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Emergency Department Nurses' Lived Experience with Compassion Fatigue

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EMERGENCY DEPARTMENT NURSES’ LIVED EXPERIENCE WITH

COMPASSION FATIGUE

By

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ABSTRACT

The profession of nursing is in the midst of a crisis brought on by a nursing shortage. Many are choosing to leave the profession of nursing coupled with fewer numbers choosing nursing as a profession. As a result, nurses are challenged with increased acuity of patient care in the face of short staffing. Compassion fatigue can result from these highly stressful situations. Much has been written in the healthcare literature about the negative effects of compassion fatigue and work-related stress on healthcare workers. However, the population of Emergency Department nurses has been virtually ignored.

This inquiry utilized a qualitative approach with a phenomenological design in order to capture and describe the lived experience of Emergency Department nurses with compassion fatigue and work-related stress. The study revealed that the work-related stressors in which Emergency Department nurses encounter are numerous as a result of the hectic and chaotic environment in which they work. The main work stressors included the large number and continuous influx of patients, the increased patient acuity, and the lack of skilled nursing staff. Those nurses included in the study were resourceful in coping with work-related stressors by relying on support systems, using internal coping measures, or simply trying to persevere or overcome through firm resolve. When these nurses were successful in coping with their work stress, they often felt a sense of accomplishment in terms of the patient care delivered. If the encounters with work stress were especially negative, many often felt abandoned and exhausted. However, by witnessing improvements in patient status or by feeling that their care giving efforts were effective in relieving the pain and suffering of those in their care, these nurses were often able to overcome their negative feelings caused by the chaotic work environment.

Generally speaking, the encounters with work stress had a negative impact on the nurses’ ability to provide care. They described feeling angry and displaying uncaring attitudes toward the patients. However, many described feeling a sense of
accomplishment if they had been successful in coping with the work stress or if they felt that the nursing care provided had a positive impact on patient outcomes.

This study provided a glimpse into the experience of Emergency Department nurses with compassion fatigue and work-related stress. However, gaps within the literature still exist. Other areas need to be investigated including the prevalence and risk of compassion fatigue as well as the comparison of larger groups of Emergency Department nurses’ experiences with compassion fatigue.
Nurses are constantly exposed to the pain and suffering of those in their care. With each patient interaction, the nurse is faced with the patient’s distress and isolation. For a number of nurses, the loss of compassion is an inevitable outcome of these exposures (Lamendola, 1996). Such interactions and exposures can be stressful to the nurse over a long period of time. Compassion fatigue, or secondary traumatization, is the final stage in a long period of stress. Secondary traumatization, also known as compassion fatigue, can occur in those who work closely with or study victims of traumatic events (McCann & Pearlman, 1990). According to Figley (1995), secondary traumatization is also an occupational risk to professionals who provide direct or indirect patient care.

Compassion involves recognizing the patient’s difficulties and responding with a desire and commitment to help regardless of the outcome of the situation (Lamendola, 1996). In caring for patients who are in the midst of a crisis, nurses frequently witness the power of the human spirit to endure hardship. These inspiring experiences spark compassion within the nurse. However, the same experiences that lead to compassion can also lead to compassion fatigue. Compassion fatigue is a condition triggered by exposure to a specific traumatic event or to an ongoing crisis (Badger, 2001). According to Schwam (1998), the concept of compassion fatigue differs from the concept of burnout in that those who suffer from burnout withdraw emotionally and possess decreased empathy toward the patient.

Work-related stress is a significant factor in the development of compassion fatigue. Work in an emergency department is hectic, fast-paced, and is often considered a “war zone” (Badger, 2001) by many nurses. Emergency Department nurses specialize in rapid assessment and treatment particularly during the initial phase of acute illness and trauma (Rothwell, 2001). According to Rothwell (2001), Emergency Department nurses
must be skillful at recognizing life-threatening problems, prioritizing the urgency of care, rapidly and effectively carrying out resuscitative measures, and acting with a high degree of autonomy to initiate needed treatment without outside direction. The Emergency Department nurse is exposed to a wide variety of health care problems varying in complexity. These nurses may also come into contact with patients experiencing psychological and psychiatric difficulties. Without hesitation, the emergency department nurse is expected to handle skillfully these distressing events with professionalism, efficiency, and caring. In addition to their clinical performance, these nurses also must be able to meet the emotional needs of their patients, families, and peers.

Because the work environment is often hectic and fast-paced, Emergency Department nurses often do not take the time to take care of themselves during their shift. These nurses are notorious for not taking their breaks to eat, go to the bathroom, or even pause for a moment after a very difficult situation (Hageness, Kreitzer, & Kinney, 2002). In addition, Emergency Department nurses are finding that their nursing time with patients is being reduced due to increased patient volume and acuity within the Emergency Department. As a result, self-care is usually not a top priority during a busy shift which makes Emergency Department nurses more susceptible to the effects of work-related stress. However, when Emergency Department nurses take the time to care for themselves, nursing becomes a more enriching experience (Hageness, Kreitzer, & Kinney, 2002).

Traumatic events are an everyday occurrence in the Emergency Department. A traumatic event is defined as a situation that is so extreme or severe, so powerful or threatening, that it demands extraordinary coping measures (Meichenbaum, 1994). Emergency Department nurses frequently encounter traumatic situations through their exposure to death and tragedy. Caring for victims of trauma can elicit a wide array of emotions. For example, a patient death may become personally significant to an Emergency Department nurse especially if the resuscitation efforts have been lengthy and extensive. Although Emergency Department nurses are usually resilient and have developed a vast range of coping techniques with which to handle the intense pressures they encounter, repeated exposure to trauma can compromise the ability to cope with stress (Badger, 2001). Emergency Department nurses may suppress their emotions and
thereby unwittingly heighten their chances of having a delayed response to traumatic situations (Badger, 2001).

Overcrowding in the Emergency Department is a major contributing factor in the development of work-related stress. Overcrowding is a grave problem because it can often cause life-threatening situations; thereby, adding more stress to an already stressful environment. Overcrowding is defined as a state where there are more people seeking health care than there are resources available to provide care (Velianoff, 2002). The trend over the last several years has shown an increase in the use of the Emergency Department for primary care which has led to overcrowding and an increase in patient volume (Derlet & Richards, 2002). According to the American Hospital Association, emergency visits rose by 15% in the 1990s to 100 million visits, although more than 1000 Emergency Departments were closed during the same period (Velianoff, 2002).

Overcrowding in the emergency department often results in long waiting times for patients and an increased risk of adverse outcomes and poor patient outcomes (Derlet & Richards, 2002). Emergency Department overcrowding threatens the safety of patients and staff. Gillespie and Melby (2003) found that physical and verbal aggression among patients was more prevalent when Emergency Department waiting times were increased. Other hazardous outcomes include patient dissatisfaction, prolonged pain and suffering, violence and frustration, and staff burnout (Velianoff, 2002). Overcrowding often results in a delay in the provision of care, pressure to move patients quickly through the system, and providing care in less desirable places such as hallways and waiting areas (Bradley, 2005). This often leads to feelings of anxiety and stress among Emergency Department nurses because these conditions prevent the nurses from providing adequate patient care.

Statement of Problem

As the cost of health care and the number of uninsured and underinsured people increase, more and more patients seek treatment in the Emergency Department and use the Emergency Department as a source of primary care (Derlet & Richards, 2002). It is estimated that 44 million people are without insurance in the United States and because these people have no insurance, the Emergency Department becomes their only option for health care (Velianoff, 2002). In the United States, Emergency Departments are required by law to treat all who seek care regardless of their ability to pay; therefore,
Emergency Departments must provide care to all who present seeking health care regardless if resources are limited (Schiver, Talmadge, Chuong, & Hedges, 2003). Because of this increase in volume, Emergency Departments have experienced overcrowding which has led to increased waiting times to be seen and treated by a physician (Derlet & Richards, 2002). Because many Americans are uninsured or underinsured, they often delay seeking health care and, as a result, are often sicker when they arrive at the Emergency Department. This increase in patient acuity has also led to increased waiting times (Derlet & Richards, 2002).

Emergency Department nurses are not only faced with understaffing and budget cuts, but also an increase in patient volume and acuity which can lead to an increase in work-related stress. This work-related stress can cause psychological and emotional problems for Emergency Department nurses which can lead to compassion fatigue. These nurses, however, must be able to maintain their own psychological health in order to carry out tasks that are required of them. Studies that lead to an understanding of the Emergency Department nurses’ experiences with compassion fatigue and work-related stress are needed in order to develop interventions to prevent and relieve psychological distress and compassion fatigue in Emergency Department nurses. The benefit of increasing awareness of compassion fatigue and its effects will be to improve Emergency Department nurses’ ability to maintain efforts to provide care and improve patient outcomes through provision of better nursing care.

The development and consequences of compassion fatigue in the health professions is a growing area of research. Although studies of the effects of compassion fatigue have focused on several areas of nursing, the literature reviewed has not specifically considered Emergency Department nurses as research subjects. However, given the negative impact that compassion fatigue can have on patient care and the seriousness of the patient population for which Emergency Department nurses care, a study of Emergency Department nurses’ experiences with compassion fatigue and work-related stress is warranted. Such a study will add to a better understanding of the experience of Emergency Department nurses with compassion fatigue and help these nurses continue their care giving efforts.
Significance of the Problem

Nursing is a particularly stressful profession where nurses give a great deal of themselves emotionally in the process of caring for their patients while giving little attention to themselves. Because nurses place their patients’ needs ahead of their own, nurses are at risk for emotional distress. This could result in a large number of nurses leaving the profession, leading to a decrease in the quality of patient care. Nurses are finding less time to recharge emotionally and physically from the strain of their work, and are, therefore, more vulnerable to negative consequences (Pfifferling & Gilley, 2000).

According to Schriver, Talmadge, Chuong, and Hedges (2003), the profession of nursing, including emergency nursing, is in a period of transition due to nursing personnel shortages, job dissatisfaction, staffing inadequacies, and a decline in those choosing nursing as a profession. This transition is further exacerbated in the Emergency Department by the remarkable growth in Emergency Department patient census in recent years (Schriver, Talmadge, Chuong, & Hedges, 2003).

The current nursing shortage is of particular concern to many. The stress of an increased hospital workload has been attributed to the nursing shortage (Bednash, 2000; Emergency Nurses Association, 2003; Miller, 1999; Schiver, Talmadge, Chuong, & Hedges, 2003). In a study completed by Peter D. Hart Research Associates (2003), 59% of those surveyed stated that the staffing level at their hospital has had a negative impact on the quality of care patients receive. The study also found that 52% of Emergency Department nurses surveyed reported that they care for more patients during a typical shift than they feel is appropriate and 55% of the Emergency Department nurses surveyed reported that they are responsible for the care of more patients now than they were 5 years ago. A combination of limited resources, greater numbers of patients, and increasing clinical responsibilities has resulted in higher patient-to-nurse ratios in the Emergency Department (Schiver, Talmadge, Chuong, & Hedges, 2003).

The nursing shortage is a major contributor to overcrowding. Shortages of registered nurses have reached critical levels. Georgia estimates a 13% vacancy rate (Velianoff, 2002). The turnover rates are estimated at up to 30% (Velianoff, 2002). In the next 10 – 15 years, a 40% retirement rate is anticipated (Velianoff, 2002). The latest
study numbers show only 9% of nurses are younger than 30 years of age, which represents a drop of 41%, and the average age of the nursing workforce is 46 years old (Velianoff, 2002). These projections show a deficit of 291,000 registered nurses by 2020 (Velianoff, 2002).

The hospital Emergency Department is among the hospital departments where employers are having difficulty finding experienced nurses (Schiver, Talmadge, Chuong, & Hedges, 2003). Undergraduate nursing studies do not prepare the nurse adequately for clinical emergency nursing practice. Until recently, most hospital Emergency Departments would not hire new graduates and would require hospital experience in other clinical areas before being hired in the Emergency Department. In some hospitals, the allocation of resources to the Emergency Department budget has not kept pace with the more recent increases in patient census and acuity, which has resulted in increased patient-to-nurse ratios, followed by decreases in nursing satisfaction and morale, and the resignation of some experienced nurses (Schiver, Talmadge, & Hedges, 2003).

Research that provides a better understanding of the nurse’s perception of work-related stress and his/her experience therewith can help nurses know themselves and their personal risks for compassion fatigue. Through increased self-awareness, nurses may be able to understand better their experience with work-related stress and compassion fatigue in order to help them continue to meet superior standards of care for their patients. This study would provide the advanced practice nurse (APN) with the information needed to understand and the ability to recognize earlier the signs of compassion fatigue. Coupled with the APN’s advanced education and clinical experience, the knowledge from this study would allow the APN to be able to help better those potential sufferers cope with the effects of compassion fatigue. The knowledge from this study would also place the APN in the position to enact change through educational offerings on compassion fatigue and its effects on nurses and patient care. Changes brought about by the APNs’ efforts may include increasing administrators’ and managers’ awareness of the existence of compassion fatigue as well as implementing policies to help nursing staff deal with this phenomenon. By having policies in place and services available such as counseling, the APN may be able to prevent the occurrence of compassion fatigue.
Statement of Purpose

The purpose of this study was to explore and describe the lived experience of Emergency Department nurses with compassion fatigue and work-related stress.

Research Questions

In this study, the following questions were addressed:

1. What is the nature of Emergency Department nurses’ lived experience with compassion fatigue and work-related stress?
2. How does this experience affect Emergency Department nurses’ ability to care for patients?
3. To what extent do the scores on the Compassion Satisfaction/Fatigue Self-Test for Helpers support the Emergency Department nurses’ lived experience with compassion fatigue?

Operational Definitions

For the purpose of this study, the following definitions were used:

*Compassion fatigue:* symptoms of work-related secondary traumatic stress resulting from ongoing exposure to highly stressful care giving as measured by interview questions four and six (Appendix A).

*Emergency Department nurse:* a nurse who is currently employed in an Emergency Department and is a graduate of an accredited school of nursing and has passed the state board examination for Registered Nurse (RN), or who is an Advanced Registered Nurse Practitioner (ARNP) or Clinical Nurse Specialist (CNS) as measured by questions eight and nine on the demographic profile (Appendix B).

Assumptions

Polit and Beck (2004) defined assumption as “a basic principle that is accepted as being true based on logic or reason, but without proof or verification” (p. 13). The basic assumptions of this study included:

1. The participants in this study were at risk for suffering from compassion fatigue.
2. Emergency Department nurses had an interest in knowing their risk for compassion fatigue.
3. The experience with compassion fatigue and work-related stress was perceived differently by each individual experiencing these phenomena. However, through
personal descriptions of these experiences both commonalities and differences were ascertained in an effort to describe these phenomena.

4. Each Emergency Department nurse interviewed for this study answered the researcher’s questions honestly and openly.

Limitations

The findings of this study cannot be generalized to the population of all Emergency Department nurses because a small number of Emergency Department nurses were interviewed from one hospital in southwest Georgia. Another limitation included a lack of interest in this study which could lead to a decreased response rate thereby not allowing the researcher to capture the Emergency Department nurses’ lived experience with compassion fatigue.

Conceptual Framework

*Watson’s Theory of Human Caring*

Jean Watson’s Theory of Human Caring (1985) describes nursing as a human science and focuses on using a human care process to help others. In Watson’s theory, caring is viewed as the essence of nursing and is intrinsically related to healing representing what the nurses do to deliver health care to patients (Watson, 1985). The nurse serves as the mediator for illness experiences in interactions with patients. According to Watson (1985), the goal of nursing is to help people increase harmony within the mind-body-soul leading to self-knowledge, self-reverence, self-healing, and self-care. Watson’s theory also asserts that caring for and loving self is requisite to caring for others.

Watson developed 10 carative factors which are the interventions used by nurses to care for patients. These factors include a formation of a humanistic-altruistic system of values; instillation of faith-hope; cultivation of sensitivity to one’s self and others; development of a helping-trusting human relationship; promotion and acceptance of the expression of positive and negative feelings; use of a creative problem solving caring process; promotion of transpersonal teaching-learning; provision of supportive, protective, or corrective mental, physical, socio-cultural, and spiritual environment; assistance with gratification of human needs, and allowance for existential-phenomenological-spiritual forces. Watson also viewed the nurse-patient relationship as
enmeshed with each other’s feelings where there is reciprocal sharing between those involved. Her theory explains that by responding to others as unique individuals, the caring person perceives the feelings of the other and recognizes the uniqueness of the other person (Watson, 1985).

Compassion fatigue inhibits the nurse’s ability to care for the patient. According to Vander Zyl (2002), in order to be successful caregivers, nurses must be able to find meaning in their work which requires involvement, commitment, and a sense of purpose. The quality of nursing care weakens in direct proportion to a loss of commitment and caring for patients (Vander Zyl, 2002). Individuals who choose nursing as a profession make an enduring commitment to the purpose of caring for others who deal with pain, hopelessness, fear, and anxiety (Vander Zyl, 2002). The nurse’s feelings of well-being are linked with his/her perceptions of personal and professional self-worth which depends upon emotional connections to others. Because of compassion fatigue, the nurse becomes angry, depressed, cynical, and overly anxious (Vander Zyl, 2002). As a result, the nurse cannot care properly for the patient. The nurse no longer has the capability to nurture or cultivate the patient’s recovery to health. Healing, health, and harmony are impeded. Nurses who are not able to practice within a caring context are reported to be hardened, robot-like, oblivious, frightened, and worn down (Watson & Foster, 2003).

Selye’s Stress Theory

Hans Selye’s Stress Theory (1956) discusses the influence of stress on the body and how stress affects one’s ability to cope with and adapt to changes in the internal and external environment. According to Selye (1994), stress is the body’s nonspecific response to any demand made upon it. In his theory, Selye (1994) described the body’s nonspecific response to stress as the General Adaptation Syndrome (GAS). The GAS has three distinct stages: alarm, where the body detects the stimulus; adaptation, where the body engages in defense mechanisms against the stressor; and exhaustion, where the body begins to run out of defenses. Through his work, Selye demonstrated that stress can directly or indirectly contribute to disorders of the body and mind and can have a major impact on the physical functioning of the human body. Stress raises the levels of adrenaline and corticosteroids in the body, which in turn, increase the heart rate,
respiratory rate, and blood pressure. Long term stress can be a contributing factor in many medical conditions such as high blood pressure, heart disease, and stroke.

During a single shift, the emergency department nurse may have to deal with several traumatic events or situations. Under pressure from constant patient care demands, Emergency Department nurses often move from one traumatic event to another without taking time to assess their responses to them (Badger, 2001). This can be overwhelming to the nurse and can lead to the manifestation of the stress response. Stress can affect the nurse’s health by inducing high blood pressure, gastritis, peptic ulcers, and fatigue, any of which may result in an increase in the number of sick days, difficulty with problem solving, isolation or withdrawal, and behavioral outbursts (Badger, 2001). These behaviors eventually compromise team unity and the quality of patient care.

Stress cannot only have negative effects on the body, but also on the mind as well. The stress response can cloud one’s judgment as well as impair one’s ability to think, reason, and feel. This impairment can result in an inability to care for others. When a nurse loses the ability to care, he/she loses a valuable connection with his/her patients. The loss of a caring attitude toward others is often the consequence of compassion fatigue which can result from stressful work-related situations (Vander Zyl, 2002).

**Figley’s Compassion Stress and Fatigue Model**

Through his work, Figley (1995) attempted to explain and define the work of trauma workers with victims of trauma in addition to clarifying how the victim’s traumatic stress is also found in the caregivers. Figley’s model, developed in 1995, is based on the assumption that empathy and emotional energy are the leading forces in working well with suffering, establishing and maintaining a therapeutic relationship, and delivering successful treatment (Figley, 2002). However, these traits of caregivers also make them susceptible to succumbing to the costs of caring. In viewing the world through the eyes of their patients, the caregivers not only bear the suffering but suffer as well. Figley’s model describes the signs of traumatic stress for both the victim and the caregiver (Figley, 1995).

The Compassion Stress and Fatigue Model (Figure. 1.1) is composed of eleven factors which, when looked at in conjunction with one another, can predict the
occurrence of compassion fatigue (Figley, 2002). Initially, exposure to the client, empathic concern, and empathic ability lead to empathic response. Empathic ability is the capability of the caregiver to recognize the pain and suffering of others. According to Figley (2002), this is the cornerstone for both helping others and being vulnerable to the costs of caring. Having empathy is not enough – the caregiver must also have the motivation to respond to those in need. With sufficient empathy and concern, the caregiver can draw upon his/her resources in order to give quality care to the patient (Figley, 2002).

However, residual emotional energy and continual demands of the patient to relieve the suffering can lead to compassion stress (Figley, 2002). The caregiver can combat compassion stress by utilizing disengagement and a sense of satisfaction to separate himself/herself from the situation as well as to determine where the caregiver’s responsibilities end and the patient’s responsibilities begin. If the caregiver cannot diminish the compassion stress though these coping techniques, then the caregiver is at risk for developing compassion fatigue. The caregiver is also at risk for the development of the physical and physiological effects of the General Adaptation Syndrome as a result of a prolonged stress response (Selye, 1965).

Three factors also play a pivotal role in the development of compassion fatigue: prolonged exposure, traumatic recollections, and life disruption (Figley, 2002). Prolonged exposure occurs when the caregiver experiences a constant feeling of responsibility for the care of the patient over an extended period of time and, at the same time, the caregiver feels as if he/she has no relief from this obligation. Traumatic recollections are memories that can trigger symptoms of anxiety whether it is from painful childhood memories or memories from working with a patient that was especially traumatic. Life disruptions include illness, a change in lifestyle, or a change in personal or professional responsibilities. These factors combined with unsuccessful coping techniques can increase the likelihood of the development of compassion fatigue (Figley, 1995).
Summary

The profession of nursing is in the midst of a crisis brought on by a nursing shortage (Bednash, 2000; Emergency Nurses Association, 2003; Hart, 2003; Miller, 1999; Schiver, Talmadge, Chuong, & Hedges, 2003). Many are choosing to leave the profession of nursing coupled with fewer numbers choosing nursing as a profession (Miller, 1999; Schiver, Talmadge, Chuong, & Hedges, 2003). Nurses are also challenged with increased acuity of patient care in the face of short staffing (Derlet & Richards, 2002; Hart, 2003). Emergency Department nurses deal with traumatic events and stressful care giving on a daily basis (Badger, 2001; Meichenbaum, 1994; Rothwell, 2001). Compassion fatigue can result from these highly stressful situations (Badger,
Stress not only has negative effects on the body but also on the nurse’s ability to care for the patient (Badger, 2001; Pfifferling & Gilley, 2000; Vander Zyl, 2002). The incidence of compassion fatigue results in decreased benevolence and concern for the patient (Badger, 2001; Vander Zyl, 2002). As a result, the nurse turns into an automaton, carrying out physician orders without the expression of human caring.

The development and consequences of compassion fatigue among caregivers in the health professions is a growing area of research. Through a study of Emergency Department nurses’ lived experience with compassion fatigue, one may gain insight into its incidence and prevalence; thereby, bringing an awareness of its occurrence to others. This awareness will assist with the development of interventions designed to help Emergency Department nurses cope with compassion fatigue. The use of Jean Watson’s Theory of Human Caring (1985) and Hans Selye’s Stress Theory (1956) will provide the theoretical framework necessary to explore the concept of compassion fatigue. Figley’s Compassion Stress and Fatigue Model (1995) will also provide a sociological perspective necessary for understanding the concept of compassion fatigue and its relationship to nursing.

A comprehensive review of literature in Chapter 2 will emphasize the concept of compassion fatigue as well as related concepts such as secondary traumatic stress, burnout, vicarious traumatization, and empathy. The review of literature will also include an in-depth evaluation of Jean Watson’s Theory of Human Caring (1985), Hans Selye’s Stress Theory (1956), and Charles Figley’s Compassion Stress and Fatigue Model (1995) as the theoretical framework for this study.
CHAPTER 2
REVIEW OF THE LITERATURE

In this chapter, the evolution of the concept of compassion fatigue will be discussed. This chapter begins with a theoretical literature review of the concepts of compassion fatigue and secondary traumatic stress as well as the related concepts of burnout, vicarious traumatization, and empathy. The impact of work-related stress on nurses and the conceptual framework serving as a basis for this study will also be included in the literature review. An empirical literature review on these concepts will follow the theoretical review.

Theoretical Review

Compassion Fatigue

Compassion fatigue is a concept that developed from research in the field of traumatic stress. Originally, the term compassion fatigue was used in the context of work-related stress suffered by mental health counselors who worked with victims of trauma. However, the term is now commonly used to describe the effects of stress in many of the helping professions. Figley (1995) stated that compassion fatigue is a natural consequence of working with people who have experienced extremely stressful situations. Joinson (1992), who investigated the nature of burnout in nurses, is credited with first coining the term compassion fatigue.

Compassion fatigue is defined as “a state of exhaustion and dysfunction as a result of prolonged exposure to compassion stress and all that it evokes” (Figley, 1995, p. 253). According to Rudolph, Stamm, and Stamm (1997) compassion fatigue results from the provider’s contact with his/her patients’ experiences. A care provider suffering from compassion fatigue often feels an unyielding sense of duty for relieving the distress of those they are trying to help in conjunction with a feeling of powerlessness to distance themselves from the experience of the victim.
Those suffering from compassion fatigue may begin to distance themselves from their patients in an effort to ameliorate their own distress. Cynicism and poor decision-making ability soon follow. Rudolph, Stamm, and Stamm (1997) stated that if a provider suffers from compassion fatigue, the ability to deliver effective health care services and to maintain personal or professional relationships becomes inadequate. Despite their feelings of distress, care providers will often continue to care for their patients but soon lose their empathy and objectivity.

Secondary Traumatic Stress

According to Figley (1999), traumatic events can affect an individual directly or indirectly. “People can be traumatized without being physically harmed or threatened with harm. Simply learning about the traumatic event carries traumatic potential” (Figley, 1999, p. 6). Secondary Traumatic Stress (STS), also known as Secondary Traumatic Stress Disorder (STSD), results from knowledge about another’s traumatic event and is the stress resulting from helping or wanting to help a victim of trauma (Figley, 1999). In 1995, Figley defined secondary traumatic stress as compassion fatigue.

Secondary stress symptoms have been categorized into three areas: psychological distress, cognitive shifts, and relational disturbances. Psychological distress includes manifestations of emotions such as sadness, grief, depression, anxiety, and dread; numbing or avoidance; and intensive imagery of the patient’s traumatic experience that intrudes into the care provider’s life such as nightmares and flashbacks. Cognitive shifts refer to changes in the beliefs and expectations that therapists hold. These shifts generally affect the areas of trust, safety, power, and independence. Examples include a chronic suspicion of others, heightened sense of vulnerability, extreme sense of helplessness, and loss of personal control and freedom (Collins & Long, 2003).

Secondary exposure to trauma can also have an impact on personal and professional relationships of the trauma workers. Findings have shown that personal relationships can suffer as a result of increased stress or difficulties related to trust and intimacy (Clark & Gioro, 1998; White, 1998). According to Dutton and Rubinstein (1995) the professional relationship between the therapist and the client may be affected when the workers experience secondary traumatic stress and respond to their clients by either detachment or over-identification. Detachment is often used to avoid dealing with
feeling overwhelmed or vulnerable – emotional reactions are blocked out. This may leave clients feeling isolated even from those people who are trying to help them (Dutton & Rubinstein, 1995). Trauma workers may feel isolated emotionally in their working environment as they may perceive that they are the only ones who feel traumatized by such difficult and painful work (Dutton & Rubinstein, 1995).

Herman (1992) reported that secondary traumatic stress reactions are considered an inevitable occurrence in trauma workers. Figley (1995) and Herman (1992) found somatic complaints among trauma workers including sleep difficulty, headaches, and gastrointestinal (GI) distress. Dutton and Rubinstein (1995) found addiction or compulsive behaviors and impairment of day-to-day functioning in social and personal roles including missed or cancelled appointments, chronic lateness, and feelings of isolation, alienation, or lack of appreciation.

**Burnout**

Burnout has been defined as a state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations (Pines & Aronson, 1988). Figley (1995) described burnout as a process that begins gradually and progresses in intensity across time. Kahill (1988) identified five categories of symptoms associated with burnout: physical symptoms such as fatigue; emotional symptoms such as anxiety; behavioral symptoms such as aggression; work-related symptoms such as absenteeism; and interpersonal symptoms such as withdrawal. Burnout includes depersonalization and feelings of reduced personal accomplishment. Included in depersonalization is cynicism which refers to negative, callous, or detached responses to various aspects of work (Maslach, 2001).

Compassion fatigue is often described as a form of burnout that manifests itself as physical, emotional, and spiritual exhaustion (Pfifferling & Gilley, 2000). Compassion fatigue, like burnout, can test the helper’s ability to provide effective assistance and the capacity to maintain personal and professional therapeutic relationships. Although these concepts appear to be similar, there are differences. The onset of compassion fatigue is sudden and acute, while the onset of burnout is a gradual wearing down of helpers who feel overwhelmed by their work (Figley, 1995). While different from compassion
fatigue, burnout is viewed by many as an important risk factor or precursor to compassion fatigue (Beaton & Murphy, 1995; Chrestman, 1995; Stamm, 1999).

According to Gillespie and Melby (2003), loss of control has been emphasized as being closely linked to burnout. Work in the Emergency Department is often chaotic and hectic, and because of this, Emergency Department nurses are often not able to work out the difficulties they may encounter during their shift which often leads to feelings of loss of control. Emergency Department nurse often encounter patients who are physically and verbally aggressive. These encounters can cause the nurses to lose their ability to empathize which is a quality critical in establishing therapeutic relationships with patients and families (Gillespie & Melby, 2003). Nurses suffering from burnout display a variety of symptoms: reduced self-esteem, lack of confidence, poor job satisfaction, inability to relax and enjoy life, and inability to keep things in perspective and form balanced judgments (Gillespie & Melby, 2003). In their study, Gillespie and Melby (2003), found that length of shifts, perceived lack of support from those in management, and poor communication contributed to the emotional exhaustion of the nursing staff. The researchers concluded that stress and burnout have far reaching effects for nurses in their clinical practice and in life outside the clinical area and argued that if nurses continue to care too much for others at the expense of themselves, then burnout would be the end result (Gillespie & Melby, 2003).

**Vicarious Traumatization**

Another concept closely related to compassion fatigue is vicarious traumatization. Vicarious traumatization is an occupational hazard for those who work with trauma victims. It has been identified in individuals, who, in the course of working with victims of trauma, fall victim to secondary traumatic stress reactions brought on by helping or wanting to help a traumatized person. Pearlman and Maclan (1995) defined vicarious traumatization as the transformation that occurs within a therapist as a result of empathic engagement with a patient’s trauma experience. Vicarious traumatization involves changes in the care provider’s beliefs as a result of contact with the patient’s powerful emotional experience.
Empathy

Empathy, also related to compassion fatigue, involves embracing another person’s suffering through expression of caring. Research has indicated that there is a relationship between clinicians’ empathy and compassion and the quality of care they provide (Bellet & Maloney, 1991). Figley (1995) stated that the use of empathy is one of the particular reasons why trauma workers are especially vulnerable to compassion fatigue. The ability to balance empathy and objectivity is an important component in maintaining a therapeutic relationship (Pfifferling & Gilley, 2000).

Watson’s Theory of Human Caring

Caring and caring acts are the essence of nursing. According to Watson (1985), caring has existed in every society and caring is transmitted by the culture as a unique way of coping with the environment. Her theory asserts that in a therapeutic relationship, effective caring promotes health and individual growth (Watson, 1985). Establishing and developing the concepts of helping and trust is essential in the therapeutic relationship. The quality of the therapeutic relationship helps to determine the effectiveness of the helping acts. According to Watson (1985), the sensitivity of the nurse in a relationship with a patient is one of the most important tools for delivering care.

Human care is best demonstrated through the interpersonal interaction between caregivers and patients that fosters a common sense of humanity (Watson, 1985). Transpersonal relationships occur as the nurse enters into the patient’s experiences and as the patient mutually enters into the nurse’s experiences. Each attaches importance to the other and hopes to detect new and unique perceptions of the world (Watson, 1988). It is important for the nurse to view the patient as a feeling and thinking human being.

The 10 carative factors developed by Watson are explained as the interventions done by the nurse with the full participation of the nurse as well as the patient (Watson, 1999). The carative factors are aimed at the caring process which helps the patient attain health or to die a peaceful death (Watson, 1985). According to Watson (1999), these interventions require a commitment to caring directed toward the preservation of humanity. All of the carative factors are achieved during the actual caring moment between the nurse and the patient such as administering an emergency intravenous treatment to a critical patient or changing the linen of an unconscious patient (Watson,
1999). Watson (1999) also asserted that the more human care is attained during the moment of patient care delivery, the more the potential exists for the health goals to be met. The presence of all 10 carative factors allows the nurse to provide care within a holistic framework.

The first carative factor, the formation of a humanistic-altruistic value system, forms the basis of the other carative factors. It is essential that caring be grounded in the values of kindness, concern, and love of self and others (Watson, 1985). This value system serves as a guide in the interactions with others and is the commitment to and the satisfaction of receiving through giving (Watson, 1985). Therefore, these values and behaviors serve to bring meaning to one’s life through relationships with other people (Watson, 1985).

The second carative factor, instillation of faith-hope, is essential in ensuring the success of the patient’s therapy or course of treatment. It is through the establishment of this carative factor that the patient can accept information from the nurse and engage in health-seeking behavior (Watson, 1999). The instillation of faith-hope can have a tremendous effect on the outcomes of the treatment and illness. It is important that the nurse discover what is meaningful and important for the patient regardless of what the treatment is so that the patient can see him/herself as an active participant in his care.

The third carative factor, cultivation of sensitivity to one’s self and others, involves the recognition of one’s feelings which can lead to self-actualization and self-growth and can also lead to the recognition and acceptance of the feelings of others (Watson, 1985). This recognition of one’s feelings provides the foundation to express empathy toward others (Watson, 1985). The nurse who is sensitive to his/her own feelings is then able to make the patient feel understood, accepted, and capable of improving his/her current level of functioning which will then foster growth within the patient (Watson, 1985).

The fourth carative factor, the development of a helping-trusting relationship, is essential in delivering therapeutic patient care. If the patient sees that the nurse truly cares about him/her, then the patient will develop trust within the nurse and believe that the nurse truly cares about the patient (Watson, 1985). The fostering of a helping-trusting relationship involves the expression of genuineness, empathy, warmth, and effective
communication (Watson, 1985). Watson (1985) asserted that the quality of the nurse’s relationship with the patient is the most significant element in determining helping effectiveness.

The fifth carative factor, the promotion and acceptance of the expression of positive and negative feelings, involves the acknowledgement of the one’s feelings which can improve one’s level of self-awareness and control over one’s behavior and actions (Watson, 1985). Watson (1985) explained that feelings can change thoughts and influence behavior and it essential for the nurse to not only recognize and accept his/her feelings but to help the patient recognize and accept his/her feelings as well. Those who are not sensitive to their own feelings often find it difficult to be sensitive to the feelings of others.

The sixth carative factor, the systematic use of the scientific problem-solving method for decision making, brings a scientific problem-solving approach to nursing care. This approach allows the nurse to synthesize information to provide holistic care to the patient (Watson, 1985). It also provides the nurse with a context in which to make nursing judgments and decisions affecting patient care (Watson, 1985). In essence, the systematic use of the scientific problem-solving method allows nurses to collect data from a variety of sources in order to develop reliable theories and practice boundaries (Watson, 1985).

The seventh carative factor, the promotion of interpersonal teaching-learning, allows the patient to be informed and shifts the responsibility for wellness and health to the patient. In the helping relationship, the nurse facilitates the teaching-learning process which will enable patients to care for themselves as well as enable the patient to determine personal needs which will lead to personal growth. It is essential that the nurse not only consider the patient’s cognitive level but also the patient’s affect, perceptions, readiness, and motivation when sharing information with the patient which can affect whether or not the patient has absorbed the information (Watson, 1985).

The eighth carative factor involves the provision of a supportive, protective, and/or corrective mental, physical, sociocultural, and spiritual environment. According to Watson (1985), the dependence of the internal and external environments upon one another strongly influences health and illness. The nurse must be able to recognize all of
the patient’s needs so that he/she can assist the patient in fulfilling these needs. This involves consideration of the patient’s mental and physical state as well as the condition of the external environment. The patient’s comfort, privacy, and safety are significant factors in determining the patient’s response to his/her illness and treatment (Watson, 1985).

The ninth carative factor, the assistance with the gratification of human needs, is important in helping the patient to attain optimal health and wellness. The nurse must be aware of the difference between the lower order needs and the higher order needs as well as determining where the patient lies on this scale (Watson, 1985). This awareness involves active participation by the nurse in the assessment, planning, and evaluation of the patient’s care.

The tenth carative factor, the allowance for existential-phenomenological forces, acknowledges the foundation of separateness and identity of each person which brings personal meaning to human relationships as well as the patient’s situation (Watson, 1985). In the process of caring, the nurse must be able to deal with the patient as he/she is in relation to what he/she would like to be (Watson, 1985). To provide holistic care to the patient, the nurse must be able to see the world through the patient’s eyes as the patient see it (Watson, 1985). This view will allow the nurse to understand how the patient copes with life events.

The 10 carative factors provide the foundation for the delivery of caring and helping behavior from the nurse to the patient. Because all of the carative factors are related to and build upon each other, the absence of one or more carative factors inhibits the provision of holistic care to the patient. Compassion fatigue hinders the nurse’s ability to care for the patient. With the presence of compassion fatigue, the nurse can no longer focus on the needs of the patient which then interferes with the establishment of a relationship based on trust and commitment. This can hinder the actualization of the patient’s health care goals.

Selye’s Stress Theory

Stress can have detrimental effects on the body as well as on an individual’s mind and attitude toward life and others. The stress response occurs when an individual is exposed to a stressor. Once the body overcomes the stressor, the stress response stops.
However, if an individual cannot adapt to the stressor, the stress response continues. A sustained stress response results in persistent stimulation of the autonomic nervous system leading to physiological, emotional, and cognitive dysfunction (Carrieri-Kohlman, Lindsey, & West, 2003).

Hans Selye studied the stress phenomena extensively and defined stressors as those demands placed on the body in order to maintain life (Selye, 1965). According to Selye (1965), “all living things are constantly under stress and anything that speeds up the intensity of life causes a temporary increase in stress” (p. 97). Selye felt that the stress experience can be pleasant as well as unpleasant and is not always the result of physical damage. He wrote of the stress experience as being on a continuum occurring between negative or unpleasant events to positive or pleasant events. The body’s response to stress is nonspecific, meaning that most of the body’s systems attempt to adapt to the changes brought on by exposure to the stressor (Selye, 1994).

The stress response serves as a means of adaptation to reestablish homeostatic function. The results of failure to adapt and regain equilibrium are sickness, emotional changes, and body system failure. The stress response has both physiological and psychological mechanisms and failure to adapt can result in pathologies in both mechanisms (Selye, 1965).

According to Carrieri-Kohlman, Lindsey and West (2003), the stress response is defined as a collection of intellectual, behavioral, metabolic, and other physiologic responses to an event, either internal or external. It is a neuroendocrine response that is generally protective and adaptive. The manifestation of the stress response depends on several things: the magnitude of the stimuli, the perception and appraisal of the stressor, and the modification of the actual physiological response. The stress response is natural - stress can be good as well as bad. Individuals encounter stress everyday and learn ways to handle these situations so that the stressor does not become overwhelming. However, there are limits in the body’s ability to compensate. The magnitude and duration of the stressors may be so great that the homeostatic mechanisms for adjustment fail, eventually leading to the death of the individual. Pathological consequences can occur when the magnitude of the stressor strains the homeostatic mechanisms (Carrieri-Kohlman, Lindsey, & West, 2003).
Selye’s General Adaptation Syndrome (GAS) explains what happens to the body once a stressor is perceived. The GAS has three stages: alarm, resistance, and exhaustion. According to McCance and Huether (2001), the alarm stage results from an increase in sympathetic nervous system (SNS) activity and an increase in the secretion of adrenocorticotropic hormone (ACTH) from the anterior pituitary. The SNS stimulates the secretion of epinephrine and norepinephrine. ACTH stimulates the adrenal cortex which increases the release of mineralcorticoids, such as aldosterone, increasing sodium and water retention thus increasing blood pressure. The alarm stage can be viewed as the “fight or flight” mechanism.

According to McCance and Huether (2001), the resistance stage begins with the actions of epinephrine, norepinephrine, and cortisol. The SNS stimulates the release of norepinephrine from peripheral nerve endings resulting in increased vasodilation in the heart and skeletal muscles, vasoconstriction in skin, viscera, and kidneys, decreased gastric secretion, dilation of the bronchial airways, and increased contraction of the arteriole smooth muscle, resulting in increased blood pressure.

The SNS also stimulates the adrenal medulla to release epinephrine which causes dilation of the bronchial airways, increased alertness allowing for a better focus, increased force of cardiac contraction, thus, increasing cardiac output, increased blood clotting to prevent hemorrhage, increased metabolic rate and oxygen consumption, increased lipolysis of triglycerides, and decreased degradation of cholesterol to bile acids. Epinephrine acts on the liver to cause decreased glycogen synthesis, increased glycogenolysis, and increased gluconeogenesis, all of which increase the blood glucose, leading to increased energy which eventually results in weight loss. The pancreas reduces its release of insulin, which increases the level of blood glucose due to the decreased uptake of glucose by the cells, which is mediated by the presence of insulin (McCance & Huether, 2001).

According to McCance and Huether (2001), the release of cortisol is also a part of the resistance stage. Cortisol results in increased liver function, increased gastric secretion, increased blood pressure and cardiac output, increased protein catabolism of the peripheral tissues, increased circulation of polymorphonuclear neutrophils (PMN), promotion of lipolysis in the extremities, decreased protein synthesis, and decreased
inflammatory response. The increase in liver function leads to increased protein synthesis and ribonucleic acid (RNA) synthesis and an increase in gluconeogenesis resulting in increased blood glucose. The increase in protein catabolism in the peripheral tissue results in increased blood levels of amino acids which results in a negative nitrogen balance. Decreased protein synthesis results in atrophy of the lymphoid tissue leading to a decreased synthesis of immunoglobulin and decreased number of eosinophils, lymphocytes, and macrophages. The anti-inflammatory effects of cortisol also contribute to decreased circulating lymphocytes, eosinophils, and macrophages. There is also a decrease in the release of kinins, prostaglandins, and histamine from the leukocytes. This all results in a decrease in immune function which can lead to the spread of infection eventually resulting in sepsis (McCance & Huether, 2001).

According to McCance and Huether (2001), if the stressor is not removed and the body continues in the resistance stage, the compensatory mechanisms will become depleted and eventually the individual will move into the exhaustion stage which can lead to death. Exhaustion occurs if the stress continues and adaptation is not successful, leading to impairment of the immune response, heart and kidney failure, and, eventually, to death. The continued effects of the ACTH secretion in this stage include decreased immune response and decreased resistance to stressors. If the stressor is relieved, the individual will move into a reparative phase. This stage results in a decrease in the excretion of urea nitrogen thus resolving the negative nitrogen balance and allowing for protein synthesis, cell proliferation, and fat deposition. There is also an increase in the amount of insulin in the blood allowing for the uptake of glucose by the cells. The secretion of growth and thyroid hormones are also increased. This phase allows for growth and repair to occur. As a result of his studies on stress, Selye concluded that the residual effects of prolonged stress and unresolved trauma can be more devastating than the critical incident (Glod, 1998).

Changes in cognitive functioning include the failure of the individual’s ability to make judgments and decisions successfully. Lazarus (1966) stated that this can be viewed as a consequence of the emotions which are generated as a result of the exposure to stress. When psychological stress becomes too high for an individual to overcome, the individual becomes unable to make rational decisions (Lazarus, 1966). The ability to
function under stress depends upon, not only the level of stress, but also the motivation of the person. Stress can divert one’s attention as well as cause anxiety. The higher the level of stress, the less likely the individual is able to function adequately (Lazarus, 1966).

**Figley’s Compassion Stress and Fatigue Model**

Figley (1995) defined compassion fatigue as a state of exhaustion resulting from exposure to compassion stress. He acknowledged the tendency of caregivers to disregard their own self care needs while focusing on the needs of their patients and asserted that caregivers must be objective in evaluating their patient’s needs (Figley, 2002). This objectivity will allow the caregivers to select and administer the best treatments for their patients. In addition to being objective, caregivers must display compassion and empathy toward their patients which enables caregivers to see the world as the patients see it; thereby, enabling the caregivers to adjust the services to best fit the needs of the patient (Figley, 2002).

The model developed by Figley in 1995 and subsequently revised over the years is based on the assumption that empathy and emotional energy are the leading forces in working effectively with suffering, establishing and maintaining a therapeutic relationship, and delivering effective health care services (Figley, 2002). However, in viewing the world through the eyes of the patients, the caregivers bear the suffering and suffer themselves as well. Compassion fatigue is associated with a sense of helplessness and confusion in addition to feelings of isolation from supporters (Figley, 2002). Compassion fatigue also reduces the caregiver’s interest in helping others.

Figley’s model illustrates that compassion fatigue is a function of eleven interacting variables which can predict the development of compassion fatigue. Six of these variables are functions of compassion stress: empathic ability, empathic concern, exposure to the client, empathic response, detachment, and a sense of satisfaction. Figley (1995) defines compassion stress as the stress that is connected with exposure to the sufferer. If the caregiver is able to detach from the patient’s experience and feel a sense of satisfaction in terms of the care that has been given, then the caregiver will avoid the development of compassion stress.
Empathic ability is defined as the ability to notice the pain of others (Figley, 1995). This ability is linked to one’s capacity to experience the feelings of the patient as a result of exposure to the patient. Figley (1995) described this as being similar to the feeling of being “swept up” in the emotion of the patient. Empathic concern is linked to the motivation to act and, without this, the caregiver does nothing to help the patient regardless of the caregiver’s ability to respond. Exposure to the client involves experiencing what the patient is feeling through direct contact with the patient. As a result of empathic ability, empathic concern, and exposure, the caregiver is able to elicit an empathic response which is the degree to which the caregiver attempts to help the patient through an understanding of the patient’s feeling through the patient’s perspective (Figley, 1995, 2002).

The concepts of disengagement and sense of satisfaction are used as ways to prevent compassion stress. Disengagement is seen as a healthy way for the caregiver to focus on self-care by letting go of feelings associated with the patient and concentrating on his/her own life (Figley, 2002). According to Figley (1995) the degree to which the caregiver is satisfied with his/her efforts and the degree to which the caregiver can distance himself/herself from the victim’s suffering explains how much the caregiver experiences compassion stress. If compassion stress continues and is not ameliorated by the caregiver’s own actions in self-preservation, then the development of compassion fatigue will ensue.

Three additional variables play a pivotal role in the development of compassion fatigue: prolonged exposure, traumatic recollections, and life disruption (Figley, 2002). Prolonged exposure occurs when the caregiver experiences a constant feeling of responsibility for the care of the patient over an extended period of time and, at the same time, the caregiver feels as if he/she has no relief from this obligation. Traumatic recollections are memories that can trigger symptoms of anxiety whether it is from painful childhood memories or memories from working with a patient that was especially traumatic. Life disruptions include illness, a change in lifestyle, or a change in personal or professional responsibilities. Work-related stressors can also add to the probability of the development of compassion fatigue (Figley, 1995). These factors combined with
unsuccessful coping techniques can increase the likelihood of the development of compassion fatigue (Figley, 1995).

Empirical Review

The concepts of compassion fatigue, secondary traumatic stress, burnout, vicarious traumatization, empathy, and work-related stress will be discussed in the following empirical literature review. The theories providing the framework for this study will also be discussed.

Compassion Fatigue

Rudolph, Stamm, and Stamm (1997) explored the impact of compassion fatigue on the quality of care as a prevailing issue for mental health care policy reform. In this study, 179 mental health workers were surveyed and the purpose was to explore the nature of individual and organizational self-care domains for mental health providers and those in training. Data were collected using several instruments: a demographic profile; the Compassion Fatigue Self-test for Practitioners (alpha = .76 - .94); Life Satisfaction Scale with three sub-scales: Subjective State (alpha = .76), Life Conditions (alpha = 0.81), and Life Conditions (alpha = .89); and Stressful Life Events Scale (alpha = .76). A total of 305 packages were distributed and 179 were returned. All scales were compared in a series of 2 (sex) x 3 (level of training) ANOVA’s using SPSS 4.1. The study indicated that one in three mental health providers reported a high risk of developing compassion fatigue and one in two providers reported a high risk for developing burnout. Thirty-seven percent reported a high risk of compassion fatigue (n=67) and 54% reported a high risk of burnout (n=97). Post hoc analyses showed that Master’s level providers were at significantly higher risk of developing compassion fatigue and burnout than the group as a whole. In both analyses, doctoral level providers were at moderate risk. The researchers asserted that if compassion fatigue is present, it is likely affecting the quality of care and, therefore, not only a concern for individual providers but also for mental health administration as well; therefore, these organizations should create an atmosphere that supports its staff and colleagues as well supporting the patients they serve (Rudolph, Stamm, & Stamm, 1997).

Wee and Myers (2003) examined compassion satisfaction, compassion fatigue, and burnout in a sample of Critical Incident Stress Management (CISM) workshop
attendees. CISM services provided by trained CISM practitioners may put them at risk for secondary traumatization and burnout as a result of hearing about the experiences of people who have been traumatized (Wee & Myers, 2003). Workshop attendees at a workshop titled “Prevention of Compassion Fatigue” were asked to complete the Critical Incident Stress Management Provider Questionnaire (CISMPQ) and the Compassion Satisfaction and Fatigue Test (CSF) at the beginning of the workshop. The CISMPQ is a self-report instrument which asked workshop attendees to provide their age, sex, race, education attainment, relationship status, years providing CISM, whether they have experienced psychological reactions associated with providing CISM services, membership on a CISM team, current occupation, years of service in current work, and religious affiliation. The CSF (alpha = .87 - .90) is a self-report test that estimates a helper’s potential for compassion satisfaction and degree of risk for compassion fatigue and burnout. This test includes items about the respondent, items about being a helper, and items about the helping environment. The respondent can self-report on each of the 66 items using a Likert scale. The numeric scores for items for the compassion satisfaction, compassion fatigue, and burnout subscales are summed and are then compared to risk groups.

Approximately 112 people attended the workshop with 71 people returning the questionnaires. The respondent sample was 42.3% female (n = 30), 42.3% male (n = 30), and 15.5% of the surveys (n = 11) were missing gender data. The mean age was 45.18 years old. The ethnicity of the sample was 80.3% (n = 57) Caucasian, with one African-American, one Native American, one person indicating other, and 15.5% (n = 11) with missing data. The sample was well educated with 33.8% (n = 24) of the sample attending graduate/professional school, 29.6% (n = 21) graduating from college, 16.9% (n = 12) one year or more of college, 4.2% (n = 3) graduating from high school, and 15.5% (n = 11) with missing data. In terms of relationship status, most of the sample reported they were married with 57.7% (n = 41) reporting they were married, 11.35 (n = 8) separated/divorced, 7% (n = 5) single, 4.2% (n = 3) living with someone, 2.8% (n = 2) living in a community, 1.4% (n = 1) widowed, and 15.5% (n = 11) with missing data. There were more than 13 primary occupations or combinations of occupations listed with 16.9% (n = 12) firefighters, 14.1% (n = 10) nurses, 8.5% (n = 6) psychologists, 7.0% (n =
5) counselors, 5.6% (n = 4) chaplains, 5.6% (n = 4) law enforcement, 4.2% (n = 3) social workers, 22.4% (n = 16) other, and 15.5% (n = 11) with missing data. The mean number of years in the participants’ current occupation was 16.875 years with the standard deviation being 9.76 years. The mean number of years providing CISM services was 5.13 years with the standard deviation being 3.05 years and 18.3% (n = 13) missing data. More than half of the respondents (57.7%, n = 14) reported experiencing psychological reactions after providing CISM services. Exactly 25.4% (n = 18) indicated they did not experience psychological reactions (Wee & Myers, 2003).

The sample mean for compassion satisfaction potential was 97.54, which was in the “good potential” group for compassion satisfaction which includes scores ranging from 82 – 99. Of the respondents completing this test, 88.8% (n = 63) had scores which indicated good potential, high potential, or extremely high potential for compassion satisfaction. Of the respondents completing the CSF, 4.2% (n = 3) scored extremely high potential for compassion satisfaction, 42.3% (n = 30) high potential, 42.3% (n = 30) good potential, 8.5% (n = 6) modest potential, and 2.8% (n = 2) low potential for compassion satisfaction (Wee & Myers, 2003).

The sample mean for the compassion fatigue risk score was 29.22 which was the low risk group including scores ranging from 27 to 30. The proportion of respondents scoring in the five risk groups was: 43.7% (n = 31) extremely low risk, 15.5% (n = 11) low risk, 14.1% (n = 10) moderate risk, 11.3% (n = 8) high risk and 15.5% (n = 11) extremely high risk. Exactly 40.9% of the respondents were moderate risk, high risk, or extremely high risk of compassion fatigue (Wee & Myers, 2003).

The sample mean for burnout was 26.89, which was in the extremely low risk category for burnout with scores ranging from 36 or less. The proportion of respondents scoring in the five risk groups was: 87.3% (n = 62) extremely low risk, 8.5% (n = 6) moderate risk and 4.2% (n = 3) high risk. Only a small portion of the respondents was at moderate risk or high risk for burnout, with 12.7% (n = 9) of the respondents having scores greater than, or equal to, 37 (Wee & Myers, 2003).

The age of the CISM provider was significantly correlated with compassion satisfaction and burnout. The correlational coefficient for compassion satisfaction was .28, n = 58, p = 0.033. The correlational coefficient for burnout was -.32, n = 9, p =
As the age of the CISM provider increased, there was significant association with increased compassion satisfaction potential and decreased risk for burnout. The number of years providing CISM services, the number of CISM services provided, and the participants’ years of education had no relationship with rates of compassion satisfaction, compassion fatigue, or burnout (Wee & Myers, 2003).

In the CISM sample studied in this research, 58% \((n = 41)\) of the sample reported symptoms of psychological stress associated with their CISM work and 40% \((n = 28)\) experienced moderate, high, or extremely high risk for compassion fatigue. In addition, the sample reported a high degree of compassion satisfaction in their CISM work, with 89% \((n = 63)\) having good, high, or extremely high potential for compassion satisfaction. Exactly 87% \((n = 62)\) of the group reported an extremely low level of burnout. This appears to indicate that, while the CISM practitioners recognized the stress associated with their work, the work provided significant rewards that outweighed the stress and alleviated the effects of burnout (Wee & Myers, 2003). Likewise, while 40% scored positive for compassion fatigue as a result of their empathy with CISM recipients, the rewards of the work appeared to mitigate the negative effects of the work (Wee & Myers, 2003). The finding that increasing age of the CISM provider was positively associated with increased potential for compassion satisfaction and decreased risk for burnout suggested that CISM providers’ experiences, knowledge, and maturity, which generally come with age, may be a protective factor for the CISM provider (Wee & Myers, 2003).

Boscarino, Figley, and Adams (2004) examined the potential prevalence of compassion fatigue among social workers who cared for victims of the September 11 attack on the World Trade Center in New York City. The researchers also set out to test the hypothesis that, controlling for demographics, trauma history, and social support, social workers more involved in counseling victims of the attack were at greater risk for compassion fatigue and that social workers who had a supportive work environment would be protected from compassion fatigue. The researchers also sought to test that, with the exception of having a supportive work environment, predictors of job burnout would be different from compassion fatigue.

The data were based on a survey of social workers living in New York City with a master’s degree in Social Work or higher who were current members of the National
Association of Social Workers (NASW). From the membership list, 600 members with New York City mailing addresses were randomly selected and were mailed a questionnaire. A second questionnaire was mailed 2 weeks later and a follow-up letter was sent 2 weeks after that to remind the social worker to return the survey. Those respondents not engaged in direct practice were asked to indicate this on the survey. In all, 236 clinically active social workers returned the completed surveys and 38 returned the surveys indicating that they were not working directly with clients and were excluded from the analyses. The overall completion rate was 46% (236 + 38/600).

This study focused on two main outcome measurements: compassion fatigue and job burnout. The items for these scales were derived from the 30-item Compassion Fatigue Scale-Revised. This scale asked respondents to rate each item as it related to their “work/life situation” using a 10-point Likert scale. Using the sample of social work practitioners, the researchers first assessed the psychometric properties of this scale and found that the original 30-item scale measured seven underlying factors. Eliminating items using factor analyses produced two clear scales that independently measured secondary trauma and burnout. The advantage of using separate scales is that they contained fewer items overall while they remained highly correlated with the original 30-item compassion fatigue scale. Additionally, separate scales allowed the researchers to test the hypothesis that secondary trauma is different from burnout. The initial validation study completed by the researchers supported the concept that compassion fatigue is a unique feature of the workplace environment and is not merely a different conceptualization for negative life events, personal trauma, or lack of social support (Boscarino, Figley, & Adams, 2004). The researchers also tested the predictive capabilities of the secondary trauma and burnout scales in a multivariate model. The regression findings indicated that the compassion fatigue 30-item (CF-30), the job burnout 8-item (JB-8), and the secondary trauma 5-item (ST-5) scales were good predictors of psychological distress, even after controlling for demographics, stress, and psychological resource factors. In this study, the researchers used the ST-5 scale items (Cronbach’s alpha = .80; mean = 4.80, SD = 5.54) and the JB-8 scale items (Cronbach’s alpha = .90; mean = 10.78; SD = 11.30) which were summed to form the composite scores (Boscarino, Figley, & Adams, 2004).
The analyses contained three demographic variables; gender, race/ethnicity, and years working in professional counseling. The researchers also included four stress-related variables in the analyses. This survey had 13-items relating to different ways of helping “those affected by the September 11 attacks” and summed these ways of involvement into an ordinal scale: no/little involvement (0-1 ways = 1), low involvement (2 ways = 2), moderate involvement (3 ways = 3), high involvement (4 ways = 4), and very high involvement (5 or more ways = 5). The survey also had seven questions about counseling people exposed to the September 11 WTC attacks, categorized as yes vs. no, which were summed into an ordinal scale: none/little (0-1 activities), low (2 activities = 2), moderate (3 activities = 3), high (4 activities = 4), and very high (5 or more activities = 5). In order to measure exposure to other traumatized clients, the researchers also asked participants what percentage of their clients were survivors of violence. Respondents were divided into low exposure, if less than 20% of their clients were victims of violence, and high exposure, if 20% or more of their clients were victims. The researchers also asked about personal experiences with trauma which were summed into an ordinal scale: no traumatic events = 1, one traumatic event (low = 2), two traumatic events (moderate = 2), three traumatic events (high = 4), and four or more traumatic events (very high = 5) (Boscarino, Figley, & Adams, 2004).

The researchers also assessed an important dimension of the work environment: having information to work effectively with clients, which was the sum of two items on the survey. The response options available were based on a 5-point Likert scale where a higher score indicated a more supportive work situation. To test the contribution of the independent variables in predicting secondary trauma and job burnout, the researchers estimated ordinary least squares regression with the demographic, stress, and resource variables discussed as predictor variables. The researchers developed two separate multivariate regression models to test their hypotheses. Since both secondary trauma and job burnout were skewed, the researchers log transformed both of the outcome variables for the regressions. The regression analysis and descriptive statistics were conducted using SPSS version 11.5. In addition to the descriptive statistics and hypothesis testing, the researchers also examined potential cutoff scores for the ST scale. This was done using results from the 12-item General Health Questionnaire (GHQ-12) were the
researchers defined a “case” as social workers who scored above the 95th percentile, which indicated a clinically high level of psychological distress. The GHQ scale was designed to be a general screening tool for psychological problems in the general population. The researchers then computed a receiver operating curve (ROC) analysis predicting a GHQ-12 case using the raw ST-5 score results. The ROC analysis indicated that a score of 7 or higher on the researchers’ ST scale had 79% sensitivity and 76% specificity in defining a case on the GHQ-12. Using the ST-5 cutoff score of 7, or higher, the researchers compared the prevalence of ST cases in this study by both low vs. high September 11 involvement and counseling, in order to examine the predictive value of the defined cut-off point. All p-values were based on two-tailed tests (Boscarino, Figley, & Adams, 2004).

The demographic information indicated that most of the sample was female, white, and over 50 years old. Also, more than 50% reported being exposed to two or more traumatic events in their lifetime and 19% were currently seeing a substantial number of patients who were victims of violence. Additionally, 38% were moderately to extensively, involved with the WTC recovery efforts and 67% were moderately to extensively, involved with counseling persons affected by the WTC disaster. Only 16% of the social workers had little or no involvement with counseling those exposed to the WTC attacks. The results also showed that the September 11 recovery involvement in the ST model was highly significant (Beta = .233, p<.001) as was supportive work environment (Beta = -.196, p<.01). In the burnout model, by comparison, only having a supportive environment was significant. Key predictor variables generally were in the hypothesized directions. With secondary trauma, involvement in recovery efforts was positively related to ST (p<.001) and having effective work support was negatively related (p<.01). Job burnout was inversely related to being married (p<.10) and having effective work support (p<.01). Job burnout was also inversely related to years working as a professional counselor (p<.10). The researchers also conducted two separate multivariate OLS models for ST and burnout for each of these outcomes because WTC recovery involvement and WTC counseling involvement tended to be correlated (r = .322, p<.001). The major finding was that WTC counseling involvement was significant (p<.05) in the ST model without WTC recovery involvement suggesting that the latter
was suppressing the effects of the former. As can be seen by the results, 52% of those with high recovery involvement were potential ST cases compared with 25% for those with low involvement ($p < .02$). In the case of high counseling involvement, 35% were potential ST cases compared with 25% for those who were low on this variable ($p = \text{ns}$) (Boscarino, Figley, & Adams, 2004).

This research supported the concept that a group of mental health professionals working with traumatized victims were at greater risk for compassion fatigue. The researchers also suggested that the important variables in predicting compassion fatigue include degree of exposure, personal history, social support, and environmental factors. As was shown in this study, job burnout appears to be a different and unique syndrome from ST, although the work environment appears to have an impact on both of these outcomes. This was the first study to validate the concept of compassion fatigue as a multivariate construct comprised of secondary trauma and burnout (Boscarino, Figley, & Adams, 2004).

Secondary Traumatic Stress

Health care workers who work with trauma victims are exposed to significant stress and are susceptible to what is known as secondary traumatic stress. Several research studies have explored how stress reactions affect the care providers’ functioning. Care providers can become plagued by exposure to the patient’s traumatic experience which can infringe upon the care providers’ everyday lives. Beaton and Murphy (1995) found a positive correlation between secondary traumatic stress reactions and reduced longevity of career, large caseloads, increased contact with clients, and long working hours. Chrestman (1995) found a positive correlation between increased longevity and severity of secondary stress symptoms.

In a cross-sectional survey of 437 ambulance drivers in a large state in Australia, Colin (2002) studied the emotional reactions and cognitive schemas associated with trauma. Variables were included that captured the emotion aspect and the cognitive schema realm. A range of demographic and covariate variables were included to control for possible confounding influences. Families of variables were constructed from the conceptual groupings of cognition, affect, defense, and demographic. A questionnaire was developed that consisted of two parts with each part containing variables from each
family of variables. Initially 2000 surveys were mailed to all ambulance officers in a large Australian state. Four hundred thirty-seven ambulance officers returned completed surveys. The respondents ranged in age from 21 to 60 years with a mean age of 37 years ($SD = 8.68$). The sample consisted of 397 men (91%) and 40 women (9%). The average length of ambulance service was 11.83 years ($SD = 7.26$). The sample was representative, confirmed by Chi-square analysis in terms of gender, rank, age, and regional distributions within the ambulance service of the state.

The questionnaires used in this study consisted of more than 600 items. The dependent variable was the stress score measured by the Everly Behavioral Stress 68, EBS68, (alpha = .93 - .95). The EBS68 was developed with health professionals in mind and the items are constructed in such a way to minimize the impact of their sophisticated health knowledge. The EBS68 contain two sections: one focuses on the psychological consequences of stress and the second section consists of physical symptoms which are highly correlated with exposure to prolonged stress. High scores were indicative of the presence of a range of psychological and stress symptoms. The Defense Style Questionnaire was also used in this study. The two classifications of defenses included in this questionnaire included affective focused defenses, where the person suppresses emotional elements of experiences, and content-focused defenses, where the person alters the content of the experience in such a way as to prevent the event from registering conscious distress. Another tool used in this study was the Toronto Alexithymia Scale 20 (TAS20) and has good split half reliability at .62 and very good test-retest reliability over 5 weeks of .75. This tool is a measure of the person’s ability to articulate his/her registered affective states. High scores on this instrument are indicative of an inability to recognize and articulate personal experiences of affect (Collin, 2002).

A series of model reductions were carried out on the families of variables in this study: cognitive, affective, defensive, and demographic/covariate. The dependent variable was the EBS68 scores expressed as an index of stress scores. The independent variables were entered in all possible combinations after examination of the correlations with the dependent variable and all independent and covariate variables. The procedure of model reduction consisted of the analysis of the four families of variables. The reduction procedure consisted of fitting the members of each family separately, after all
other variables, to ascertain each variable’s unique contribution. This produced a reduced model consisting of three defenses and the demographic variable of total service that was highly significant ($F = 32.26$, $df = 5,315$, $p<.0001$). As a result of the process of model reduction, the variables left in the equation were reduced to the minimum set which included affect defenses 1 and 2, alexithymia, and the covariate total service. This set of variables was then regressed on stress. This analysis was highly significant ($F = 43.00$, $df = 5,403$, $p<.001$). The results indicated that the suppression of emotion is the largest predictor of stress scores. The findings also indicated that recognition and expression of emotion is crucial for maintaining health during stressful conditions (Colin, 2002). Colin (2002) also asserted that suppression of emotional reactions to trauma is an ongoing source of physical and psychological harm to emergency services personnel.

In a qualitative and quantitative longitudinal study conducted by Collins and Long (2003), the researchers examined the effects on caregivers working therapeutically with seriously traumatized people. The participants included 13 healthcare workers who were members of a trauma and recovery team set up to help those traumatized by the Omagh bombing in Northern Ireland. Quantitative data were collected using the Compassion Satisfaction/Fatigue Test and the Life Status Review Questionnaire. The Compassion Satisfaction/Fatigue Self-Test for Helpers ($\alpha = .87 - .90$) has 3 subscales covering the items compassion satisfaction, burnout, and compassion fatigue. Respondents were asked to rate the frequency of experience of each item in the previous week. The Life Status Review ($\alpha = 0.84$) reviews 30 areas, divided into eight subscales: medical, health/wellness, financial, housing/transportation, employment, legal/criminal, alcohol/substance abuse, and self/social/interpersonal. This tool asks participants to rate their overall satisfaction with life on a scale of 0 – 100%. The questionnaires were completed at four points in time: August 1998, December 1998, August 1999, and February 2001 (Collins & Long, 2003).

Qualitative data were gathered using open-ended questions regarding the positive and negative aspects of working with traumatized people as well as the caregiver’s experience leaving the trauma response team. Three open ended questions were included in the last data set (February 2001). The first question asked the participants to list five positive things about working on the team. The second question asked the participants to
list five negative things about working on the team. The third question asked the participants about their experiences of leaving the team. Qualitative data were reduced into themes using content analysis (Collins & Long, 2003).

Participants ranged in age from 30 - 49 years: 53.8% \( (n = 7) \) were female, 77% \( (n = 10) \) were married, 69.2% \( (n = 9) \) had a mental health background, 77% \( (n = 10) \) had experience working with trauma previously, 77% \( (n = 10) \) worked full-time in the team for at least one year before returning to their original place of work, the other 23% \( (n = 3) \) worked part-time in the trauma team in addition to their regular jobs. The researchers computed means and standard deviations of the subscales of the Compassion Satisfaction/Fatigue Test for the entire sample at the four different points of time that the questionnaires were completed. The overall mean for burnout and compassion fatigue increased from 22.38 to 29.62 and 18.85 to 34.46, respectively. There was also a corresponding reduction in compassion satisfaction mean scores from 87.62 to 80.15. The LSR was the only measure that revealed a significant difference when sample characteristics were compared using a paired sample \( t \)-test. By August 1999, the life status of females was significantly worse than males \( (t = 3.459, df = 11, p < 0.01) \). There was a positive correlation between compassion fatigue and burnout. This was most evident in August 1999 \( (r = 0.783, p < 0.01) \) (Collins & Long, 2003).

Qualitative data collected revealed a number of themes. The most commonly mentioned positive aspect of working in the team was team spirit (92.4%, \( n = 12 \)). This was closely followed by the satisfaction of seeing clients recover and move on (84.7%, \( n = 11 \)) coupled with the feeling of being part of the community (84.7%, \( n = 11 \)). Thirdly, the development of new skills and applying knowledge to a new situation was listed as a positive aspect (77%, \( n = 10 \)). One negative aspect listed by 100% \( (n = 13) \) of the sample was high profile of the team and media interest which at times was intrusive and invasive. Other negative aspects listed included dealing with the content of the client’s stories (61.6%, \( n = 8 \)), working with clients the staff knew (46.2%, \( n = 6 \)), and working with the bereaved was extremely stressful (38.5%, \( n = 5 \)). On leaving the team, 61.6% \( (n = 8) \) of the participants stated that they found returning to their original workplace a positive experience which provided them with a sense of relief. Other themes that emerged included: lack of plan for starting, working through, and finishing (38.5%, \( n = 5 \); no
clear support from non-trauma team managers (30.8%, \( n = 4 \)); and no time off or time given to adjust (23.1%, \( n = 3 \)) (Collins & Long, 2003).

Analysis of the quantitative data indicated that the levels of compassion fatigue and burnout increased after the first year. However, there was insufficient evidence to establish if burnout was an important risk factor or precursor to compassion fatigue. These findings were negatively correlated with compassion satisfaction, satisfaction with life, and life status scores. The negative correlations indicate that compassion satisfaction may be a protective factor. The findings from this study support findings from other studies which indicated that secondary traumatic stress is a consequence of caring for traumatized people (Collins & Long, 2003).

**Burnout**

In a study of 233 nurses in five hospitals in Athens, Greece, Adali and Priami (2002) compared the levels of burnout among nurses in different nursing specialties and the environmental factors that contribute to the development of burnout. In particular, the researchers recorded the views of nursing personnel working in five Emergency Departments, 20 internal medicine wards, and seven intensive care units. A total of 414 questionnaires were distributed in which 233 surveys were returned (response rate of 56.2%). The sample included 42.5% of the nurses working in internal medicine wards (\( n = 99 \)), 35.6% working in intensive care units (\( n = 83 \)), and 21.9% working in Emergency Departments (\( n = 51 \)). The following tools were used for data collection: the Maslach Burnout Inventory, the Work Environment Scale, and a demographic profile questionnaire. The questionnaires were translated in Greek and then an independent translator made an inverse translation.

The possible association of burnout with different independent variables such as age, number of children, and work experience were evaluated by using the Spearman’s correlation coefficient. Multiple linear regressions were used to define the variables that are statistically significant to the interpretation of the presence of burnout. The selection of variables was done by the backward elimination procedure in the level of significance \( p = .05 \). High scores of burnout reflected high scores of emotional exhaustion and depersonalization and low scores of personal accomplishments (Adali & Priami, 2002).
The majority of participants were female (91.3%) with a mean age of 34 years. Most nurses were married with 1-2 children and up to 10 years of work experience. The educational level of the nurses included: a university degree (5.7%), technological educational institution graduate (38.7%), masters degree or Ph.D (6%), and nursing specialization title (23.8%). Concerning the time that nursing personnel spent during its working hours caring for patients, 44.5% of the nurses dedicated less than 25% of their time and 22.9% of the nurses spent 50% of their time caring for patients. Emergency Department nurses reported a higher degree of burnout compared to nurses working in the ICU. Study results indicated the Emergency Department nurses showed significantly higher levels of emotional exhaustion in comparison to nurses working in intensive care and internal medicine units. Significant predictors for emotional exhaustion in Emergency Department nurses included low level of involvement ($p = 0.003$), work overload ($p = 0.006$), and lack of innovation ($p = 0.010$). The supervisor support influenced the depersonalization ($p = 0.036$), while age ($p = 0.006$) and task orientation ($p = 0.000$) influenced the personal accomplishments (Adali & Priami, 2002).

The study reported that the total degree of the reported burnout in the sample of this study is thought to be moderate compared with American levels (Adali & Primari, 2002). Nurses working in the Emergency Departments reported a statistically higher degree of burnout compared with nurses working in the intensive care units and internal medicine wards. The degree of depersonalization was also higher in Emergency Departments but not in a statistically significant degree compared with intensive care units and internal medicine wards. In terms of the work setting, the work pressure is statistically higher in Emergency Departments in comparison to the other wards (Adali & Primari, 2002).

In a study of 177 members of the Society of Emergency Medicine Physician Assistants (SEMPA), Bell, Davison, and Sefcik (2002), examined the burnout levels of emergency medicine physician assistants (PAs) and the presence of characteristics associated with higher burnout levels. Of all the members of the SEMPA, 397 members were randomly selected to be included in this study. The tools used included the Maslach Burnout Inventory, the EMPA Demographic Sheet, and the Lifestyle Characteristics Survey. Spearman’s correlation coefficient was used to test for significance between
different personal characteristics (except for age) and the three Maslach Burnout Inventory (MBI) subscales (emotional exhaustion, depersonalization, and personal accomplishment). Of the total of 177 surveys returned (return rate of 44.6%), 160 surveys were available for analysis.

The ages of the participants ranged from 25 – 57 years and average age was 40.4 years ($SD = +/- 7.5$ years). Most participants were Caucasian (91.9%), male (73%), and married or living with a partner (75%). Forty-four percent of the participants ($n = 71$) had been in emergency medicine for 1 – 5 years. Responsibilities included clinical (98.8%), administrative (31.9%), research (6.2%), teaching (48.8%), and other duties (5.6%). More than 88% of the participants felt that their level of autonomy was average, or better, compared to other PAs. Almost 87% had average, or better, levels of satisfaction with their physician supervision. Twenty-eight percent ($n = 45$) reported self-assessed burnout (Bell, Davison, & Sefcik, 2002).

Fifty-nine percent had moderate or high burnout levels on the Emotional Exhaustion subscale; 66% on the Depersonalization subscale, and 34% on the Personal Accomplishment subscale. Pearson’s correlation coefficient was used to compare the three MBI subscales and age. Tests with $p$ values of .05, or less, were considered statistically significant. No significant correlation was found between the Emotional Exhaustion and Depersonalization subscales. A positive correlation was found between the Personal Accomplishment subscale and age. Spearman’s coefficient was also used to compare MBI results with data from the EMPA Characteristics Survey. Eighteen tests were found to be significant, including 11 tests having a $p$ value less than .010. No statistical correlation was found between the MBI and respondent demographics, duration or location of practice, or number of hours worked each month. The EMPA Characteristics Survey asked participants if they felt burned out. Forty-five of the 159 respondents (28.1%) stated they felt burned out at least part of the time. Answers to this question were tested against responses to the other questions on the EMPA Characteristics Survey using the Mann-Whitney $U$ test for nonparametric data. Six tests showed significant differences ($p$ less than 0.05) in self-assessed burnout among possible responses to questions. Female gender, planning to leave emergency medicine within one year, low satisfaction with physician supervisors, smoking 1 to 2 packs of cigarettes
each day, drinking more than six alcoholic beverages a week, and more frequent insomnia were associated with higher levels of self-assessed burnout (Bell, Davison, & Sefcik, 2002).

The emotions that emergency clinicians routinely see and experience contributed significantly to emotional exhaustion (Bell, Davison, & Sefcik, 2002). EMPAs regularly witness tragedy, which may encourage them to become emotionally disengaged as a defense mechanism (Bell, Davison, & Sefcik, 2002).

**Vicarious Traumatization**

In a study of 188 self-identified trauma therapists conducted by Pearlman and Maclan (1995), the researchers examined vicarious traumatization and the harmful effects of trauma therapy on the therapist. The participants included 136 (72%) females and 52 (28%) males. They were primarily Caucasian (93%); ranged in age from 23 to 74 years with a mean age of 43 (female $M = 42$, male $M = 47$); married or living with a partner (71%); in the field of psychology (58%) or social work (27%); and had been working with trauma survivors an average of 9.59 years ($SD = 9.00$). Approximately 780 questionnaires were distributed to members of an international trauma professional organization during a day-long professional trauma training seminar and to graduate students in New England area training programs. One hundred eighty-eight completed questionnaires were returned – 65 blank questionnaires were returned in response to the researchers’ instructions to complete the packet only if the participant considered himself/herself a trauma therapist (overall return rate of 32%). The researcher developed a questionnaire that examined the therapists’ work with trauma survivors. Other variables used in the exploratory analyses included therapist trauma history, age, income, education, work setting, and use of personal therapy to address the effects of one’s trauma work. Other tools used included the Traumatic Stress Institute Belief Scale (alpha = .83), Impact of Event Scale (alpha = .86), Symptom Checklist 90R (alpha = .96), and the Marlowe Crowne Social Desirability Scale (alpha not listed) (Pearlman & Maclan, 1995).

The mean TSI Belief Scale score for the entire sample was 184. The mean TSI Belief Scale score for the therapists with a personal trauma history was 190 ($SD = 38$) and was 174 ($SD = 34$) for those without trauma history, a significant difference, $F(1,
In the sample, only the self-trust scores correlated significantly with percentage of survivors ($r = -.22, p < .01$). The study found that the greater proportion of one’s clinical work devoted to trauma work, the fewer the disruptions in self-trust schemas. Those newer to trauma work (less than 2 years of therapy experience) had more disruptions in self-trust, self-intimacy, and self-esteem as well as higher overall symptoms as measured by the Symptom Checklist 90R (Pearlman & MacIan, 1995).

The researchers also conducted a multiple regression analysis using the following independent variables: gender, personal trauma, history, therapy, age, length of time doing work, income, level of education, and work setting. Taken together, these variables predicted SCL-90R scores ($R^2 = .22, p < .001$), total IES scores ($R^2 = .14, p < .01$), and total TSI Belief Scale scores ($R^2 = .12, p < .01$). The findings suggested that those trauma therapists who were talking about the effects of their trauma work in their personal therapies and who had a personal trauma history showed the most disturbances on general and trauma-specific measures (Pearlman & MacIan, 1995).

The study found that trauma therapists with a personal history of trauma showed more negative effects from the work than those without a personal history of trauma. Most of the therapists’ disruptions were in regard to self-esteem, self-trust, and self-intimacy. They also found that those therapists without a trauma history who had been doing trauma work longer experienced greater disruption in self-intimacy. According to Pearlman and Maclan (1995), this represents a detachment from one’s inner experience which may be a way of not feeling so much pain related to work. The newest therapists in the trauma history group were experiencing the most difficulties which is consistent with the literature on burnout that shows being younger or newer is correlated with the highest levels of burnout (Pearlman & MacIan, 1995).

Empathy

As stated previously, empathy is a major component in the health care provider and patient relationship. In a study of empathy in medical students, Hojat et al. (2002) examined the relationship between empathy scores and clinical competence. The researchers hypothesized that medical students with higher empathy scores would obtain higher ratings of clinical competence in core clinical clerkships. The researchers also hypothesized that female students would obtain a higher mean score than their male
counterparts on the empathy scale. The Jefferson Scale of Physician Empathy, a 20-item questionnaire developed by the researchers, was given to 371 third-year medical students during two academic years (alpha = .87 - .89). The sample included 198 men and 173 women which represented 83% of total students in two classes. The researchers used the school faculty’s global ratings of students’ clinical competence in each of the six third-year core clerkships (family medicine, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, and surgery) to examine their associations with empathy scores (Cronbach’s alpha = .71 for the sample of this study) (Hojat et al, 2002).

The empathy scale was completed voluntarily by all participants during orientation at the beginning of the academic year. The students’ empathy scores were merged with data retrieved from the Jefferson Longitudinal Study of Medical Education. Analysis of variance (ANOVA), t-test, and Chi-square test were used for group comparisons. Pearson product-moment correlation coefficients were calculated to examine associations between empathy and scores in the Medical College Admission Test (MCAT), first and second year grade point averages (GPA) in medical school, and the United States Medical Licensing Examination (USMLE) scores (Hojat, et al, 2002).

The study found that the lowest mean of empathy scores was obtained by students who received no High Honors ratings in the six third-year core clerkships. The highest mean score was obtained by those who achieved three or more High Honors ratings (out of six maximum). Students with at least one High Honors rating had a mean empathy score that was considerably higher than their classmates with no such ratings. Correlation coefficients between empathy scores and scores in the biological sciences, physical sciences, and verbal reasoning sections of the MCAT, first and second year GPAs, and scores in Steps 1 and 2 of the USMLE were all statistically nonsignificant (ranging from $r = .01$ to -.06). The study also found that women scored considerably higher ($M = 122$, $SD = 10$) than men ($M = 119$, $SD = 11$) in empathy scores. Additional analysis was done to test whether gender and clinical ratings were significantly associated. The associations between gender and High Honors clinical ratings ($X^2(1) = 0.36$) and between gender and low clinical competence ratings ($X^2(1) = 0.54$) were not statistically significant. This suggested that empathy and clinical competence are not affected by the students’ gender. This study also suggested that the personal orientation
of medical students toward empathy is significantly and positively associated with ratings of clinical competence and gender.

*Work-related Stress*

Posttraumatic Stress Disorder (PSTD) is an anxiety condition that develops subsequent to traumatic events (Laposa, Alden, & Fullerton, 2003). PSTD can generate considerable problems in one’s life affecting work, school, and family. According to Laposa, Alden, and Fullerton (2003), researchers have demonstrated that PSTD can develop in persons who witness upsetting events in the workplace including those who work in the Emergency Department. This study is a secondary analysis of data previously reported. The purpose of the primary study was to establish the prevalence of PSTD in a sample of Emergency Department personnel and to examine several key aspects of a proposed cognitive model of PSTD. In their analysis of these data, Laposa, Alden, and Fullerton (2003) determined whether associations existed between symptoms of PSTD and sources of workplace stress, and how emergency personnel responded to workplace stress or trauma.

This study included 51 Emergency Department workers in a large urban center in British Columbia. Sixty-seven percent of those who picked up a questionnaire package completed it, which represented 44% of the Emergency Department staff who had extensive patient contact. The participants were primarily European Canadian with a mean age of 36.5 years and working in the Emergency Department of this hospital for an average of 7.5 years (Laposa, Alden, & Fullerton, 2003).

Stress was assessed using the Health Professionals Stress Inventory - Revised (HSPI –R). Factor analysis of the original items revealed four underlying factors, or dimensions. Because one dimension was characterized by low internal consistency and item overlap with the other factors, the researchers chose to focus on the three factors: organizational characteristics, patient care, and interpersonal conflict. Cronbach’s alphas for the three factors and total scores were .63, .76, .71, and .81, respectively (Laposa, Alden, & Fullerton, 2003).

PSTD was assessed with the Posttraumatic Stress Diagnostic Scale (PDS) in which respondents completed the scale with reference to potentially traumatic work events. The list of events was based on situations identified in previous research as
critical ED incidents. After indicating which events they have experienced on the job, the respondents chose the event that upset them the most. The PDS provided scores for the three symptoms of symptom clusters of PTSD: re-experiencing, avoidance and numbing; and arousal (Cronbach’s alpha = .83) (Laposa, Alden, & Fullerton, 2003).

Six items regarding reaction to stress/trauma were assessed including whether they attended critical incident stress debriefing, sought professional help elsewhere, felt supported by their administration, believed that the event affected their previous ability to interact with co-workers, and considered changing jobs (Laposa, Alden, & Fullerton, 2003).

Out of a possible total of 90 on the HPSI – R, the average stress score was 57.19 (SD = 10.15). The average PTSD symptom severity score was 6.85 (SD = 5.58) out of a possible of 51. Twelve percent of the participants met full criteria for PTSD and 20% met criteria for the three symptom cluster. The top three events chosen as most upsetting included providing care to a patient who is a relative or close friend and is dying or is in serious condition; threatened physical assault of self; and multiple trauma with massive bleeding or dismemberment. To determine if any of the HPSI – R factors were rated as more stressful than others, repeated measures of analysis of variance were conducted that compared the severity of the stress caused by each factor. This analysis revealed that all three HPSI – R factors were rated as equally stressful (F 1,49 = 0.73; p > .1). Pearson correlation coefficients computed between the HPSI – R factor and total scores and PTSD symptom severity revealed that interpersonal conflict was the only type of stress to significantly predict PTSD symptom severity (r = .36, p< .05). Interpersonal conflict was significantly associated with avoidance (r = .32, p <.01) and arousal (r = .37, p<.01) clusters. The participants’ responses to the six work-place related change questions indicated that a majority of the participants felt they had received inadequate support from hospital administrators following the traumatic incident (Laposa, Alden, & Fullerton, 2003).

The results of this study pointed to a relationship between stress caused by interpersonal conflict in the workplace and PTSD symptoms. Stress created by organizational factors and patient care was less problematic indicating that Emergency Department personnel can manage their work but that it was the job’s interpersonal
environment that was more relevant to PTSD levels. The implication of this study is that changes in the interpersonal climate, including enhancing administrative support, may be useful in ameliorating PTSD symptoms (Laposa, Alden, & Fullerton, 2003).

In a study completed by Norbeck (1985), the researcher explored the effects of perceived work stress and work satisfaction on psychological symptoms in critical care nursing. The study aimed to determine if higher levels of perceived occupational stress in critical care nursing were related to lower levels of work satisfaction and higher levels of psychological symptoms experienced by critical care nurses. A passive observational design was used to study the relationships among variables measured at one point in time. The sample consisted of 180 critical care nurses from eight hospitals with adult critical care units in an urban-suburban area in the west. Of the 382 nurses contacted, 216 (56.6%) returned a postcard indicating an interest in participating, and 84.7% of these completed the questionnaires. The sample was predominantly female (91%), Caucasian (88%), and unmarried (32% single, 23% divorced/separated/widowed).

The instrument used in this study to measure stress was the Questionnaire of Stressful Factors in the Intensive Care Unit (alpha = .90). This 32-question survey focused on four main categories of stressful events in critical care nursing: interpersonal communication problems, need for extensive knowledge base, environmental problems, and patient care problems. The instrument used in this study to measure job satisfaction was the Nursing Job Satisfaction Scale (alpha = .86). This 35-item questionnaire focused on six dimensions: job enjoyment, quality of care, care/comfort measures, job interest, time to do job, and feedback. The instrument used to measure psychological symptoms was the Brief Symptom Inventory, a 53-item tool that focuses on nine primary symptom dimensions and three global indices of distress (alpha = .71 - .85). A demographic data and work history sheet was used to obtain data on age, sex, ethnicity, marital status, type and amount of education, years of experience in nursing and in critical care nursing, shift, type of critical care unit, perceived acuity of patients on the unit, and number of patients usually assigned for care (Norbeck, 1985).

Pearson correlation and one-way analysis of variance were used in preliminary analyses to test the need to control any demographic or work history variables that might be related to the study variables: perceived job stress, job satisfaction, and psychological
symptoms. The hypotheses were tested first with Pearson correlation and then with multiple regression analysis to control for certain work history variables. One-way analysis of variance was used to study the generalizability of the findings in relation to the multiple sites and types of critical care units used in this study (Norbeck, 1985).

The results yielded no significant findings for work history with perceived work stress. There were significant relationships between work stress and work satisfaction. Both age and years in nursing were related to job satisfaction and symptoms. Shift is related significantly to job satisfaction: night shift nurses are significantly lower in job satisfaction than those from other shifts. The hypotheses were confirmed in the zero-order correlations that show significant relationships between perceived job stress and job satisfaction ($r = -.24, p<.001$) and between perceived job stress and psychological symptoms ($r = .33, p<.000$). Factors perceived as stressful most frequently were not those that had a significant impact on the nurses’ job dissatisfaction or symptom levels. The cluster of factors descriptive of the intrinsic nature of critical care nursing (number of rapid decisions required, cardiac arrest, death of a patient, and amount of knowledge needed) ranked with high frequency as high stressors was not significantly related to low job satisfaction or psychological symptoms. Interpersonal communication problems between unit nurses were less frequently ranked as stressors; however, this factor was the most related to the two outcome measures. Workload was both highly ranked as a stressor and was significantly related to low job satisfaction. All four factors concerning the physical environment of critical care (physical set-up, noise level, equipment, and injury) were significantly related to psychological symptom levels as was the factor of meeting the psychological needs of the patient. The researcher concluded that the higher the perceived work stress, the lower the work satisfaction in critical nursing. It was also concluded that the well-being of nurses was at risk when nurses worked in a stressful environment (Norbeck, 1985).

Hall (2004) attempted to identify the common work-related stressors and coping mechanisms of registered nurses within a hospital setting. In this qualitative study, the researcher used the grounded theory method to investigate what registered nurses appraise as stressful and how registered nurses engage in coping with those stressors. The sample included ten nurses (one man and nine women) employed in clinical areas at
a university hospital Level I Trauma Center selected to represent different clinical areas, age ranges, and gender. The participants ranged in age from 22 to 52 years; three of the nurses had less than 18 months of experience with an overall range of less than one year to more than 18 years. Educational background ranged from an associate degree in nursing to one nurse with several baccalaureate degrees. The sample was evenly divided between nurses who worked nightshift and dayshift. Clinical areas represented included medical-surgical, critical care, pediatrics, Emergency Department, and psychiatry.

Each nurse was interviewed and audiotaped and each interview was transcribed and reviewed by the researcher. The nurses were also observed for four 15-minute periods during normal working conditions to provide credibility for themes found during the interviews. Each interview was analyzed twice for substantive coding related to stress, stressors, and coping and compared for differences in coding. A table of work stressors, coping strategies, results after stressful situations, and worst stress situation was developed for axial coding. A table was also created to combine all the comments, to note the number of times similar comments were made, and to determine if themes were more common in certain demographic groups (Hall, 2004).

A pattern of stressor categories was identified for the nurses. Seven major categories were identified by most of the nurses with these categories being reduced to four themes: meeting patients’ needs; self-expectations of the registered nurse; quantitative workload; and colleagues’ inexperience. There were differences with how the nurses coped with stress at work and stress at home and they expressed a strong desire to separate the two types of stress. Overall, the perception of stress at work was higher than at home because the nurse could not escape the stressors while in the hospital setting. Although coping with work-related stressors was an individual process, there were two common strategies used by the participants: talking to and getting help from co-workers and problem solving. The theme of meeting patients’ needs had two categories: systems barriers to meeting patient needs and patients’ changing condition. The theme of workload also contained three categories: shortage of skilled labor, polychronicity, and pressure for immediate results (Hall, 2004).

Because of the results of this study, Hall (2004) concluded that the development of realistic, appropriate, and evidence- or research-based standards of patient care is
important in the orientation of both graduate nurses and newly hired nurses. The study also found that staff development personnel need to evaluate the expectations of new nursing staff to lessen both reality shock and job dissatisfaction and to determine if their institution’s standards are adequate (Hall, 2004).

*Watson’s Theory of Caring*

Vincent, Alexander, Money, and Patterson (1996) conducted a study which examined the perceptions of caring from the context of a critically ill child. The researchers used a phenomenological approach in order to interpret and understand the lived experiences of parents with critically ill children. Ten sets of parents of critically ill children were asked to describe their perceptions of caring. The parents had children in three pediatric units in a children’s hospital in Alabama. The participants in this study described caring in terms of their own personal feelings, the needs of their child, and the nurse’s personal attributes and clinical competence. During multiple readings of the descriptions, major characteristics of the nurse were identified. The researchers interpreted and described experiences and summarized the expressions in themes and sub-themes that retained the parents’ perceptions while clarifying the essential elements of caring. Finally, the descriptions were summarized into elements that captured the essence of the themes. Four themes were identified and clustered as follows: characteristics of the nurse, meeting the child’s needs, meeting the parent’s needs, and feelings evoked by caring. Three sub-themes emerged: security, cared for, and relieved of stress. The study demonstrated that caring behaviors were communicated by the nurse’s personality, clinical competence, and skills. The study also showed that the nurse demonstrated caring by ensuring that the child’s needs were met as well as providing information and support to the parents. Responding to parents in a caring manner helped to relieve stress, affected the parents’ feelings of security, and offered a sense of being cared for during a stressful time.

Erci, Sayan, Tortumluoglu, Kilic, Sahin, and Gungormus (2003) attempted to determine the relationship between the quality of life and hypertension and the effect of Watson’s Caring Model on the quality of life and the blood pressure of a group of patients with hypertension in a city in Turkey. The study used the one group pretest posttest design. All patients with hypertension in four primary health care units were
identified \((n = 56)\). The study included 52 patients who agreed to participate. Before the care was given, a questionnaire consisting of demographic characteristics and the quality of life scale were administered to the study group for a pretest and the first blood pressure measurement of the patients was taken. At the end of care, the patients were observed; the quality of life scale was applied to the patients; and the final blood pressure measurement of the patients was taken for the posttest.

This study was based on home visits using the Watson Caring Model to guide practice. The Watson Caring Model considers persons holistically together with their physical, psychological, and social environment (Erci, Sayan, Tortumluoglu, Kilic, Sahin, & Gungormus, 2003). The demographic characteristics and care given formed the independent variables. The score of the quality of life scale and the measurements of the blood pressure of the patients formed the dependent variables. The statistical analysis included paired \(t\)-test to determine the difference between pre- and post-measurement of blood pressure and the score of pre- and post-test of the quality of life. Independent \(t\)-tests were used to examine the difference between blood pressure and gender, marital status, advice, adoption of hypertension, other chronic disease, other person with hypertension in their family, nutrition, and exercise. This test was also used to examine the difference between the score of the quality of life scale and gender and marital status. Kruskal-Wallis variance was used to investigate difference between blood pressure and education, measurement of blood pressure, medicine use, and between the score of the quality of life scale and education. Correlation was used to determine the relationship between blood pressure and scale scores and between blood pressure and age, monthly income and duration of hypertension, and between the score of the quality of life scale and age and monthly income. In addition, the boxplot graphic and linear model in curve estimation of regression analysis with 95% confidence intervals were used to evaluate the trends of blood pressure (Eric, Sayan, Tortumluoglu, Kilic, Sahin, & Gungormus, 2003).

The mean age of the sample group was 55.41 +/- 8.88 years, 91.2% of the sample was female, only 46% had graduated from primary school, 33% of them were secondary school graduates, and 1.1% had a bachelor’s degree. In terms of relationship status, 73.6% of the participants were married and 25.6% were widowed or single. The average duration of the disease was 7.82 years and 78.6% of the participants stated they had
adapted to life with hypertension (Eric, Sayan, Tortumluoglu, Kilic, Sahin, & Gungormus, 2003).

In the statistical evaluation of demographic features with quality of life scales, there were no statistically significant differences between quality of life scales and sex, age, level of education, and monthly income. Only differences between marital status and general well-being subscale were found statistically significant ($t = 2.246, df = 54, p = 0.029$). Before the intervention, the mean systolic blood pressure of the patients was 152.50 +/- 21.50 mmHg; the mean diastolic blood pressure was 91.91 +/- 12.83 mmHg. Prior to the researchers’ intervention, 19.6% of the sample had exercised and only 28.6% followed a diet suitable for hypertension. Exactly 62.5% of the patients took their medications regularly, 28.6% took their medicine irregularly, and 8.9% did not take any medication (Eric, Sayan, Tortumluoglu, Kilic, Sahin, & Gungormus, 2003).

The results of the post-test quality of life scale indicated an increase in the mean scores of general well-being, physical symptoms and activity, sleep dysfunction, cognitive function, medical interaction and social participation and work performance scales and total mean score. This increase was statistically significant for differences between the pre- and post-test scores. After the nursing care intervention, the mean systolic blood pressure was measured at 139.27 +/- 16.37 mmHg and the diastolic blood pressure was 85.01 +/- 10.75 mmHg. The differences in blood pressure before the intervention and after the intervention were found to be statistically significant (systolic: $t = 4.830, df = 51, p < 0.0000$; diastolic: $t = 3.51, df = 51, p < 0.001$). The use of the Watson Caring Model in this research study was associated with a downward trend in the blood pressure of the patients. In this study prior to the nursing intervention, the data confirmed the evidence that there was a negative correlation between the general well-being score and increase in the blood pressure. Care given according to the Watson Caring Model was associated with increased quality of life and decreased blood pressure and this model also assisted nurses with their own caring-healing practices for self (Erci, Sayan, Tortumluoglu, Kilic, Sahin, Gungormus, 2003).

Swanson (1999) examined the effects of caring-based counseling, measurement, and time on the integration of loss and women’s emotional well-being in the first year after miscarrying. Three hypotheses were tested: compared to controls, counseled
women will experience less miscarriage impact, higher self-esteem, and less disturbed moods; the passage of time will result in women experiencing less miscarriage impact, higher self-esteem, and less disturbed moods; and there will be no difference in miscarriage impact, disturbed moods, or self-esteem an 4 months and 1 year after loss between women completing early versus delayed outcome measures.

Hour-long counseling sessions were conducted by the researcher or research associate at 1, 5, and 11 weeks after the study entry. Although the protocol outlined the intended content, the intervention process (personalized caring) often meant the topics were addressed out of order according to each participant’s needs. A Solomon four-group randomized experimental design with delayed measurement for some was chosen to address the possibility that early measurement could serve as a form of treatment. Treatment levels included intervention and control (no intervention). Measurement occurred immediately after enrolling (t₁), at 6 weeks (t₂), 4 months (t₃), and 1 year (t₄) or it was delayed until 4 months (t₃) and 1 year (t₄) after enrolling (Swanson, 1999).

The sample size was set at 60 participants per group with the following criteria: at least 18 years of age, miscarried at 20 weeks or less, within 5 weeks of loss, and could speak and write English. The sample size included 242 women randomly assigned to groups: 56 to treated, early measures; 60 to treated, delayed measures; 64 to control, early measures; and 62 to control, delayed measures. All surveys were returned by 185 participants (46 treated, early measures; 44 treated, delayed measures; 43 control, early measures; and 53 control, delayed measures). The overall attrition rate was 24% (n = 57) (Swanson, 1999).

The measures used in this study included self-esteem measured by the Rosenberg Scale (alpha = 0.89), mood states measured by the Profile of Mood States (alpha = 0.90), and impact of miscarriage measured by the Impact of Miscarriage Scale developed by the researcher (alpha = 0.93). Measures of central tendency and dispersion were examined for all variables. To confirm group equivalence at t₁ and to account for potentially confounding t₄ historical data, ANOVA or Chi-square analysis were performed on selected obstetric, demographic, and descriptive variables. To control for Type I errors, a repeated measures MANCOVA was performed on data from subjects who completed all four measures. The alpha level was set at \( p = 0.05 \) when testing the three research
hypotheses. The test of treatment ($H_1$) and time ($H_2$) effects over 1 year involved repeated measures of ANCOVA of data from early measures groups. Time and treatment were factors and $t_1$ scores were used as covariates. The test of treatment ($H_1$), time ($H_2$), and measurement ($H_3$) effects between all 4 months and 1 year involved repeated measures of ANOVA of data gathered at $t_3$ and $t_4$ from all participants (Swanson, 1999).

There were no significant differences between groups on any of the recruitment criteria. Maternal age ranged from 19 -45 years ($M = 32.5$, $SD = 5.5$); mean gestational loss was 10.41 weeks ($SD = 3.3$); and participants enrolled from 0-35 days post miscarriage ($M = 7.86$, $SD = 7.5$). There were also no significant differences between the groups on any of the demographic variables. The majority of the participants were married (88%), employed (76.4%), well educated ($M = 15.65$ years, $SD = 2.3$), and financially secure (average annual income was approximately $50,000). There were no significant differences between groups in obstetrical backgrounds: 71% stated their pregnancies were planned and participants had miscarried from 1 to 6 times ($M = 1.44$, $SD = 0.79$). There were also no differences in care received at time of miscarrying (Swanson, 1999).

Repeated measures of MANCOVA using data from those early measured participants who had completed data for all measures at all four time points ($n = 75$) was near significant for both treatment (Omnibus $F = 2.47$, $df = 3$, $p = 0.069$) and time (Omnibus $F = 2.00$, $df = 6.68$, $p = .078$). Focusing on women completing four measures (early measures, treated and control) significant effects for time were demonstrated by decline in overall emotional disturbance, anxiety, depression, anger, confusion, and personal significance of miscarrying, and an enhancement of self-esteem.

Repeated measures MANOVA using data from both delayed and early measures participants who had complete data at 4 months and 1 year ($n = 176$) was significant for both measurement (Omnibus $F = 3.97$, $df = 3$, 170; $p = 0.009$) and time (Omnibus $F = 0.891$; $df = 3$, 170; $p = 0.447$). There was one significant effect for treatment. Treated women (both early and delayed measures) had lower anger scores than controls ($F = 4.35$; $p = 0.038$). Between 4 month and 1 year, there was a main effect for time on several variables as indicated by a statistically significant increase in self-esteem ($F = 6.00$, $p = 0.015$) and decrease in overall emotional disturbance ($F = 18.35$, $p = 0.001$),
anxiety ($F = 8.51, p = 0.004$), depression ($F = 10.59, p = 0.001$), anger ($F = 21.48, p = 0.001$), confusion ($F = 11.87, p = 0.001$), overall impact of miscarriage ($F = 9.91, p = 0.002$), and personal significance of miscarrying ($F = 13.58, p = 0.001$).

According to the Swanson (1999), hypothesis 1 was partially supported. For those in early measurement groups, significant treatment effects were found for overall emotional disturbance, depression, and anger. Treated women had significantly lower anger scores than controls. Hypothesis 2 received substantial support as time had a significant healing effect in many instances. Hypothesis 3 could not be totally accepted because women in the delayed measures group were angrier than their counterparts and less likely to view their loss as a baby than their early measures counterparts. This research project was an attempt to translate caring into a potentially replicable therapeutic intervention.

**Selye’s Stress Theory**

The research study completed by Sluiter, van der Beek, and Frings-Dresen (2003) examined the neuroendocrine reactions experienced by emergency caregivers during emergency situations. The sample included 20 Dutch male paramedics with a mean age of 42 years ($SD = 5$) and mean job experience of 16 years ($SD = 7$). A stress protocol was developed in which the biomarker cortisol was measured in saliva at baseline at the moment of the incoming emergency call, followed by repeated sampling after delivery of the patient to the hospital, and two recovery samples were taken at 15 minutes and 30 minutes after delivery of the patient. Salivary cortisol was analyzed with a time resolved fluorescence immunoassay. Four scenarios were tested between subjects which included acute heart failure, accidents, shootings, and stabbings. The time of day was also taken into account. After testing differences in mean baseline cortisol excretion between the four described scenarios, the mean endocrine reaction per scenario was calculated and as multivariate analyses of variance was performed with cortisol excretion as dependent variables and severity and time of day as independent variables.

Overall, 54 emergency protocols were monitored, time framed, and labeled as severe or not severe. Of these, 21 protocols were interrupted and could not be included in the analysis. Of the remaining 33 protocols, 16 were categorized as not severe during the low circadian period; five as not severe during the high circadian period; seven as severe
during the high circadian period; and five as severe during the low circadian period. At baseline, no significant differences in cortisol excretion between the four scenarios were found. Both severity of patients and time of day showed significant effects in reactivity (post 0: \( p = 0.00 \) and \( p = 0.01 \), respectively) and recovery (post 15: \( p = 0.02 \) and \( p = 0.09 \), respectively; post 30: \( p = 0.07 \) and \( p = 0.01 \), respectively). The study discovered that both the severity of the patients and time of day affected the cortisol levels. No endocrine reactions were observed on average during or after non-severe emergencies regardless of the time of day (Sluiter, van der Beek, and Frings-Dresen, 2003).

**Figley’s Compassion Fatigue and Stress Model**

McNally (2004) explored the impact of compassion fatigue, compassion satisfaction, and burnout on the crisis (hostage) negotiator. The researcher administered the Compassion Satisfaction and Fatigue Self-Test for Helpers during two compassion fatigue breakout sessions conducted at the Florida Hostage Negotiation Conference in June 2003. This instrument was developed by Dr. Charles Figley and Dr. B.H. Stamm and the alpha reliabilities for this instrument are compassion satisfaction alpha = .87; burnout alpha = .90, and compassion fatigue alpha = .87. In addition to administering this test, the researcher also asked three additional questions regarding the number of years in law enforcement, the number of years spent in other professions, and the number of years as a hostage negotiator. A total of 44 tests were returned.

The demographic data of the research participants indicated that the average years of experience as a law enforcement officer was 17.3 years and as a hostage negotiator was 6.7 years. Twenty-five percent of the research participants had ten years or less of experience in law enforcement while 75% had over eleven years of experience in law enforcement. Approximately three-quarters of the participants had less than ten years of experience as a hostage negotiator while over 25% had over eleven years of experience as a hostage negotiator.

McNally (2004) also found that over 75% of the research participants had a good, high, or extremely high potential of compassion satisfaction as a hostage negotiator. The mean score of the research participants was 90.84 which was in the good potential range for compassion satisfaction. The study also found an extremely low risk for burnout among the research participants. The mean score for burnout among the research
participants was 25.68 which was in the extremely low risk range. Eighty-four percent of the research participants were in the extremely low risk range and 16% were in the moderate risk range for burnout (McNally, 2004). None of the research participants scored in the high or extremely high risk ranges for burnout. The mean score of the research participants for compassion fatigue was 24.95 which was in the extremely low risk category. In terms of compassion fatigue, seventy-eight percent of the research participants were in the low risk range, eleven percent of the research participants were in the moderate risk range, and eleven percent of the research participants were in the extremely high risk range (McNally, 2004). Those research participants that scored in the extremely high risk categories had an average of 18.6 years of experience in law enforcement and 2.3 years of experience as a hostage negotiator (McNally, 2004).

McNally (2004) concluded that the results of this study indicated an extremely low risk of burnout in the research participants which was associated with a low risk of compassion fatigue. Seventy-five percent of the research participants had compassion satisfaction with their work as a hostage negotiator (McNally, 2004). Seventy-five percent of the research participants had over 11 years of experience in law enforcement with 40% of them having over 21 years of experience which led the researcher to conclude that the more experience an officer has, the more he/she is be able to deal with the most difficult hostage/crisis situations (McNally, 2004). Applying this study’s findings to current practice in law enforcement and hostage negotiation, the researcher stated that the administration in law enforcement must be proactive and flexible when dealing with the stress the officers encounter as hostage negotiators (McNally, 2004). In addition, McNally (2004) asserted that the prevention of compassion fatigue is also the responsibility of the individual police officer who must take control of his/her own life and make positive lifestyle changes.

Summary

As was discovered in the literature review, highly stressful events affect people in a variety of ways. Some people experience no change and some develop severe psychological difficulties. Stamm (1999) argued that not all trauma workers succumb to secondary traumatic stress because the motivation of trauma workers to help is shaped, in part, by the satisfaction derived from the work of helping others. The irony remains,
though, that the compassionate act of helping people who have been traumatized can also have a detrimental effect on care providers (Figley, 1995; Rudolph, Stamm, & Stamm, 1997).

The concepts of burnout, vicarious traumatization and empathy are directly related to the concept of compassion fatigue also known as secondary traumatic stress. The effects of work-related stress on the body and mind can leave the nurse vulnerable to the development of compassion fatigue thereby hindering the nurse’s ability to care for his/her patient. In Chapter 3, a discussion of the methodology involved in discovering and exploring Emergency Department nurses’ lived experience with compassion fatigue will be developed. This discussion will include the study design, sample, instrumentation, protection of human subjects, procedure, and data analysis.
CHAPTER 3
METHODOLOGY

The purpose of this study was to understand better the occurrence of compassion fatigue in Emergency Department nurses and its relationship with work-related stress. The study further intended that knowledge concerning the incidence and prevalence of compassion fatigue and work-related stress would enable an understanding among nursing co-workers and managers and would instill a sense of hope into those Emergency Department nurses who suffer from compassion fatigue. The need for this effort arose from the influence that compassion fatigue and work-related stress have upon Emergency Department nurses as well as upon the patient, families, and staff. This chapter discusses the design, sample selection, instrumentation, protection of human subjects, procedure, and data analysis of this study.

Design

A qualitative design was used to collect descriptive data from the sample using a phenomenological approach. According to Polit and Beck (2004), the goal of most qualitative studies is to “develop a rich understanding of a phenomenon as it exists in the world and as it is constructed in the context of that world” (p. 247). Phenomenology, a type of qualitative research, attempts to “discover the meaning of a person’s lived experiences which gives meaning to each person’s perception of a particular phenomenon” (Polit & Beck, 2004, p. 253). It is felt that this type of design would best support a discovery and description of the meaning of Emergency Department nurses’ lived experience with compassion fatigue. “Phenomenologists believe that critical truths about reality are grounded in people’s lived experiences” (Polit & Beck, 2004, p. 253). Data was interpreted using Colaizzi’s (1978) method of phenomenological analysis.

Quantitative data obtained from the Compassion Satisfaction/Fatigue Self-Test for Helpers (Appendix E) completed by the research participants was used to triangulate the qualitative data obtained from the interviews. This measurement tool assessed the
participant’s compassion satisfaction as well as the participant’s risk for burnout or risk for compassion fatigue. According to Polit and Beck (2004), data triangulation involves the use of multiple data sources for the purpose of validating conclusions, which can enhance the credibility of the results obtained from the study. Triangulation also helps to capture a more complete picture of the phenomenon under study (Polit & Beck, 2004). In this study, data triangulation was used by comparing the data obtained from the Compassion Satisfaction/Fatigue Self-Test for Helpers to the data obtained from the interviews with the research participants. This non-experimental study created an emergent design allowing for adaptations and changes as perceptions and perspectives of the participants were discovered.

Sample

The target population for this study was registered nurses, advanced registered nurse practitioners (ARNP), or clinical nurse specialists (CNS) who met the following inclusion criteria: a) at least 18 years of age or older, b) currently employed as Emergency Department nurses in an urban hospital in southwest Georgia and c) interacts directly with patients and families. The hospital chosen for research participant selection is located in a city with a population of approximately 96,065 where approximately 60.1% of the residents are African-American, 37.8% are Caucasian, and 2.1% are of other ethnic or racial origin (U.S. Census Bureau, 2002). This 450-bed acute care hospital had been selected as the setting from which to recruit participants because of the large volume of patients that are seen yearly (approximately 57,000 patients per year) in the Emergency Department. It was thought that this large volume of patients would expose the Emergency Department nurses to a wide variety of work-related stressors, thus, making them susceptible to the development of compassion fatigue.

Instrumentation

According to Norwood (2000), in qualitative research, the researcher is the instrument. Qualitative research findings are considered reliable when the descriptions are so authentic that the participants recognize their experiences from the researcher’s descriptions or others recognize the experience after having only read it in a study (Norwood, 2000). Internal validity in qualitative research refers to the discovery of human phenomena as they are experienced by the study participants and the major threat
to internal validity occurs when the researcher becomes so involved with the participants’ experiences that he/she loses objectivity (Norwood, 2000). Qualitative researchers can avoid losing objectivity by monitoring their responses through techniques such as journaling or debriefing with a colleague (Norwood, 2000).

The semi-structured interview consisted of a series of open ended questions developed into an interview schedule (Appendix C) designed to elicit each Emergency Department nurse’s individual experience with compassion fatigue and work-related stress. According to Polit and Beck (2004), the researcher does not lead the interview; rather, he/she helps the participant describe lived experiences and records the participant’s responses. Because many Emergency Department nurses were not familiar with the term compassion fatigue, the researcher used several open-ended questions designed to guide the participant to share experiences related to compassion fatigue. Each interview was audiotaped and transcribed after the interview. Prior to the interview, each participant was asked to complete a researcher-developed demographic profile (Appendix D).

After the interview, each participant was asked to complete the Compassion Satisfaction/Fatigue Self-Test for Helpers developed by Dr. C. Figley and Dr. B.H. Stamm (Appendix E). The alpha reliabilities of this measurement are: potential for compassion satisfaction alpha = .87; burnout alpha = .72; and compassion fatigue alpha = .87 (Figley & Stamm, 1996). It was believed that following each interview with the completion of the Compassion Satisfaction/Fatigue Self-Test for Helpers by the research participants would allow the researcher to fully capture each research participant’s experiences with compassion fatigue and work-related stress.

Protection of Human Subjects

Approval for implementation of this study was obtained from the Florida State University’s Institutional Review Board and the hospital’s Institutional Review Board prior to initiation of data collection. Study participants were recruited through a letter that was distributed in the hospital staff mailboxes (Appendix H). The letter included contact information for the researcher such as the researcher’s phone number and e-mail address as well as the phone number and e-mail address of this study’s chairperson and the phone number of Florida State University’s Institutional Review Board. It was then
each Emergency Department nurse’s choice to contact the researcher if he/she was interested in participating in this study. No monetary rewards were offered for participation in this study.

An informed consent letter (Appendix F) was developed which was signed by each participant prior to the commencement of the interview. The letter also stated that participation was voluntary and that the participant could withdraw at any time during the study. The participant was made aware of any potential risks involved in this study including fear and apprehension over recalling and describing one’s experiences with uncomfortable and/or stressful events. If this did occur, the participant was referred to a psychologist associated with the hospital’s Employee Assistance Program with whom prior arrangements were made at no cost to the study participants. Potential benefits of participation in this study included self-awareness and an opportunity to help other nurses suffering from compassion fatigue through the sharing of experiences. The participant was also made aware that his/her identity would remain confidential to the extent allowed by law. Data collected in this study is stored in a locked filing cabinet in the researcher’s home. The audiotapes, transcribed documents, and other associated information will be destroyed on December 31, 2009.

Procedure

This study involved the recruitment of nurses employed in the Emergency Department to participate in a research study that would allow an articulation of their feelings and experiences with compassion fatigue and work-related stress.

Once the hospital’s Institutional Review Board agreed to allow the study to move forward, a letter (Appendix G) was sent to the Emergency Department director explaining the purpose of the study as well as the desire to select participants for this study. After establishing a mutually agreed upon date with the Emergency Department director, the researcher presented a letter to the director that was to be distributed to all Emergency Department nurses within the hospital in their staff mailboxes requesting participants for this study (Appendix H). It was believed a scripted request would limit any inconsistencies that could be created by the researcher’s impromptu presentation to spontaneously formed groups of Emergency Department nurses.
As soon as the potential participant contacted the researcher by phone or e-mail, the researcher reviewed the letter of informed consent (Appendix F) with the participant which was also given to the participant to sign prior to the interview. The researcher explained the purpose of the study along with stressing the protection of the participant’s identity. This confidentiality allowed candid expression of each participant’s experience with compassion fatigue and work-related stress. The researcher also explained the estimated length of time for the interview (approximately 30 minutes), the estimated length of time for completing the demographic profile (approximately 10 minutes), and the estimated length of time for completing the Compassion Satisfaction/Fatigue Self-Test for Helpers (approximately 15 minutes). The researcher also explained that the interview would be audiotaped and transcribed. Only interviews that were audiotaped were used for this study. The researcher also explained that the participant could withdraw from the study at any time. If the potential participant was still agreeable to participation, then a mutually agreed upon time and date was scheduled for a face-to-face interview. Each interview occurred in a private office in the hospital to which no one had access during the interview. The location was pre-arranged by the researcher.

At the beginning of the interview, any questions about the informed consent letter (Appendix F) were addressed. Potential benefits and risks were explained to the participant. Contact information for a psychologist within the hospital’s Employee Assistance Program was also given to the participant if any anxiety occurred during the interview as a result of recalling one’s experiences with uncomfortable and/or stressful events. The researcher also explained that a second and third meeting with each participant will follow the initial interview so as to allow clarification and understanding of each participant’s interview. Each subsequent meeting occurred in a private office in the hospital to which no one had access during the interview. The location was pre-arranged by the researcher.

Participation in this study was strictly voluntary. The identities of all participants remained confidential, to the extent allowed by law, so that each participant had the opportunity to discuss openly his/her experience with uncomfortable and/or stressful events without fear of repercussion from the hospital administration especially if the participant’s feelings toward the events were harsh.
The audiotapes, transcribed documents, and the completed questionnaires will remain in the researcher’s possession for a period of 5 years after the interview and are located in a locked filing cabinet in the researcher’s home to which only the researcher and the thesis committee chairperson have access. Only the researcher and the researcher’s thesis committee members had access to the information contained in the transcribed interviews. The audiotapes, transcribed documents, and the completed questionnaires will be destroyed on December 31, 2009.

Data Analysis

The data collected were examined utilizing Colaizzi’s method of phenomenological analysis. This method of analysis required the researcher to engage in active listening, reflection, clarification, and intuiting during the interview process. The framework for data analysis described by Colaizzi (1978) included seven stages. First, the transcripts were read to relive the experience of the interviews and then the transcripts were re-read in conjunction with the taped interviews to enable understanding of the meaning of the experience as a whole for each participant. Stage two involved manually extracting significant statements that directly pertained to the phenomena being studied. Stage three involved the formation of meanings from the phrases by placing similar phrases into piles to create understanding and identify themes. This stage used the phenomenological process of intuiting to identify the meaning behind the participant’s words. The fourth stage involved organizing the themes into clusters. Once the clusters were formed, the researcher met with each participant for validation. The sixth step involved exhaustive descriptive writing which was designed to capture the experience of the phenomenon as it presented itself to the participants. Once the writing was completed, the researcher moved into the final step - returned to each participant again for validation. Once the validation process was completed with the participants, the researcher met with the committee chairperson to review the completed process to ensure that saturation of data had been achieved.

Quantitative data was also obtained so that triangulation of data was utilized. Descriptive statistics were used to synthesize and describe data pertaining to the research participants. This data was obtained from the researcher developed demographic profile (Appendix D) as well as the Compassion Satisfaction/Fatigue Self-Test for Helpers
(Appendix E). Averages and percentages were used to describe the characteristics of the sample under investigation as well as the scores on the Compassion Satisfaction/Fatigue Self-Test for Helpers. The scores obtained were compared the themes resulting from the interviews in order to capture a more complete picture of the Emergency Department nurses’ lived experience with compassion fatigue.

Summary

This qualitative descriptive study examined the occurrence of compassion fatigue in Emergency Department nurses and its relationship with work-related stress. A phenomenological approach was used in investigating its occurrence in an attempt to discover and describe the meaning of Emergency Department nurses’ lived experience with compassion fatigue. A discussion of the themes resulting from the interviews as well as the development of any theories emerging from these themes will follow in Chapter 4.
CHAPTER 4
RESULTS

This study investigated the lived experience of Emergency Department nurses with compassion fatigue within a population of southwest Georgia Emergency Department nurses. A qualitative design with a phenomenological approach was used in order to discover and describe the phenomenon of compassion fatigue as it existed and was felt by Emergency Department nurses. This study was guided by Watson’s Theory of Human Caring (1985) and Selye’s Stress Theory (1956). Figley’s Compassion Stress and Fatigue Model (1995) was also integrated into this study in order to provide additional support to the guiding conceptual framework.

This chapter addresses the themes discovered from the interviews with a group of Emergency Department nurses in southwest Georgia. Quantitative data from Figley’s Compassion Satisfaction/Fatigue Self-Test for Helpers was used to triangulate the data in order to validate the conclusions obtained from this study.

Description of the Sample

The sample was obtained from one urban hospital in southwest Georgia. A total of 46 registered nurses were available with 18 registered nurses agreeing to participate. These registered nurses met the following inclusion criteria: a) at least 18 years of age or older, b) currently employed as Emergency Department nurses in an urban hospital in southwest Georgia, and c) interacts directly with patients and families. The research participants completed an audiotaped interview (Appendix C) in addition to completing the researcher-developed demographic profile (Appendix D) and Figley’s Compassion Satisfaction/Fatigue Self-Test for Helpers (Appendix E).

The sample consisted of registered nurses ranging in ages from 26 to 49, with a mean age of 35.9. Table 4.1 displays the description of the sample for this study. Eleven percent ($n = 2$) of the participants were male and 89% ($n = 16$) were female. Ninety-four percent ($n = 17$) were Caucasian and six percent ($n = 1$) were Hispanic. Fifty
<table>
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<tr>
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<tr>
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<td>2</td>
<td>11%</td>
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percent ($n = 9$) were married, $28\%$ ($n = 5$) were divorced, $11\%$ ($n = 2$) were single, and $11\%$ ($n = 2$) were separated from their spouses. Six percent ($n = 1$) had four children living at home, $45\%$ ($n = 8$) had three children living at home, $27\%$ ($n = 5$) had two children living at home, $11\%$ ($n = 2$) had one child living at home, and $11\%$ ($n = 2$) had no children.

Sixty-one percent ($n = 11$) had received an associate’s degree in nursing, $22\%$ ($n = 4$) had received a bachelor’s degree in nursing, and $17\%$ ($n = 3$) had received a master’s degree in nursing. Only six percent ($n = 1$) had achieved the Certification in Emergency Nursing (CEN).

Twenty-eight percent ($n = 5$) earned a yearly income of over $70,000$, $39\%$ ($n = 7$) earned a yearly income of $56,000$ to $70,000$, $22\%$ ($n = 4$) earned a yearly income of $41,000$ to $55,000$, and $11\%$ ($n = 2$) earned a yearly income of $25,000$ to $40,000$.

The number of years of experience as a registered nurse ranged from two years to 30 years with the mean number of years of experience as a registered nurse of 11 years.
The number of years of worked in the Emergency Department ranged from two years to 25 years with the mean number of years worked in the Emergency Department of seven years. The number of years worked at the current facility in the Emergency Department ranged from two years to 15 years with the mean number of years worked at the current facility in the Emergency Department of six years.

Seventy-four percent \((n = 13)\) were employed full time at the current facility and 26% \((n = 5)\) were employed on an as needed basis. Fifty percent \((n = 9)\) worked day shift \((7\text{ am to }7\text{ pm})\), 28% \((n = 5)\) worked night shift \((7\text{ pm to }7\text{ am})\), and 22% \((n = 4)\) worked variable hours to include both day and night hours. The mean number of hours worked per week was 37 hours. Sixty-one percent \((n = 11)\) did not work in another facility and 39% \((n = 7)\) worked in another facility in addition to working in the current facility. Other areas/facilities worked included hospice, other emergency departments, forensic nursing, emergency medical services, long term care, and undergraduate nursing education.

**Research Question One**

Research question one inquired about the nature of Emergency Department nurses’ lived experience with compassion fatigue and work-related stress. The interview questions (Appendix C) were designed to elicit descriptions from the research participants about their experiences with compassion fatigue and work-related stress. Specifically, interview questions one through five and seven through nine were used to guide the research participants in their descriptions since many Emergency Department nurses were not familiar with the term compassion fatigue. Several themes emerged from these interviews relating to the various facets of the research participants’ experiences with compassion fatigue and work-related stress. These facets will be described in separate sections.

*Definition of work-related stressor*

In their discussion of the definition of a work-related stressor, the research participants’ descriptions centered around four themes: loss of control, feeling overpowered, frustration, and the negative environment.

*Loss of control.* The theme of loss of control was echoed by many of the research participants. Loss of control occurs when something does not go as planned or when the
work environment becomes so overwhelming that one cannot handle the demands placed upon oneself. The setting within which Emergency Department nurses work is fast-paced and hectic and is often described as “organized chaos”. Therefore, it is essential that these nurses maintain a sense of order in terms of what is happening around them so that they are able to provide safe, therapeutic care to their patients while still maintaining their own ability to think clearly and act quickly. Several research participants attributed the loss of control to outside issues over which they had no power to manage and, as a result, were unable to meet goals that they had established for their patients.

I think most work-related stressors are when you don’t have control over situations. There is something that you want to do but you can’t for whatever reason be it family or you can’t get a hold of a physician - there are external factors that make it difficult.

Feelings of pressure and helplessness were described as the consequences of the loss of control. Others described feeling as if they could not handle the demands placed upon them which resulted in feeling out of balance with the environment. The inability to spend an adequate amount of time with each patient due to the heavy patient volume and increased patient acuity also resulted in feelings of loss of control.

I’m stressed all the time when I get here. My thing is not having enough time to spend with each patient. I think that is what gets me. And then when I get home, it’s like, “Did I do right by that patient?” It may be one particular patient that was sick and it just spins off for the rest of the day.

Because of the challenging environment in which they work, Emergency Department nurses must be able to handle skillfully multiple demanding situations simultaneously. However, feeling as if one has lost control often results in one doubting his/her abilities. Several research participants explained that the loss of control affected not only how they felt about themselves but also how they felt about the care they provided to their patients. Many worried that the care they provided when they felt as if they had lost control was less than adequate and they feared that the patients would suffer as a result. Others stated that they felt angry with themselves and sometimes blamed themselves when they could not handle multiple demanding situations because these
situations often interfered with patient care delivery, potentially causing adverse patient outcomes.

*Feeling overpowered.* This theme was also described by many of the research participants as they explained their encounters with work-related stressors. Feeling overpowered occurs when the amount of work to be done is too overwhelming to accomplish. During any given shift, Emergency Department nurses encounter a multitude of patient problems ranging from minor injuries and illnesses to severe traumatic injuries and complex illnesses encompassing several body systems. These nurses must be skillful at recognizing life-threatening problems and prioritizing the urgency of care. Emergency Department nurses must be efficient in their patient care delivery; otherwise, the amount of work to be done can become overwhelming. Many described the workload in the Emergency Department as insurmountable due to the large volume of patients, increased patient acuity, and lack of staff to help in caring for the patients.

A work-related stressor is a moment in time or several moments in time when you are stretched thin. You have more than one thing that needs to be done right at that moment and you are not capable of doing that. It’s the pressure that you feel at that one moment when you can’t do everything that you need to do and you either have too many patients and too many things to get done or not enough help.

Several research participants voiced concern over the lack of time available to care for their patients. Many stated that they felt as if they were cheating the patients out of quality nursing care simply because the volume of patients kept them from spending the time they felt was necessary to provide therapeutic nursing care. The acuity of the patients was also a concern since higher acuity patients require more of the nurse’s time for patient care which then takes away time from the other patients who also need care. The lack of skilled nursing staff available to help with patient care also contributed to feeling overpowered since many of the research participants stated that they relied on their co-workers to assist them in patient care delivery.

*Frustration.* Frustration was also discovered as a common theme in defining a work-related stressor. Frustration resulted when the research participants felt that they
could not be in all places at one time due to the volume of tasks that had to be accomplished. One research participant explained that the excessive workload in the Emergency Department caused by increased patient volume and acuity and lack of nursing staff made her feel as if “there is too little you to fill all of the gaps.” Feelings of anxiety and anger were often described as the consequences of the experience with frustration. Frustration also resulted in the research participants feeling incapable of providing therapeutic care to their patients. Some even explained that they also became irritated with their patients as a result of their own frustration.

A work-related stressor is anything that gets me flustered or makes me have a negative attitude towards all the people – all my patients. It doesn’t matter if someone’s real sweet and they’ve come in and asked for, you know, some ice water. And I’m just like “I don’t have time to get it right now.” And when I feel like I am not able to do my job because I am just flustered.

Several research participants explained that difficult patients and families also contributed to feelings of frustration. While these nurses wanted to provide care to these patients, the negative attitude of these patients led the nurses to feel unappreciated in their capacity to provide care. Frustration resulted because these difficult patients were not only demanding the nurses’ time and attention but were also taking time away from other patients that the nurses felt could have benefited more from their time and nursing care.

You try to help folks and you get cussed at and things thrown at you. They are demanding. And I guess the high level of frustration for me comes from the fact that people who seem to be the most demanding are those that there is the least wrong with medically. And they are the ones that are wanting all the time, wanting all the attention. Yet, you have somebody else here in another bed that is genuinely sick and you know that you need to be spending more time with him but you can’t because you are dealing with this one over here who is doing all the squalling.

Several research participants stated that physicians are just as demanding of the nurses’ time adding to their already overwhelming workload and increasing their feelings of frustration.

I feel sometimes the doctors don’t realize when they
come to us with an order that I’ve got their patient but I’ve got other patients too. And they want to know why I didn’t recheck this blood pressure. I am trying, I am getting there, bear with me. I know I gave this guy Clonidine and his blood pressure needs to be rechecked but this one over here doesn’t have a blood pressure – she’s having a heart attack. The doctors need to understand that we’re taking care of their patients but there may be another doctor there that may have a patient too that we are taking care of.

The frustration that the research participants experienced was rooted in their heavy workload as a result of increased patient volume and acuity due to overcrowding in the Emergency Department. These nurses explained that while they worked diligently in providing therapeutic patient care, the demands placed upon them by the work environment often impeded their efforts of which the end result was anger, irritation, and exasperation.

**Negative environment.** With this group of research participants, the environment within the Emergency Department played a substantial role in defining a work-related stressor. Because the setting of the Emergency Department is chaotic and frenzied due to the large volume of patients with health care problems varying in complexity that present seeking care, many of the research participants described this environment as negative. In relation to the work environment, the research participants defined a work-related stressor as anything in the work environment that causes stress to the individual or anything that one encounters during the work period that causes stress. Many research participants explained that the work environment in the Emergency Department is frightening and can evoke feelings of apprehension.

It can be very intimidating. I started here as a brand new nurse and I prayed for six months on the way to work, “God, please don’t let anybody die in my zone today.” It’s intimidating and scary in an environment like this because it’s fast-paced and high stress. You’ve got so many things happening at one time and you have to learn to prioritize quick.

Many of the research participants echoed the distress they endured related to the large volume of patients that they treated daily which increased their work-related stress.
Emergency Departments are required by law to treat all who present seeking healthcare; therefore, all patients presenting to the Emergency Department must be treated whether there is space available for them or not. One research participant explained that the Emergency Department never closes its doors regardless if maximum capacity has been reached – space must be found to treat the patients which often resulted in caring for patients in less than desirable conditions.

You are never full. Like when you work on the floor, you only have so many beds and when those are full, you don’t get to take anymore. In the ER, they never stop coming. It is a continuous influx of patients.

The consequences of the tremendous workload that these nurses endured were described as both physical and mental stress. Physically, the nurses described feeling fatigued, exhausted, and worn out as a result of dealing with the workload. Mentally, the nurses described feeling aggravated and upset because they were physically unable to meet the needs of all of the patients simply because the volume of patients was too great. Because of the large volume of patients, several nurses were fearful that they might fail to notice a critical piece of information that could make a difference in the patient’s outcome.

You can’t meet everybody’s needs 100% and there’s times when you’re like “Oh, maybe I should have done something different.” Especially under stressful times when you have those feelings come up and that’s bothersome to me and in those times too is when you are afraid you are going to miss something.

Because the work environment was described as dangerous and unsafe due to the heavy volume of patients, increased patient acuity, and lack of nursing staff, the research participants feared not only for their patients’ safety but also for their own well-being. This fear coupled with their daily encounters with the negative work environment added tremendously to their feelings of work-related stress.

Work-related stressors encountered

In their discussion of work-related stressors encountered, the research participants’ descriptions centered around two themes: workload and lack of support.
Workload. All of the research participants lamented over the tremendous workload that they encountered on a regular basis and voiced their fears over being unable to keep up with the hectic pace of the Emergency Department as a result of the increased patient volume and acuity as well as the lack of skilled nursing staff. The shortage of nurses available to assist with patient care figured prominently in increasing the research participants’ perception of the overwhelming workload that they faced which in turn affected their perception of their patient care delivery.

I feel like that the patient load is so big that you cannot spend a lot of time with your patients and then they are out the door and you feel like you should have done something different. I don’t feel like I am doing everything I can do as a nurse.

Because of their huge workload, Emergency Department nurses must skilled in multi-tasking. These nurses must be able to move quickly and efficiently from one task to another while simultaneously juggling other tasks in order to complete their work as well as to ensure the safety and well-being of their patients. Multi-tasking can become overwhelming especially if the volume of patients is enormous and the number of very ill patients is high. The task of assessing and sorting patients based on their severity of illness can become very daunting especially if one must assess a large number of very sick patients. The nurse can quickly become inundated and swamped by this enormous responsibility.

When you are in triage and you are so backed up and there are some really, really, sick people out there and there’s nothing else you can do. I find myself trying to make a decision between making them a (triage level) 2 or 3 depending on how backed up it is. I shouldn’t be doing that but I find myself doing that. Whoever is the sickest out there has got to come back. And if I am busy, I feel like I may miss something, forget to draw the second level of something or the patients aren’t getting the care that they should.

Several research participants expressed their trepidation in being able to manage their workload while still being able to maintain their own sanity. One research participant stated that the huge workload she has encountered regularly has often brought
her to tears. Many voiced their fears in being able to sustain sound nursing judgment in
the face of the massive workload with which they must confront day after day.

*Lack of support.* The lack of support from management, hospital nursing staff,
and co-workers was a common theme repeated by many of the research participants. It is
imperative that all members of the hospital staff work in conjunction with one another in
order to promote the health, safety, and well-being of the patients. Several research
participants explained that many other nursing areas within the hospital do not support
the work of the Emergency Department nurses. One research participant stated that many
other areas of the hospital do not carry their portion of the workload which then increases
the workload in the Emergency Department. In addition it was explained that several
nursing floors are slow to give room assignments to admitted patients as well as to take
report on these patients. As a result, the patient flow through the Emergency Department
slows down as the patients become enmeshed in the quagmire of the system. Because
these patients cannot be moved quickly out of the Emergency Department, other patients
waiting to be treated cannot be cared for in a timely manner. This further contributes to
the increased workload of the Emergency Department nurses as well as overcrowding
within the Emergency Department.

Many research participants felt that they were not supported by the management
staff of the Emergency Department explaining that “management doesn’t understand
what it’s like to be on the floor.” One research participant thought that the management
staff is not “in touch with what is going on, how we feel, or what we are up against.”
Many believed that the cohesiveness of the Emergency Department staff was undermined
by this lack of support from the management staff which affected staff morale as well as
patient care delivery. The feelings expressed by many of the research participants were
often angry and harsh.

The people that run this place think they know but they
don’t. And I think if they would come and see, it might
open their eyes to see how we struggle at night because
we’re short (staffed) or when you come on at 7 am and
there’s not enough nurses, you know, to take the shift
or run the zones at 7 am ‘cause they (management)
don’t get here until 8:30 am. I think they need to see
what everybody goes through.
Several of the research participants stated that they depend upon their co-workers to not only help with patient care delivery but also to boost morale through positive attitudes. One research participant explained that teamwork is essential in order to combat the large volume of work that they experience daily. Those co-workers who do not complete their share of the workload unwittingly add to the workload of others which has led to feelings of anger and hostility. Others explained that support from co-workers is also important in diffusing the stress one encounters from interaction with the work environment. One researcher participant explained that pessimism from co-workers breeds more pessimism; thereby creating an unfriendly and aggressive atmosphere which has often affected patient care delivery.

Negativity from co-workers. You know you walk in and you are happy and it’s like you hit a wall with someone who is already making bad comments about how their work day is going to go.

Support in the work environment from management, other hospital staff, and co-workers is necessary in order to ensure quality patient care delivery as well as to ensure the mental and physical well-being of the nursing staff. Several research participants felt that the lack of support caused them to question the usefulness of their efforts in caring for patients.

Coping with work-related stressors

In their discussion of measures used to cope with work-related stressors, the research participants’ descriptions focused on three themes: interaction with support systems, perseverance, and internal controlling measures.

Interaction with support systems. Dealing with work-related stressors using external coping measures was very common among the research participants. All of the research participants described talking over their fears, frustration, and anger with someone else as a way of coping with the stressors that they faced on a daily basis. Many stated that sharing their feelings with co-workers allowed them to express their thoughts as a way of diffusing the irritation that occurred when they felt overwhelmed by their work environment. Many research participants also explained that expressing themselves at work allowed them to “let off steam” giving them an outlet to release the emotions associated with feeling weighed down by the tremendous workload and feeling
ineffective and incompetent in providing therapeutic nursing care because of the large volume of patients and lack of skilled nursing staff. Letting go of their feelings allowed many of the research participants to refocus and regroup enabling them to recharge and to move on to the next patient care task without any residual effects. One research participant explained that being unable to release her feelings affected the care delivered after the stressful encounter.

I vent. A lot. Venting seems to work best. When it’s all over with, if I can vent, then I can seem to let go of it. If I don’t get to vent, then I hold on to it and it ruins the rest of my night even if the stressful part of the moment is over with.

While many of the research participants chose to talk things over with co-workers, others stated that they also shared their feelings with close family members and friends. However, several research participants stated that they did not want to bring home their feelings that resulted from encounters with work-related stressors. These research participants further explained that they did not want their stressful work environment to have an impact upon their family life. Several research participants stated that they have been successful at being able to “leave work at work” while others stated that they occasionally needed additional coping measures especially after a particularly stressful work day.

A 45 minute drive home gives you time to wind down and you can kind of recap the night’s events and discuss what could have been better or what could have been prevented. And that helps me a lot to just kind of vent my anger and my frustrations of the night’s events. I try to have all of that cleared up by the time I get home.

For other research participants, simply going home and seeing their own children was a way to “melt away” the negative feelings that had accumulated during the work day. For many, going home after a remarkably stressful work day was a way to recharge and refuel in preparation for their future subsequent encounters with work-related stressors.

Perseverance. The ability to persist or to persevere was another coping measure employed by these research participants when confronting work-related stressors. While
many of the research participants preferred to talk things over with co-workers, close friends, or family members, sometimes doing this was not feasible especially if the workload was particularly heavy or the work environment was very chaotic. In these situations, many of the research participants chose to hunker down, push through, and persist with their care giving efforts. One research participant explained that when faced with a situation in which she cannot share her feelings with her co-workers, she “takes a deep breath and keeps going.” Another stated that she “tries to keep a steady pace and keep at it.” When faced with a heavy workload and no other way in which to deal with the stress that it evoked, others turned inward and relied upon themselves to keep a positive outlook.

I think to myself that tomorrow is another day and that’s just the way things are around here. I have to just try to get through it the best way I can.

Other research participants used a rational approach when confronting work-related stressors which involved stopping for a moment and surveying the entire situation. This pause allowed these research participants to take a moment to think about the situation at hand and also served as a calming measure giving them the strength to momentarily overcome the disorder and confusion evident in the work environment.

Just stepping back and realizing I am not but just one person, I am not but just one nurse, and you do all you can do for that patient at that minute.

Using this technique also enabled the research participants to accept the fact that they could not do “everything for everybody.” They also realized that what they were accomplishing was worthwhile despite the pandemonium that surrounded them.

Internal controlling measures. Another coping technique described by the research participants was to deal with the work-related stressors alone. Many of the research participants described activities in which they engaged either at work or outside work that enabled them to deal with the pressure and frustration that resulted from encountering work-related stress. The activities engaged in at work allowed the research participants to remove themselves from the stressful situation. These activities include going to the hospital gift shop, going to the cafeteria for a snack or drink, or going outside to smoke a cigarette. This break from the work environment allowed the research
participants to think about and process what they had just endured and to refresh themselves psychologically so that they could come back ready to face new challenges.

Sometimes you just have to go to the bathroom and sit for a few minutes and hope that nobody is banging on the door or paging you. Or just leave the floor for a few minutes and come back and you know you are mentally equipped to finish the challenge.

Activities engaged in away from the work environment encompassed both physical and mental activities. The physical activities engaged in included exercising at the gym, bike riding, and horse back riding. The mental activities engaged in included relaxing with friends, reading non-work related material, taking a relaxing bath, and sitting alone contemplating life and one’s place in it. One research participant stated that while sitting alone and thinking after a very stressful shift, she often told herself that she must continue with her work for the sake of her family. She was giving herself a mental pep talk in order to revive her worn out spirit.

Realizing that if I don’t do this job and I don’t stay with it, then I won’t have my house. I guess a way to cope is to realize that this is just a job and you gotta do what you gotta do sometimes.

The use of internal controlling measures by the research participants was constant throughout the work day and continued after leaving the work environment. Several research participants stated that their continuous efforts to internally control their reactions to work-related stressors allowed them to navigate their frequent encounters with work stress.

**Final result after coping with work-related stressors**

In their discussion of how they felt after coping with work-related stressors, the research participants’ descriptions focused on three themes: exhaustion, feeling abandoned, and a sense of accomplishment.

**Exhaustion.** After coping with work-related stressors, many of the research participants described feeling exhausted, tired, and fatigued. Many described feeling not only physically exhausted but also mentally exhausted as well. One research participant commented that this mental exhaustion was often tremendous due to the continuous use of coping mechanisms throughout the shift in order to deal with numerous work-related
stressors encountered. Frequently, this exhaustion led many of the research participants to question whether or not they could continue with their care giving efforts.

After a particularly busy shift I have felt dang near dead. I am exhausted, tired, and fatigued. There have been some nights where after I have worked all night and went home in the morning, I thought “I just can’t go back to that place.”

Occasionally, the negative atmosphere created by the work-related stressors caused feelings of increased fatigue among the research participants in comparison to the amount of work that had been accomplished by the caregivers. Several of the research participants stated that although performing patient care can be tiring, the tone of the encounters with patients, family members, and hospital staff can amplify the exhaustion felt at the end of the shift.

I feel more tired out of proportion to the work that I have done if it has been a really bad day. I feel particularly exhausted if I have had numerous negative encounters be it staff members or patients.

While many of the research participants described feeling exhausted because of the huge workload, several stated that they have often worked through their exhaustion in order to provide care to those they felt really needed their attention and nursing expertise.

Feeling abandoned. Feeling abandoned or alone was also described by the research participants as a common theme of how they felt after coping with work-related stressors. Words such as alone, neglected, and dumped were used by the research participants in describing their experiences with abandonment.

Sometimes it feels like you are in it all by yourself and you are trying to wade through mud – sinking fast.

Many of the research participants explained that teamwork is often essential in order to handle the huge workload and to accomplish the goal of providing safe, therapeutic nursing care. However, several of the research participants stated that there had been times when other nurses were not available to assist them with patient care because these nurses were just as busy trying to take care of their own patients. One research participant described feeling overwhelmed during a busy shift because of the large number of patient care tasks she faced in addition to the fact that there was no one
else to help her accomplish her tasks. She stated that she felt abandoned because she thought that the management staff had let her down because there were not enough nurses to cover the shift that day. Feeling abandoned also figured prominently with feeling a lack of support from management and other hospital staff.

A lot of times it feels like you have nobody on your side. Nobody going to bat for you trying to get the patients out of the department onto the floors or wherever.

Several research participants stated that when teamwork was present within the Emergency Department, they did not feel alone but felt supported despite the heavy workload.

Sense of accomplishment. Feeling a sense of accomplishment in terms of one’s care giving efforts was another theme described by the research participants. Several research participants explained that feeling a sense of accomplishment is important in maintaining one’s well-being because it makes one feel valued for his/her abilities in addition to feeling satisfied that he/she was able to help others through his/her actions. Despite the vast number of work-related stressors encountered, many of the research participants stated that they still felt a sense of accomplishment at the end of the shift because they were able to provide care to those who needed it. One research participant explained that she usually felt good about how her shift had gone even though she was exhausted when her shift was over. For others, simply surviving the stress-filled shift resulted in a sense of accomplishment.

If I have done well with coping with the stressors, then I feel a satisfaction at the end of the day that yes, it was a very busy day but I held my own, I did a good job at taking care of the patients that I had and I did all that I could do. I feel like I get some fulfillment out of that. It’s the feeling of satisfaction you get surviving that stress. It’s like going to war and making it home. It’s feeling like you have accomplished what you came to do and, yes, it kicked your butt, but you did a fine job when you were done.

Often, this sense of accomplishment comes from within. According to several research participants, patients treated in the Emergency Department rarely give thanks for the care that has been given to them; however, one is usually able to see if their actions
have made a difference by witnessing an improvement in the patient’s condition. Knowing that one has made a difference also resulted in feeling a sense of accomplishment. Another research participant explained that knowing one did the best he/she could under the circumstances using the resources available also resulted in feeling a sense of accomplishment.

I go away from the shift feeling pretty good that I did the best job that I could with what I had to work with. Sometimes I come away thinking “Thank God, nobody died.”

Recognizing that a patient benefited from one’s nursing care led to feelings of usefulness and competence among the research participants adding to their sense of accomplishment. One research participant added that knowing that the care she provided to her patients was beneficial made enduring the work-related stressors worthwhile. Another research participant explained that having a sense of accomplishment increases one’s self-esteem in addition to making one feel that they have a purpose in helping others.

Most fulfilling features of work as an Emergency Department nurse

In their discussion of what is most fulfilling in their work as an Emergency Department nurse, the research participants’ discussion centered around two themes: helping others and a sense of accomplishment.

Helping others. The ability to help others in their time of need is the essence of nursing. Many of the research participants stated that being able to help others in their greatest time of need is what drew them into emergency nursing. Many also derived pleasure from knowing that their actions made a positive difference in patient outcomes. Saving lives was a common denominator voiced by many of the research participants.

Knowing that the measures I took or the medicines that I gave or assisted in or the chest compressions that I assisted with were beneficial to the individual. Knowing that something I picked up in triage or in my assessment that the doctor may not have picked up on, you know, saved somebody’s life.

Emergency nurses must be adept at picking up subtle cues during their patient assessment in order to deliver effective care pertinent to the patient’s condition and to
avoid potential adverse outcomes. One research participant explained that this ability has allowed her to intervene and help patients avoid possible unfavorable results.

I was at the nurses’ station one night and I saw a guy walk through that had the classic look of an MI. He went into one of the rooms. I was in there immediately and started an IV on him. I called for some help. The doctor walked into the room. About that time, we laid him down and the guy went out. He went into cardiac arrest. And a five minute delay – if he had been sitting at a red light or waited five more minutes at home – the delay would have made all of the difference in the man’s life. He ended up, when he left the ER, he was sitting up and talking. He had gone into cardiac arrest like 20 times or something and we ended up shocking him each time. He is alive and he has been back to visit us numerous times to thank us. I mean we really made a difference in that guy’s life. That’s the most fulfilling thing. Ending the shift feeling that you really made a difference in somebody’s life and you really did something that was worth while. You had some reason for being there that day.

Another research participant explained that knowing that one has made a difference in someone’s life, even if it was only one patient during a particular shift, makes coming to work worthwhile.

*Sense of accomplishment.* The theme of sense of accomplishment is closely related to the theme of helping others. Many research participants explained that by helping others and knowing that their nursing care was beneficial to the patient resulted in feeling a sense of accomplishment. Providing comfort to patients was also crucial in feeling a sense of accomplishment as a result of one’s work.

To me it’s not just the patients that you save but it’s also the patients that you can be there to comfort. One time I had a guy that came it who was a Hospice patient. I knew that he was going to die during that shift. I really tried to go above and beyond with the family. And that was meaningful to me because when their daddy passed away, the family came to me as a whole and thanked me for being there and thanked me for
trying to make them feel comfortable. I went above and beyond trying to make his dying experience as comfortable as if he were upstairs in a (hospital) room or at home.

The setting of the Emergency Department often gives rise to many exciting and thrilling moments due to the large volume of acutely ill patients that present seeking care. One research participant explained that the adrenaline rush she received by saving lives gave her a sense of accomplishment.

It’s the people that come in like asthma. It’s not a resuscitation but they are struggling and you keep them from being just an asthma in room six to a resuscitation. To improve their status, to see the improvement, and to get thanks from them. Even if they don’t thank you, you can tell by looking at them that they are better. That’s rewarding.

For most of the research participants, feeling as if one had done something worthwhile, made a difference in some way in the patient’s life, and established a healing relationship with the patient led to a sense of accomplishment.

Research Question Two

Research question two inquired how the Emergency Department nurse’s experience with compassion fatigue and work-related stress affected one’s ability to care for the patient. Interview question number six (Appendix C) was designed to elicit descriptions from the research participants in terms of how their experiences with compassion fatigue and work-related stress have influenced the care that they provided to their patients. Three themes emerged from this discussion: Anger, not caring, and lack of time. Each theme will be discussed in a separate section.

Anger

Feelings of anger were very common among the research participants as they described the care that they gave when confronted with numerous work-related stressors. Several research participants spoke of feeling angry as a result of their experiences with the large patient volume and lack of nursing staff. They felt overwhelmed and abandoned and, as a result, became angry at the work environment. A few of the research participants were able to recognize their feelings of anger and used coping
techniques in which to deal with these feelings so that these feelings of anger were not
projected onto the patient. However, many of the research participants occasionally
allowed their feelings of anger and hostility to interfere with the care that they provided
to the patients.

At times, it makes you very angry, very hostile,
especially on a very stressful night – you may
catch yourself not being as caring, friendly, or
nice as you would have been if it had been a
different circumstance.

Many of the research participants described feeling more short-tempered and less
tolerant toward their patients as a result of the stressors encountered in the work
environment. One research participant described feeling hostile toward the patients
simply because they had come to the Emergency Department seeking care. This research
participant explained that this was a direct result of her experience with work-related
stress and her inability to cope with it.

Sometimes it gets so busy that I don’t have the
time to take a moment to calm myself and when
I go to the next patient I feel like I get mad at them
for being sick, for being there. It doesn’t matter to
me why they are here – the stress has gotten to me.

Still others described feeling angry because the patients did not appreciate the
care that was being provided to them. Several explained that it was very difficult for
them to provide compassionate care to those patients who were hostile and ungrateful
toward them. A number of research participants stated that they often became annoyed
with these patients.

I get angry because they don’t see the big picture –
they don’t realize how much we are doing trying to
take care of them – they are nitpicking and it is very
frustrating to me.

Feelings of anger, irritation, and resentment were frequent descriptions expressed
by the research participants as they illustrated the relationship between the patient care
provided and their encounters with work-related stressors. However, many of the
research participants explained that the amount of work stress was directly associated
with the feelings of anger displayed toward the patients. If the research participants had a
very stressful shift, then they had more unpleasant interactions with their patients. On the other hand, if the shift was perceived as not very stressful, then the patient interactions were more therapeutic.

_Not caring_

Lack of caring actions was another common theme expressed by the research participants as they described their patient interactions when facing a magnitude of work-related stressors. Generally speaking, these research participants offered kind, gentle, and considerate nursing care to their patients. However, these research participants described feeling calloused, cold, and uncaring toward patients when under pressure from numerous work-related stressors. Several research participants explained that their perception of the legitimacy of the patient’s reason for seeking health care often influenced their feelings. Many of these research participants stated that if they thought the patient’s reason for seeking health care was not emergent, or if they felt that the patient was manipulating or using the system, they became indifferent toward the patient and delivered care that was less than compassionate because many felt that this was a waste of their time which could have been better used to help someone else who was truly in need.

It kind of calluses me. I think it’s stressful sometimes knowing that you have clinic patients coming into the Emergency Center and they are arguing with you why they are not seen fast or they are arguing with you wanting food trays in the back when they have a splinter when you know you can use your time more beneficially to a patient that really needs your care at that time.

Another research participant further illustrated this indifference displayed toward patients that were perceived as weighing down the system.

It has affected me to the point where I don’t care anymore. It’s just a job. But that’s not true for the people that really need to be there. My heart really aches for those people. It’s the “I sprained my ankle three nights ago” that affect my care. I give it and there’s nothing wrong with it except that I know I’m not projecting an air of compassion to those people. I am just there to sign them out and let them go. I am not friendly – I am very blunt and to the point. If it is a true medical emergency and families are in crisis,
then I am there and my compassion is where it needs to be.

Although many of these research participants admitted that the care they deliver is less compassionate to those whose legitimacy they question, they did realize that this approach is not therapeutic and did not promote a healthy nurse-patient relationship. However, feeling the burden of a heavy workload played a significant role in their delivery of uncaring actions toward patients. Also noted in this discussion was the fact that certain groups of patients, such as chronic alcohol and drug abusers, triggered uncaring feelings from the nurses which was often projected into other patient interactions especially if the shift was particularly stressful.

It has made me very jaded. You are very insincere. Instead of seeing one patient as what’s going on with that one, you kind of develop this mentality that everybody’s a drug seeker or everybody’s whining and complaining.

As was noted with feelings of anger, the lack of caring displayed toward the patients was related to the research participants’ encounters with work stress and their perception of the level of stress associated with these encounters.

*Lack of time*

Lack of time was another common theme expressed by the research participants. Several of the research participants explained that the demands placed upon them as well as lack of resources, increased patient volume, and lack of nursing staff took away from the time available in which to deliver therapeutic nursing care. The lack of time to spend with patients led to increased frustration, anxiety, and anger. Many of the research participants stated that the lack of time often affected the quality of care delivered to patients.

I don’t feel like I can interact with patients hardly at all. You go in one room and sometimes you forget to tell them your name because you are trying to get done so fast because you got four other patients waiting on you.

Several research participants voiced concern over the inability to perform a thorough assessment for each patient because of the lack of time available to them as a result of the heavy workload that they faced. One research participant explained that a
cursory assessment could lead to missed information that may be important in determining the patient’s plan of care.

At times you don’t feel like you can give the care that you would like to give. The time you spend with your patients, you actually get a lot more information about the patient and when you are busy and stressed out, you don’t have that time. You are trying to get their immediate needs met and that’s not always ideal for the patient. You might miss something.

Worry and concern expressed by the research participants about the hasty care provided to patients because of the lack of time was evident throughout the interviews. Several described feeling overwhelmed because they knew that they had to provide care simultaneously for several patients that needed their immediate attention. However, lack of time prevented many of these research participants from delivering the care they felt was necessary. Because so many patients needed their attention, many found it difficult to focus on providing care to one patient while knowing that another patient also needed their attention.

The feeling of being overwhelmed and knowing that you are working on one patient and there’s another patient that needs you just as bad as that patient does and you are only one person. I think it takes away from your patient care. You are not giving 100% on that particular patient when you know there’s another patient next door that needs the same amount of attention.

The lack of time available to deliver effective patient care weighed heavily on the minds of these research participants. Several described feeling inadequate because they could not deliver the quality of care that they thought was necessary. Others described feeling frustrated and angry because they felt useless in combating the overwhelming demands of the work environment.

Research Question Three

Research question three investigated the extent to which the scores on the Compassion Satisfaction/Fatigue Self-Test for Helpers (Appendix E) supported the Emergency Department nurses’ lived experience with compassion fatigue. After the audio taped interview, the research participants were asked to complete Figley’s
Compassion Satisfaction/Fatigue Self-Test for Helpers (Appendix E). The results from the tool were compared to the qualitative data obtained from the interviews.

Figley’s Compassion Satisfaction/Fatigue Self-Test for Helpers (Appendix E) evaluates one’s compassion status. This tool helps the caregiver to determine how much he/she is at risk for developing burnout and compassion fatigue as well as to determine his/her satisfaction with helping others. This 66-item tool asks questions pertaining to the self in addition to asking questions about being a helper in the helping environment. The scores are broken down into three sections: potential for compassion satisfaction, risk for burnout, and risk for compassion fatigue.

The scores indicated that 11% \((n = 2)\) of the research participants had an extremely high potential for compassion satisfaction; 39% \((n = 7)\) had a high potential for compassion satisfaction, 39% \((n = 7)\) had a good potential for compassion satisfaction; 5% \((n = 1)\) had a modest potential for compassion satisfaction; and 5% \((n = 1)\) had a low potential for compassion satisfaction. In terms of the risk for burnout, 78% \((n = 14)\) of the research participants had an extremely low risk for developing burnout and 22% \((n = 4)\) had a moderate risk for developing burnout. Examining the risk for compassion fatigue, 39% \((n = 7)\) had an extremely low risk for developing compassion fatigue; 11% \((n = 2)\) had a low risk for developing compassion fatigue; 17% \((n = 3)\) had a moderate risk for developing compassion fatigue; 5% \((n = 1)\) had a high risk for developing compassion fatigue; and 28% \((n = 5)\) had an extremely high risk for developing compassion fatigue. Table 4.2 displays the scores obtained from the Compassion Satisfaction/Fatigue Self-Test for Helpers.

The results of these scores do validate the descriptions of the lived experience of these Emergency Department nurses with compassion fatigue. The scores indicated that one-third of the research participants had a high to extremely high risk for developing compassion fatigue. Work-related stress is a significant factor in the development of compassion fatigue. By examining the research participants’ descriptions of their experiences with work-related stressors, coping techniques, and the final results after coping with work stress, one can ascertain that, while these nurses have the ability to give compassionate patient care, they are under tremendous pressure from their encounters
### Table 4.2

**Results of the Compassion Satisfaction/Fatigue Self-Test for Helpers**

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Freq. (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Compassion Satisfaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely high potential</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>High potential</td>
<td>7</td>
<td>39%</td>
</tr>
<tr>
<td>Good potential</td>
<td>7</td>
<td>39%</td>
</tr>
<tr>
<td>Moderate potential</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Low potential</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Burnout</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely low risk</td>
<td>14</td>
<td>78%</td>
</tr>
<tr>
<td>Moderate risk</td>
<td>4</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Compassion Fatigue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely low risk</td>
<td>7</td>
<td>39%</td>
</tr>
<tr>
<td>Low risk</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Moderate risk</td>
<td>3</td>
<td>17%</td>
</tr>
<tr>
<td>High risk</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Extremely high risk</td>
<td>5</td>
<td>28%</td>
</tr>
</tbody>
</table>

with a huge workload and lack of support. The coping measures described by the research participants did offer a way in which to handle the stress that they suffered.

However, the research participants’ descriptions of the final result after coping depicted negative effects such as exhaustion and feeling abandoned. Taking that one step further and examining how these research participants’ encounters with work stress has affected their ability to care for patients, one can determine that these experiences had an adverse effect on the care delivered to patients. The research participants described feeling angry and not displaying a caring attitude toward patients. The research participants also described not having enough time to provide nursing care as a result of their workload which in turn led them to feel frustrated and overwhelmed which further fueled their feelings of anger as well as lack of caring.

While the scores indicated that several of the research participants were at risk for developing compassion fatigue, the scores also indicated that a majority of the research participants had an excellent chance for developing satisfaction from their patient care interactions. According to Stamm (2002), it is possible for caregivers to have compassion satisfaction while simultaneously being at risk for experiencing compassion fatigue. The explanation for the existence of this possibility is that caregivers like what
they do and feel positive benefits from it which keeps them returning to do their work (Stamm, 2002). This explanation is evident through the research participants’ descriptions of feeling a sense of accomplishment after their patient care interactions and coping with their stressful work environment. Many of the research participants depicted their work environment as hectic and often felt overwhelmed and frustrated by the workload. However, many described feeling good about the work that they do especially if they witnessed positive outcomes as a result of the care that they provided.

Conclusions

The work-related stressors in which Emergency Department nurses encounter on a daily basis are numerous. The main work-related stressors voiced by the research participants included the large number and continuous influx of patients, the increased patient acuity, and lack of skilled nursing staff. These research participants were resourceful in coping with these often negative encounters by relying on support systems, using internal coping measures, or simply trying to persevere or overcome through firm resolve. If the research participants were successful in coping with their work-related stressors, many often felt a sense of accomplishment in terms of the patient care that they delivered. If the encounters were significantly negative, these research participants often felt exhausted and abandoned. However, by witnessing improvements in patient status or by feeling that their care giving efforts were effective in relieving the pain and suffering of those in their care, these research participants were often able to overcome their negative feelings caused by the chaotic environment. Although many felt exhausted, they still returned to the work environment in order to continue providing safe, therapeutic care to their patients.

Generally speaking, work stress had a negative impact on the research participants’ ability to provide care. The research participants described feeling angry and displaying anger and uncaring attitudes toward the patients. However, many described feeling a sense of accomplishment if they had been successful in coping with work stress or if they felt that the nursing care provided had a positive impact on patient outcomes.
Summary

This chapter provided qualitative data to describe the lived experience of Emergency Department nurses with compassion fatigue and work-related stressors. A small group of Emergency Department nurses from one southwest Georgia Emergency Department were used as a sample for this study. Quantitative data from Figley’s Compassion Satisfaction/Fatigue Self-Test for Helpers was also used to triangulate the data and support the conclusions obtained from this study. A discussion of the study findings as well as the relationship to the literature and guiding conceptual framework will be discussed in Chapter 5.
CHAPTER 5
DISCUSSION

The occurrence of compassion fatigue within the health care professions has undergone significant investigation. However, the prevalence of compassion fatigue among Emergency Department nurses has gone practically unnoticed. Work in the Emergency Department is often described as a “war zone” (Badger, 2001). Emergency Department nurses endure numerous work-related stressors as a result of the environment in which they practice. These nurses are at risk for developing compassion fatigue as a consequence of the stressors that they encounter.

The intent of this study was to provide insight into and describe the lived experience of Emergency Department nurses with compassion fatigue and work-related stress. Understanding this lived experience will allow others such as those in hospital management to become aware of the detrimental effects that the phenomenon of compassion fatigue can have upon self-care and self-esteem, as well as upon staff morale and patient care and safety.

This chapter discusses the findings of the study and its relationship to the current literature and guiding conceptual framework. The chapter also discusses the limitations and strengths of the study as well as recommendations for future research and implications for nursing practice, advanced nursing practice, nursing administration, and nursing education.

Discussion of the Findings

Emergency Department nurses encounter numerous work-related stressors as a result of the hectic and chaotic environment in which they work. These nurses must be adept at handling multiple tasks at the same time in order to meet the demands placed upon them by the increased patient volume and high patient acuity as well as the lack of nursing staff. These circumstances often lead to situations where Emergency Department nurses are providing care in less than desirable conditions such as in overcrowded
Emergency Departments where there are not enough nurses to provide safe, therapeutic care to the patients. Many of the nurses interviewed described the work environment in the Emergency Department as frightening creating feelings of apprehension. It is not surprising, then, that these nurses defined a work-related stressor as anything that causes them to feel a loss of control, overpowered, or frustrated.

It is essential that Emergency Department nurses maintain a sense of order in terms of what is happening around them so that they will be able to provide, safe, therapeutic care to their patients while still maintaining their own ability to think clearly and act quickly. Feeling a loss of control often resulted when these nurses felt that they could not manage the work environment and were unable to meet patient care goals. Some described feeling pressured and helpless as they confronted situations which they could not manage. Others described that the loss of control resulted from frequent encounters with increased patient volume and high patient acuity which decreased the amount of time these nurses could spend in caring for their patients. As a result in feeling out of balance with the work environment, some nurses described feeling angry and doubting their care-giving abilities.

Closely related to the feeling of loss of control is feeling overpowered by the work environment. As a result of their frequent encounters with increased patient volume, high patient acuity, and lack of nursing staff these nurses described the work as overwhelming. Emergency Department nurses must be skillful in prioritizing the urgency of care and in the face of a magnitude of patients seeking health care, this task can become daunting. The lack of time available to spend with patients also figured prominently in feeling overpowered. High acuity patients were a concern for many of the nurses as they explained that higher acuity patients require more nursing time thus taking away time from other patients that also need nursing care.

In conjunction with feeling a loss of control and overpowered, the nurses also described feeling frustrated as they dealt with the work-related stressors. These nurses described feeling frustrated because they could not be in all places at the same time. The volume of tasks that needed to be accomplished was described as overwhelming and this led to feelings of frustration because the nurses saw no plausible plan in which to conquer the large volume of work. The nurses also described becoming irritated with the patients
because they themselves felt overwhelmed and frustrated by the workload. The frustration experienced by these nurses was rooted in their heavy workload which often impeded their care-giving efforts resulting in anger, irritation, and exasperation.

In their descriptions of the work-related stressors encountered, the nurses interviewed focused on the workload and lack of support. The trend in increased patient volume, high patient acuity, and lack of nursing staff played an important role in their perception of the magnitude of the workload. Many nurses described the workload as massive. It is interesting to note that several of the nurses expressed their fear of being unable to manage the enormous workload and, therefore, unable to maintain their own sanity. Many voiced their fears in being unable to maintain sound nursing judgment in the face of the enormous workload encountered.

The lack of support from management, hospital nursing staff, and co-workers was perceived as a work-related stressor. Many nurses described feeling unsupported by the department management. These nurses described feeling that the department managers were not aware of nor understood the stressors faced by the nurses. The nurses also described feeling unsupported by the hospital nursing staff when it came to admitting patients from the Emergency Department. Several described certain nursing areas within the hospital as dragging their feet when accepting patients from the Emergency Department which then impeded patient flow through the department and resulted in an increased the work load for the Emergency Department nurses. Teamwork is essential within the Emergency Department because of the enormous work load. Lack of support from co-workers who did not complete their share of the work also was perceived as a work-related stressor.

Despite the amount and frequency of the encounters with work-related stressors, the nurses interviewed described several coping mechanisms that they used. The coping mechanisms described can be grouped into interaction with support systems, perseverance, and internal controlling measures. Interaction with support systems involved sharing their feelings of frustration and anger with co-workers as well as close family members and friends. Being able to let go of feelings of frustration and anger at work was a very common coping mechanism which allowed these nurses to release of their feelings and be able to move on to the next task at hand. If they were not able to
share their feelings at work, some became stuck in that moment that caused their frustration which they then carried with them throughout their shift and it negatively impacted the care provided. Perseverance was another coping mechanism employed in which the nurses simply pushed through the stress and continued with their care giving efforts. Internal controlling measures were used by the nurses in which they dealt with the work-related stressors alone. While at work, some measures used included going to the hospital gift shop, going to the cafeteria for a snack or drink, or going outside to smoke a cigarette. This mental break allowed these nurses to process their experiences so that they could come back refreshed and ready to handle the next challenge. Away from work, several engaged in activities such as exercise or relaxing with friends.

If the nurses were not very successful in coping with work-related stressors, they described experiencing feelings of exhaustion and abandonment. These feelings were directly related to the continuous use of coping mechanisms used to deal with the numerous work-related stressors encountered. They were also related to feeling a loss of control, overwhelmed, and frustrated.

If the nurses were successful in coping with the work-related stressors, they described feeling a sense of accomplishment. Despite the numerous work-related stressors encountered, these nurse were able to feel good at the end of their shift because they were successful in providing care to those who needed it. For some of the nurses, simply surviving the stress-filled shift resulted in a sense of accomplishment.

The lived experience of Emergency Department nurses with compassion fatigue is filled with frequent encounters with work-related stress. Increased patient volume, high patient acuity, lack of nursing staff, and lack of support were the common work-related stressors encountered. These encounters often resulted in feeling a loss of control and feeling overwhelmed and frustrated as a result of interaction with the negative environment of the Emergency Department. Coping mechanisms were commonly used to combat the work-related stressors. If successful, the nurses reported feeling a sense of accomplishment. If unsuccessful, the nurses reported feeling exhausted and abandoned. Despite these numerous encounters with work-related stressors, these nurses have returned to continue providing care to those who seek it. What keeps these nurses returning to an environment that is often negative is the opportunity to help others as well
as feeling a sense of accomplishment. Many nurses explained that they derived pleasure from knowing that their actions made a positive difference in patient outcomes which resulted in feeling a sense of satisfaction.

The experience with compassion fatigue and work-related stress did have a negative impact on the nurses’ ability to provide care to the patients. The amount of work stress was directly associated with the feelings of anger displayed toward the patients. The consequences of these experiences were feelings of anger and uncaring and lack of time. Many described becoming angry as a result of their contact with the negative work environment and work-related stressors. Other nurses described feeling more short-tempered and less tolerant toward their patients. Several nurses described feeling calloused and uncaring toward their patients when under pressure from numerous work-related stressors. Feeling the burden of a heavy workload played a significant role in their delivery of uncaring actions toward the patients. The lack of time available to spend with patients led to increased frustration, anxiety, and anger which affected the quality of care delivered to the patients.

The themes discussed by the research participants were supported by the scores on the Compassion Satisfaction/Fatigue Self-Test for Helpers (Appendix E). The scores indicated that one-third of the nurses had a high to extremely high risk for developing compassion fatigue. The scores also indicated that the nurses had an excellent chance for developing compassion satisfaction from their patient care interactions. The ability to experience compassion satisfaction is directly related to the nurse’s ability to adequately cope with the work-related stressors. The nurses described feeling a sense of satisfaction if they felt that they coped well with the stressors and if they felt that the care they gave was beneficial to the patient.

Relationship to Literature

Much has been written about compassion fatigue and the negative impact that it can have on health care workers (Lamendola, 1996; McCann & Pearlman, 1990; Rudolph, Stamm, & Stamm, 1997; Clark & Gioro, 1998; White, 1998; Pfifferling & Gilley, 2000; Figley, 2002; Vander Zyl, 2002). Additionally, the literature has revealed several pieces addressing the work stress endured by Emergency Department nurses (Rothwell, 2001; Derlet & Richards, 2002; Hagness, Kreitzer, & Kinney, 2002;
Velianoff, 2002; Hart, 2003). The nurses that were interviewed described their frequent encounters with work-related stressors such as increased patient volume and high patient acuity which was echoed by Derlet and Richards (2002) who wrote how the trend over the last several years has seen an increase in the numbers of patients who use the Emergency Department as a source of primary care in addition to the number of patients that wait to seek health care because of the lack of health insurance and, as a result, are sicker when they present to the Emergency Department.

The finding that repeated exposure to work-related stressors can affect one’s ability to cope was echoed by Badger (2001) who noted that despite the resiliency of and vast range of coping techniques used by Emergency Department nurses, repeated exposure can compromise the ability to cope with stress. The nurses in this study described feeling exhausted and abandoned after their repeated exposures to work-related stressors as well as their inability to cope with them. This finding was further supported by Hageness, Kreitzer, and Kinney (2002) who noted that self-care is usually not a top priority during a busy shift which makes Emergency Department nurses more susceptible to the effects of work-related stress. Several of the nurses in this study explained that if they did not have time to deal with the work stress, they simply pushed through the stress and dealt with it later. A few of these nurses admitted to feeling more fatigued as a result of that strategy.

The nurses in this study also reported feeling a sense of accomplishment when they were able to successfully cope with work-related stressors and were able to witness an improvement in the patients’ condition as a result of their nursing interventions. This finding is supported by Hageness, Kreitzer, and Kinney (2002) who reported that when nurses take the time to care for themselves, then nursing becomes a more enriching experience. Many nurses in this study stated that when they were able to vent to their co-workers, they were able to let go of their feelings of anger and frustration which enabled them to continue with their care giving efforts. However, if they were unable to express their feelings, the negativity of their encounters affected their patient interactions throughout the rest of the shift.

In this study, the nurses reported feeling anger, cold and calloused toward their patients as a result of their frequent exposures to work-related stressors. This finding is
supported by Vander Zyl (2002) who noted that loss of a caring attitude toward others is often the consequence of compassion fatigue which can result from stressful work-related situations. Many of the nurses in this study reported feeling more short-tempered toward their patients especially if the shift was particularly stressful and felt that they were unable to provide compassionate care to their patients. This is echoed by Rudolph, Stamm, and Stamm (1997) who found that if a caregiver suffers from compassion fatigue, then the ability to deliver effective health care services and to maintain professional relationships becomes inadequate. Additionally, Gillespie and Melby (2003) found that frequent encounters with work stress can cause nurses to lose their ability to empathize which is a critical quality in establishing therapeutic patient relationships.

Gaps in the literature do exist because there were no studies found that investigated the prevalence and effects of compassion fatigue on Emergency Department nurses. However, several studies reported that Emergency Department nurses engage in traumatic work which makes them vulnerable to the effects of these encounters (Clark & Gioro, 1998; Adali & Priami, 2002; Hagness, Kreitzer, & Kinney; 2002; Lapaosa, Alden, & Fullerton, 2003). In a study of 51 Emergency Department staff members of a large urban hospital in British Columbia, Lapaosa, Alden, and Fullerton (2003) found that 12% of the participants met full criteria for the diagnosis of Post-Traumatic Stress Disorder (PTSD) while 20% met criteria for the three symptom cluster. The top three events chosen as most upsetting included providing care to a patient who is a relative or close friend and is dying or is in serious condition; threatened physical assault of self; and multiple trauma with massive bleeding and dismemberment (Lapaosa, Alden, & Fullerton, 2003). The results of this study are similar in that exposure to work-related stressors can affect the physical and mental well-being of nurses providing care to those suffering from traumatic events. While PSTD differs slightly from Secondary Traumatic Stress Disorder (STSD) or compassion fatigue, the exposure to work-related stressors has been shown to have negative consequences for the care givers.

Conceptual Framework

Three theories were integrated in order to form the conceptual framework used in guiding this study. Watson’s Theory of Human Caring (1985) and Selye’s Stress Theory (1956) formed the basis for the investigation of how the encounters with work-related stressors impact...
stress can lead to compassion fatigue and, thereby, affect one’s ability to provide therapeutic care to the patient. Figley’s Compassion Stress and Fatigue Model (1995) provided further understanding of how one’s encounters with work stress and the inability to cope with it can lead to compassion stress and fatigue, and as a result, hinder one’s ability to provide care.

*Watson’s Theory of Human Caring*

Watson’s Theory of Human Caring (1985) describes nursing as a human care process used to help others. In her theory, Watson explains that caring is the essence of nursing and is related to healing which is what nurses do in caring for their patients. The goal of nursing, according to Watson, is to help people increase harmony within the mind, body, and soul which leads to knowledge and care of the self (Watson, 1985). Watson also explained that caring for and loving the self is a prerequisite before one can care for others (Watson, 1985). Watson’s theory discusses carative factors which are defined as the interventions used by nurses in providing care to patients. The carative factors that figured prominently in the research participants’ descriptions of their lived experience with compassion fatigue include development of a instillation of faith-hope, cultivation of sensitivity to one’s self and others, helping-trusting human relationship, and assistance with gratification of human needs.

The establishment of a therapeutic relationship between the nurse and the patient is a key element in Watson’s theory. The relationship between the nurse and the patient is seen as a reciprocal interaction where feelings are shared and respected. In establishing this relationship, the nurse must be able to view the patient’s world from his/her eyes as well as be able to detach from it once the interaction is over. The inability to detach oneself from the interaction can lead to becoming overwhelmed by the patient’s experiences.

The presence of compassion fatigue hinders the nurse’s ability to provide therapeutic care to the patient. Because of compassion fatigue, the nurse does not have the ability to focus on the needs of the patient which then interferes with the establishment of a relationship based on trust and commitment. As a direct result of their interactions with a negative work environment, the research participants were not able to establish therapeutic relationships with their patients. They described feeling angry and
uncaring toward the patients after their encounters with work-related stressors. Only when the research participants felt as if their caring actions helped others, did they feel a sense of accomplishment in providing therapeutic nursing care.

*Selye’s Stress Theory*

Selye’s Stress Theory (1956) describes the influences that stress has on the body as well as how stress affects one’s ability to cope. This theory asserts that internal as well as external stressors can lead to both physical and psychological symptoms within the individual who is unable to handle these stressors. Prolonged exposure to stress can be a contributing factor in many medical conditions such as high blood pressure, heart disease, and stroke. Prolonged exposure to stress may also cloud one’s judgment as well as impair one’s ability to think which can result in feelings of anxiety and an inability to care for others.

The work-related stressors encountered in the Emergency Department are numerous. The research participants defined work-related stressors as anything that caused them to feel a loss of control, overwhelmed, or frustrated. These feelings were a direct result of their interaction with a negative environment that they explained was fraught with a heavy workload and lack of support. Coping mechanisms employed by the research participants were internal as well as external. If the research participants were successful in coping with their work stress, they described feeling a sense of accomplishment. If they were unsuccessful in coping, the research participants described feeling exhausted and abandoned.

*Figley’s Compassion Stress and Fatigue Model*

In his model, Figley (1995) defined compassion fatigue as a state of exhaustion resulting from exposure to compassion stress. Figley’s model is based upon the assumption that empathy from the caregiver is necessary in order to deal effectively with the patient’s needs as well as to establish a therapeutic relationship with the patient (Figley, 1995). However, the caregiver is at risk for developing compassion fatigue if the caregiver is not able to employ adequate coping mechanisms as the caregiver comes into contact with the patient’s suffering. If the caregiver is able to detach from the patient’s experiences and feel a sense of satisfaction in terms of the care that has been given, then the caregiver will avoid the development of compassion stress and compassion fatigue.
Several of the variables contained in Figley’s model were evident in the research participants’ descriptions of their experiences with work-related stressors, the coping mechanisms that they used, the final result for them after coping, and the effect these experiences had on patient care delivery. The variables of concern, empathy, prolonged exposure, sense of satisfaction, and compassion stress can be found throughout the research participants’ descriptions. The research participants in this study described feeling exhausted and abandoned after coping with work stressors especially if the exposure to the stressors was prolonged. Those that were unable to effectively cope with the work stressors described feeling angry and uncaring toward their patients which led many to become frustrated and fatigued. However, those research participants that were successful in coping stated that they felt a sense of accomplishment in terms of the care that they provided to their patients.

*Emergency Department Nurses’ Compassion Fatigue Lived Experience Model*

Concepts from the theories of Watson, Selye, and Figley were combined with concepts derived from data in this study in order to form the Emergency Department Nurses’ Compassion Fatigue Lived Experience Model. In this model (Figure 5.1), the caregiver inherently possesses the ability to provide therapeutic care to the patient through the exhibition of caring interactions as well as the display of empathy. Under normal conditions, the caregiver responds to the patient’s needs by delivering healing nursing care. The caregiver is also able to maintain his/her own identity and promote self-care by the use of healthy coping mechanisms. However, external stressors such as loss of control, feeling overpowered, frustration, and the negative environment can infringe upon the relationship between the caregiver and the patient; thereby having a damaging effect on the caring relationship and the care provided to the patient. Additionally, the preservation of self can also be affected by the external stressors if adequate coping mechanisms are not employed by the caregiver. This can lead to compassion stress.

Healthy coping mechanisms that can be used by the caregiver are interaction with supports systems, perseverance, and internal controlling measures. If the caregiver is able to adequately use these mechanisms, the effects of compassion stress can be avoided and the caregiver will experience compassion satisfaction through his/her caring patient
interactions as well as his/her ability to provide comfort to the patient. If the caregiver is not successful in controlling the external stressors, then compassion stress will build and compassion fatigue will result. The consequence of the development of compassion fatigue is mind, body, and soul discord within the caregiver in which the caregiver becomes emotionally dead. Not only does the caregiver suffer as a result of compassion fatigue, but the patient suffers as well because the caregiver has lost the ability to nurture and care for his/her patients.

*Figure 5.1 Emergency Department Nurses’ Compassion Fatigue Lived Experience Model*
Limitations of the Study

This study investigated the lived experience of Emergency Department nurses with compassion fatigue. However, the findings of this study cannot be generalized to the population of all Emergency Department nurses because only a small number of Emergency Department nurses were interviewed from one hospital in southwest Georgia. The experiences of these nurses may be different from other Emergency Department nurses in Georgia as well as across the United States. Similar studies conducted with other populations of Emergency Department nurses may yield different results in terms of describing the lived experience with compassion fatigue. Likewise, the work-related stressors encountered by other Emergency Department nurses may not be analogous to the work-related stressors described in this study.

Another limitation of this study is that the lived experience with compassion fatigue and work-related stress was captured at a single point in time. It is possible that the research participants’ awareness could have been later modified as a result of further encounters with or diminished encounters with work stressors.

Lastly, not all Emergency Department nurses available to participate in this study elected to take part in this investigation. This lack of participation may not have allowed the researcher to truly capture the Emergency Department nurses’ lived experience with compassion fatigue in its entirety.

Strengths of the Study

The strength of this study is rooted in the phenomenological approach used as a design for this inquiry. This approach gave the research participants a venue to describe, in their own words, their experiences with compassion fatigue and work-related stress allowing for a meaningful discovery of their lived experience. The descriptions expressed by the research participants provided a view of their world letting others come into contact with the research participants’ experiences. The descriptions also offered a glimpse of what Emergency Department nurses endure, feel, and go through as they attempt to provide therapeutic patient care within the chaotic setting of the Emergency Department.
Implications for Nursing

*Nursing Practice*

Emergency nursing is a very stressful profession. These nurses encounter numerous work-related stressors as they attempt to deliver quality nursing care to their patients. During the patient care process, these nurses often give a lot of themselves emotionally while giving little attention to themselves. Because these nurses often place the patients’ needs ahead of their own, they are at risk for developing emotional distress and suffering from its negative consequences. Ineffective coping techniques and not having enough time to recharge emotionally make Emergency Department nurses vulnerable to the effects of compassion fatigue. Untreated compassion fatigue could lead to feelings of despair and hopelessness causing many nurses to leave the profession; thereby exacerbating the nursing shortage and leading to a decrease in the quality of patient care.

This study’s findings could increase Emergency Department nurses’ awareness of compassion fatigue, work-related stress, and their effects on the ability to provide genuine nursing care. Through increased self-awareness, these nurses may be able to understand better their experience with work-related stress and compassion fatigue in order to help them continue to meet superior standards of care for their patients. The increased knowledge of the existence of compassion fatigue and its symptoms and effects would also enable these nurses to become aware of others that may be suffering from compassion fatigue which would facilitate the development of a peer support network enabling others to seek assistance in dealing with the deleterious effects of compassion fatigue.

*Advanced Nursing Practice*

Advanced Practice Nurses (APNs) could play an important role in assessing the risk factors for and the existence of compassion fatigue; implementing interventions designed to reduce the risk of and fight the effects of compassion fatigue; and evaluating the success and usefulness of the implemented interventions. This study’s findings would provide the APN with the information needed to understand and the ability to recognize earlier the signs of compassion fatigue. Coupled with the APN’s advanced education and clinical experience, the study’s findings would allow the APN to be able to
help better those potential sufferers cope with the effects of compassion fatigue. The knowledge from this study would also place the APN in the position to enact change through educational offerings on compassion fatigue and its effects on nurses and patient care. Changes brought about by the APNs’ efforts may include increasing administrators’ and managers’ awareness of the existence of compassion fatigue as well as implementing policies to help nursing staff deal with this phenomenon. By having policies in place and services available such as counseling, the APN may be able to prevent the occurrence of compassion fatigue.

*Nursing Administration*

It is essential that nurse administrators thoroughly understand the phenomenon of compassion fatigue and its potential effects on nurses as well as patients. This understanding would promote the development of policies that would improve nurse retention as well as promote the development of a healthy organization. The provision of quality patient care would also be enhanced by the development of these policies.

Increased knowledge and understanding of compassion fatigue would also enable nurse administrators to be aware of the signs and symptoms of compassion fatigue as well as the risk factors for the development of compassion fatigue. This increased awareness would allow the nurse administrators to become more observant of their nurses and would enable them to intervene in a timely manner if the risk factors were present or if the signs of compassion fatigue were exhibited.

*Nursing Education*

The main focus of the nurse educator is to provide information to nurses on issues that affect nursing practice. Compassion fatigue is one such issue that could potentially have very negative consequences for the nurse as well as the patient. It is the responsibility of the nurse educator to communicate information that is research-based which facilitates evidence-based learning. The nurse educator should not only share the results of research on compassion fatigue and its effects on nurses and patients but should also conduct more research delving into the prevalence, risk factors, and treatment of compassion fatigue.

With knowledge gained through research on compassion fatigue, the nurse educator is prepared to promote policy changes, increase understanding of the risk factors
associated with the development of compassion fatigue, and develop measures to help those who suffer from compassion fatigue cope with its effects. As a result of his/her increased knowledge of compassion fatigue, the nurse educator has the opportunity and duty to share this knowledge with others through educational opportunities such as continuing education and seminars. This distribution of knowledge would expand the knowledge base of other health care professionals which would hopefully prevent the spread of compassion fatigue.

*Higher Education*

It is imperative that information regarding compassion fatigue and its associated risk factors be imparted to nursing students both at the baccalaureate and graduate levels of education. Undergraduate nursing students are often not aware of the stress that nurses endure; therefore, these students must be armed with pertinent and useful information so that they are able to cope with the work stressors once they begin to practice as nurses. Awareness of compassion fatigue and the effects that it can have on nursing practice will prepare baccalaureate nurses as they navigate their new work environment. This will allow them to be more cognizant of the development of compassion fatigue not only within themselves but also with their co-workers which will help to avoid adverse effects on patient outcomes.

Graduate level nurses are preparing to become leaders within their respective fields; therefore, it is essential that these students become adequately prepared with research-based information regarding compassion fatigue and the effects it can have on self-care as well as patient care. This information will allow these future nurse leaders to recognize the development of compassion fatigue within the work environment and to develop strategies to cope with compassion fatigue. As leaders, graduate nursing students also have the responsibility of promoting further research on the phenomenon of compassion fatigue.

Recommendations for Future Research

It would be beneficial to conduct further qualitative studies investigating the phenomenon of compassion fatigue utilizing Emergency Department nurses from other areas of the United States. This approach would allow a comprehensive discovery of the lived experience with compassion fatigue since other Emergency Departments may have
different patient populations as well as different work-related stressors which may affect the perception and prevalence of compassion fatigue.

Additionally, quantitative studies that investigate the risk of compassion fatigue within the population of Emergency Department nurses should also be conducted. These studies would be useful in predicting the risk and prevalence of compassion fatigue which would enhance the growth of policies and programs to help these nurses combat the development of this debilitating phenomenon. Furthermore, quantitative studies should also be conducted comparing the risk and prevalence of compassion fatigue within emergency nursing to different areas of nursing that also experience high stress such as hospice and critical care nursing.

Summary

This study investigated the lived experience of Emergency Department nurses with compassion fatigue and work-related stress. By investigating this phenomenon, the researcher attempted to provide insight into the perspectives and experiences of Emergency Department nurses with compassion fatigue and work-related stress and the consequences of those experiences, specifically, the impact on caregiving. The literature revealed that much research has been conducted on compassion fatigue and its effects on health care workers. However, Emergency Department nurses have not been specifically considered as research subjects. The framework guiding this study was an integration of Watson’s Theory of Human Caring and Selye’s Stress Theory. Figley’s Compassion Stress and Fatigue Model was also incorporated and it provided a sociological perspective tying together all aspects of the conceptual framework.

The study discovered that the experiences with compassion fatigue and work-related stress endured by Emergency Department nurses affect the care provided to patients as well as the mental and physical well-being of those providing the care. This study provided a starting point for defining and describing Emergency Department nurses’ lived experience with compassion fatigue. However, gaps within the literature still exist. Other areas need to be investigated including the prevalence and risk of compassion fatigue as well as the comparison of larger groups of Emergency Department nurses’ experiences with compassion fatigue.

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APPENDIX A
HUMAN SUBJECTS APPROVAL LETTER
Office of the Vice President For Research  
Human Subjects Committee  
Tallahassee, Florida 32306-2763  
(850) 644-8673 : FAX (850) 644-4392

APPROVAL MEMORANDUM

Date: 11/24/2004

To:  
Michelle Chase  
221 Covington Avenue Apt 213  
Thomasville, GA 31792

Dept:  NURSING

From: John Tomkowiak, Chair

Re: Use of Human Subjects in Research  
Emergency Department Nurses' Lived Experience with Compassion Fatigue

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Secretary, the Chair, and two members of the Human Subjects Committee. Your project is determined to be Exempt per 45 CFR § 46.101(b) 2 and has been approved by an accelerated review process.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals, which may be required.

If the project has not been completed by 11/23/2005 you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. Also, the principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

Cc: Sandra Faria  
HSC No. 2004.792
APPENDIX B
HOSPITAL RESEARCH COMMITTEE APPROVAL LETTER
January 18, 2005

Michelle Chase, RN, BSN
221 Covington Ave.
Apartment 213
Thomasville, GA 31792

Dear Ms. Chase,

The Multidisciplinary Research Committee (MRC) is delighted that the Institutional Review Board (IRB) of Phoebe has approved your research project (letter attached) to be conducted here at Phoebe. We are looking forward to the results!

Your thesis "Emergency Department Nurses' Lived Experience with Compassion Fatigue" will provide valuable insight into improving Nurses' lives. As a member of the MRC I will be following your project and am delighted to help you in any way possible to complete this important work.

During National Nurses Week, which coincides with National Hospital Week in May, we will have our second annual poster presentation (storyboard type) competition. Be ready to enter your project. There are nice awards presented.

The MRC annually conducts classes on research. There is one on January 21st in 5T on the IRB, protecting human subjects, basic research designs etc. That is followed up by 4 other topics such as statistics - then the last one is on poster presentations. I'll keep you informed.

Sincerely,

Darlene Prickett RN BSN
Chair Multidisciplinary Research Committee
Phoebe Putney Memorial Hospital

To be nationally recognized as a nursing culture committed to excellence
APPENDIX C
INTERVIEW QUESTIONS
1.) How do you define a work-related stressor?
2.) What work-related stressors do you encounter on a regular basis?
3.) How do you cope with work-related stressors?
4.) What is the final result for you (at the end of the day) after coping with work-related stressors?
5.) Describe one of the most stressful situations/shifts you can remember.
6.) How has your encounter with work-related stress affected your ability to care for your patients?
7.) What some positive things about working in the emergency department?
8.) What are some negative things about working in the emergency department?
9.) What is most fulfilling in your work as an Emergency Department nurse?
APPENDIX D
DEMOGRAPHIC PROFILE
Demographic Profile

1. Age ______
2. Ethnicity: Caucasian  African-American  Hispanic  Other: ____________
3. Gender:  M    F
4. Marital status:  Single   Married   Divorced   Separated   Widowed
5. How many children do you have? ______
6. How many of your children currently live with you? ______
7. Yearly income:  Less than $25,000  $25,000 - $40,000  $41,000 - $55,000
   $56,000 - $70,000  Over $70,000
8. Education level:  Diploma  Associate’s  Bachelor’s  Master’s  Doctorate
9. What is your current job title? ________________
10. Are you a Certified Emergency Nurse (CEN)? ______
11. Are you certified as a Critical Care Registered Nurse (CCRN)? ______
12. Years of experience as a registered nurse ______
13. Years of experience working in the emergency department ______
14. Number of years at current facility in the Emergency Department: __________
15. Work status:  Full time  Part time  PRN
16. Shift:  Day (7a – 7p)  Night (7p – 7a)  Other: ____________
17. How many hours worked per week in the Emergency Department? ______
18. Do you also currently work at another facility? Yes  No
19. If yes, in what area do you work? ___________________
APPENDIX E

COMPASSION SATISFACTION/FATIGUE SELF-TEST FOR HELPERS
Helping others puts you in direct contact with other people’s lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self-test helps you estimate your compassion status: How much at risk you are of burnout and compassion fatigue and also the degree of satisfaction with your helping others. Consider each of the following characteristics about you and your current situation. Print a copy of this test so that you can fill out the numbers and keep them for your use. Using a pen or pencil, write in the number that honestly reflects how frequently you experienced these characteristics in the last week. Then follow the scoring directions at the end of the self-test.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>Never</td>
<td>Rarely</td>
<td>A Few Times</td>
<td>Somewhat Often</td>
<td>Often</td>
<td>Very Often</td>
</tr>
</tbody>
</table>

**Items About You**

1. I am happy.
2. I find my life satisfying.
3. I have beliefs that sustain me.
4. I feel estranged from others.
5. I find that I learn new things from those I care for.
6. I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
7. I find myself avoiding certain activities or situations because they remind me of a frightening experience.
8. I have gaps in my memory about frightening events.
9. I feel connected to others.
10. I feel calm.
11. I believe that I have a good balance between my work and my free time.
12. I have difficulty falling or staying asleep.
13. I have outburst of anger or irritability with little provocation.
14. I am the person I always wanted to be.
15. I startle easily.
16. While working with a victim, I thought about violence against the perpetrator.
17. I am a sensitive person.
18. I have flashbacks connected to those I help.
19. I have good peer support when I need to work through a highly stressful experience.
20. I have had first-hand experience with traumatic events in my adult life.
21. I have had first-hand experience with traumatic events in my childhood.
22. I think that I need to "work through" a traumatic experience in my life.
23. I think that I need more close friends.
24. I think that there is no one to talk with about highly stressful experiences.
25. I have concluded that I work too hard for my own good.
26. Working with those I help brings me a great deal of satisfaction.
27. I feel invigorated after working with those I help.
28. I am frightened of things a person I helped has said or done to me.
29. I experience troubling dreams similar to those I help.
30. I have happy thoughts about those I help and how I could help them.
31. I have experienced intrusive thoughts of times with especially difficult people I helped.
32. I have suddenly and involuntarily recalled a frightening experience while working with a person I helped.
33. I am preoccupied with more than one person I help.
34. I am losing sleep over a person I help's traumatic experiences.
35. I have joyful feelings about how I can help the victims I work with.
36. I think that I might have been "infected" by the traumatic stress of those I help.
37. I think that I might be positively "inoculated" by the traumatic stress of those I help.
38. I remind myself to be less concerned about the well being of those I help.
39. I have felt trapped by my work as a helper.
40. I have a sense of hopelessness associated with working with those I help.
41. I have felt "on edge" about various things and I attribute this to working with certain people I help.
42. I wish that I could avoid working with some people I help.
43. Some people I help are particularly enjoyable to work with.
44. I have been in danger working with people I help.
45. I feel that some people I help dislike me personally.

Items About Being a Helper and Your Helping Environment

46. I like my work as a helper.
47. I feel like I have the tools and resources that I need to do my work as a helper.
48. I have felt weak, tired, run down as a result of my work as helper.
49. I have felt depressed as a result of my work as a helper.
50. I have thoughts that I am a "success" as a helper.
51. I am unsuccessful at separating helping from personal life.
52. I enjoy my co-workers.
53. I depend on my co-workers to help me when I need it.
54. My co-workers can depend on me for help when they need it.
55. I trust my co-workers.
56. I feel little compassion toward most of my co-workers.
57. I am pleased with how I am able to keep up with helping technology.
58. I feel I am working more for the money/prestige than for personal fulfillment.
59. Although I have to do paperwork that I don’t like, I still have time to work with those I help.
60. I find it difficult separating my personal life from my helper life.
61. I am pleased with how I am able to keep up with helping techniques and protocols.
62. I have a sense of worthlessness/disillusionment/resentment associated with my role as a helper.
63. I have thoughts that I am a "failure" as a helper.
64. I have thoughts that I am not succeeding at achieving my life goals.
65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.
66. I plan to be a helper for a long time.
Scoring Instructions

Please note that research is ongoing on this scale and the following scores should be used as a guide, not confirmatory information. Cut points are theoretically derived and should be used with caution and only for educational purposes.

1. Be certain you respond to all items.

2. Mark the items for scoring:
   a. Circle the following 23 items: 4, 6-8, 12, 13, 15, 16, 18, 20-22, 28, 29, 31-34, 36, 38-40, 44.
   b. Put a check by the following 16 items: 17, 23-25, 41, 42, 45, 48, 49, 51, 56, 58, 60, 62-65.
   c. Put an x by the following 26 items: 1-3, 5, 9-11, 14, 19, 26-27, 30, 35, 37, 43, 46-47, 50, 52-55, 57, 59, 61, 66.

3. Add the numbers you wrote next to the items for each set of items and note:
   a. Your potential for Compassion Satisfaction (x): 118 and above=extremely high potential; 100-117=high potential; 82-99=good potential; 64-81=modest potential; below 63=low potential. **Your score:**
   b. Your risk for Burnout (check): 36 or less=extremely low risk; 37-50=moderate risk; 51-75=high risk; 76-85=extremely high risk. **Your score:**
   c. Your risk for Compassion Fatigue (circle): 26 or less=extremely low risk, 27-30=low risk; 31-35=moderate risk; 36-40=high risk; 41 or more=extremely high risk. **Your score:**

APPENDIX F
INFORMED CONSENT
Informed Consent Form

I freely and voluntarily and without element of force or coercion, consent to be a participant in the research project entitled “The Lived Experience of Emergency Department Nurses with Compassion Fatigue.”

This research is being conducted by Michelle Chase, R.N., B.S.N., who is a graduate student in the School of Nursing at Florida State University under the guidance of Dr. Sandra Faria, a faculty member in the School of Nursing. I understand the purpose of her research project is to understand better the incidence and prevalence of compassion fatigue and work-related stress in emergency department nurses. I understand that if I participate in this project, I will be asked questions about my feelings about my compassion satisfaction and my experiences with compassion fatigue and stress related to the work I do in the emergency department. I will also be asked demographic questions about myself. At the conclusion of the interview, I will be asked to complete the Compassion Satisfaction/Fatigue Self-Test for Helpers.

I understand that I will be asked questions during an interview. The total time commitment for the interview would be about 90 minutes. The total time for completing the demographic profile and the Compassion Satisfaction/Fatigue Self-Test for Helpers would be about 20 minutes. I will not receive any compensation for participating in this project. My questions will be answered by the researcher or she will refer me to a knowledgeable source.

I understand that the interview with the researcher will be audiotaped which will then be transcribed. After transcription of the interview, I understand that the researcher will contact me to arrange another meeting in order to validate the transcription of the interview. A third meeting will also be scheduled once the data collection is completed in order to validate the researcher’s interpretation of the interview. The audiotape and transcribed document will be kept in a locked filing cabinet in the researcher’s home to which only the researcher and Dr. Faria have access. The audiotape, transcribed document, and other associated information will be destroyed on December 31, 2009.

I understand my participation is totally voluntary and I may stop participation at any time. All of my answers to the questions will be kept confidential to the extent allowed by law and identified by a subject code number. My name will not appear on any of the results.

I understand that there is a possibility of a minimal level of risk involved if I agree to participate in this study. I might experience anxiety thinking about my work experiences in the emergency department. The researcher will be available to talk with me about any emotional discomfort I may experience while I am participating. I may also be referred to a psychologist by the researcher, if I so desire, for any further assistance. This service will be provided at no cost to me. I am also able to stop my participation at any time I wish.

I understand that there are benefits for participating in this research project. First, my own awareness about my compassion satisfaction level will be increased. Also, I will be providing health care professionals with valuable insight into emergency department nurses’ feelings of compassion satisfaction or compassion fatigue. This knowledge can assist them in developing methods for preventing and coping with compassion fatigue.

I understand that this consent may be withdrawn at any time without prejudice, penalty, or loss of benefits to which I am otherwise entitled. I have been given the right to ask and have answered any questions concerning this study. Questions, if any, have been answered to my satisfaction.

I understand that I may contact Michelle Chase, Florida State University, School of Nursing, (229) 225-9252, nolegirl@mchsi.com, for answers to my questions about this research or my rights. I may also contact Dr. Sandra Faria, Florida State University, School of Nursing, (850) 644-6844, sfaria@nursing.fsu.edu. Results of the study will be sent to me upon my request.

In case of injury or in the event I have questions about my rights as a participant in this research study, or if I feel I have been placed at risk, I can contact the Chair of the Human Subjects Committee Institutional Review Board, through the Office of the Vice President for Research at (850) 644 – 8633.

I have read and understand this consent form. My signature below indicates consent.

Signature  Date
APPENDIX G
LETTER TO EMERGENCY CENTER DIRECTOR
Dear Mr. Braswell,

My name is Michelle Chase and I am a graduate student in Florida State University’s School of Nursing. As part of my requirement for graduation, I am developing a research study for my thesis which is entitled “The Lived Experience of Emergency Department Nurses with Compassion Fatigue” under the guidance of Dr. Sandra Faria, Florida State University, School of Nursing. Pending approval from your hospital’s Institutional Review Board, I would like to recruit nurses from your department for participation in my study.

I have drafted a letter explaining the purpose of my study and requesting participation in my study that I would like to distribute to your staff nurses. I would like to schedule a meeting with you at your convenience to discuss my study along with the participation request letter.

Please feel free to contact me at any time. My telephone number is (229) 225-9252 and my e-mail address is nolegirl@mchsi.com. I look forward to hearing from you. Your assistance in my research study is greatly appreciated.

Sincerely,

Michelle M. Chase, R.N., B.S.N.
APPENDIX H
LETTER TO EMERGENCY CENTER NURSES
To Emergency Department staff nurses:

My name is Michelle Chase and I am a graduate student in Florida State University’s School of Nursing. I am currently working on a research study for my thesis entitled “Emergency Department Nurses Lived Experience with Compassion Fatigue” under the guidance of Dr. Sandra Faria, Florida State University, School of Nursing. The purpose of my study is to explore and describe the experiences of emergency department nurses with work-related stress and compassion fatigue and to explore the relationship of various nurse characteristics to the onset and prevalence of compassion fatigue.

I am looking for emergency department nurses who may be interested in participating in my study. Participation in this study will involve an interview with me where we will discuss your experiences with work-related stress and compassion fatigue. The interview will take approximately 30 minutes of your time and can take place at any date and time of your choice. You will also be asked to fill-out a demographic profile which will take approximately 10 minutes to complete as well as a self-test that will take approximately 15 minutes to complete. Participation in this study is strictly voluntary and your participation will remain confidential, to the extent allowed by law. If you are interested in participating or have any questions regarding my study, please feel free to contact me at any time by calling me at home at (229) 225 -9252 or via e-mail at nolegirl@mchsi.com.

Thank you for your consideration in helping me to achieve my academic endeavors.

Sincerely,

Michelle M. Chase, R.N., B.S.N.
REFERENCES


Miller, A. (1999, August, 1). Nursing alert: Caring touch has been compromised by


White, G. (1998) Trauma treatment training for Bosnian and Croatian mental health
BIOGRAPHICAL SKETCH

Michelle Chase graduated from Valdosta State University in Valdosta, Georgia with a Bachelor of Science in Nursing in 1999. She currently resides in Thomasville, Georgia.

Michelle is currently employed as an Emergency Department nurse and as a flight nurse in southwest Georgia. She has also served as a graduate teaching assistant as well as a teaching associate for the School of Nursing at Florida State University. She plans to pursue a career in nursing case management following completion of graduate school. Michelle’s personal interests include reading and interior home decorating. She plans to publish her thesis manuscript to increase awareness of compassion fatigue, its relationship with work-related stressors, and its effects on Emergency Department nurses.