distress, burnout, or compassion fatigue, is highly relevant to, yet little spoken of within, the healthcare environment. Doka et al. (1994) suggest that caregivers are expected to keep their distress ‘in the closet’ even though ethical decisions concerning patient care affect them on an emotional, as well as an intellectual, level (Doka et al. 1994, p. 347). Emotion (the patients’, the families’, or the
professionals’) is seen as dangerous. This can lead to the notion that distance and objectivity are valued over relations (Gadow 1984). Yet the factors that seem to protect against compassion fatigue—seeing patients recover, compassion satisfaction, and a supportive team and adequate resources (Clark & Gioro 1998; Collins & Long 2003a,b; Gentry et al. 1997)—can only occur in relationship. Brenda Sabo, a Canadian nurse (2006), suggests a shift in focus is needed from the pathology of secondary stress/compassion fatigue to protective factors. She points out that empathy, even if associated with risk, is an integral component of helping relationships. Empathy must be seen as integral to ethical practice (Reynolds et al. 2000).

Can it be that the shared space between professional and patient is a dangerous place? Invariably, we must conclude ‘yes’, but the danger lies not in the sharing of the space created in the nurse–patient relationship but in its negation and the isolation that the patient and professional both feel when genuine engagement does not occur. As we see in the accounts given by the nurse participants, compassion fatigue does not result from over-engagement with patients or the over-expression of the professional’s compassion, but rather compassion fatigue seems to emerge when professional–patient engagement is not supported, nor valued as an integral part of nursing practice.

The nurses’ experiences also point to the role of something larger, something beyond them, in the development of compassion fatigue in health care. At the end of each interview, participants were asked: if there was a magic wand that would allow you to change something, what would that be? What would you like? For Erin it was simple: ‘If I had more help. I could do such a good job. If I had more help’. Pia, likewise, identified ‘the workload. The number of patients … I would like to continue the care each day; have the same patient, at least for a time.’ Leslie asked for ‘support by management in a concrete way … I need the tools, the equipment’. For her, equipment and tools did not mean fancy machinery. As a mental health nurse, it meant more time to be with patients, more resources for group therapy, and more social supports of these patients.

What these nurses wanted to change was aimed at systemic issues of getting support for their practice. They did seem to think that it would take magic to get what was necessary. Erin said:

I honestly feel hopeless [for systemic change]. I don’t know the answer. I am a total doer. If I knew the answer, I would be on a committee making it happen.

Eighteen months ago, she said she thought the answer was more beds but now she knows ‘there are no nurses’. For Erin, for each of these nurses, the cause of their compassion fatigue lies deep within the structure of the healthcare system, an aspect of the phenomenon that has yet to be adequately taken up and explored within the research literature. While compassion fatigue manifests itself in the nurses’ interactions with patients, colleagues, and their families, its roots stretch far and wide through a healthcare system that has been cut, reorganized, and reconceptualized over the past two decades. The nurse participants’
descriptions point to the necessity of including in the predominant conceptualization of compassion fatigue (which posits compassion fatigue as an individual psychological phenomenon) an awareness of its systemic nature and environmental origins. To fully understand the phenomenon of compassion fatigue and how to best address it, researchers must begin to conceive of it as an individual experience rooted within, formed by, and manifesting macro changes.

Implications for Practice

Developing a greater understanding of compassion fatigue contributes to our understanding of engagement as essential to ethical practice and the supports required to foster it. This has implications for the well-being of professionals, the availability and retention as staff, and the maintenance of quality work environments in health services. Nurses, for example, lose more work time due to illness/disability than any other group (Canadian Institute for Health Information 2001), amounting to a loss of 17.7 million hours annually (CNA 2006). Compassion fatigue may be a factor. Furthermore, compassion fatigue can directly motivate professionals to leave their place of employment and even their discipline. There are implications for patients, as well. A professional with compassion fatigue can place them at risk. Acknowledging and addressing compassion fatigue, therefore, is essential for safe, ethical practice.

References


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