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Compassion Fatigue in Mental Health Nurses: Understanding Cause, Effect, Prevention and Intervention

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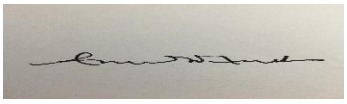
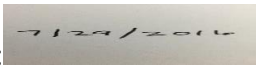
Signature: 

Date: 

Abstract

This independent study project researched the cause and effect of compassion fatigue in mental health nurses and identified strategies for prevention and intervention. A literature review was conducted and 15 articles were included for discussion. Compassion fatigue is a phenomenon seen in health care providers who have direct, prolonged exposure to working with individuals who have experienced trauma or suffering. Mental health nurses work with victims of trauma and individuals suffering from severe and persistent mental illness. In addition, mental health nurses are exposed to workplace violence including physical and emotional threats or attacks. This places the mental health nurse at an increased risk for development of compassion fatigue. Organizational factors that increase risk for compassion fatigue are lack of psychiatric resources, staffing issues, ineffective management and low compassion satisfaction in nurses. Compassion fatigue is overlooked in the healthcare system. Education regarding risk factors and symptoms increases awareness of compassion fatigue in nurses. Self-care activities can help to prevent or reduce compassion fatigue. Organizational strategies can be implemented to prevent and treat compassion fatigue.

Compassion Fatigue in Mental Health Nurses: Understanding Cause, Effect, Prevention and Intervention.

Mental health nurses are an invaluable asset within the medical community. Working in mental health is a challenging yet rewarding field, in which empathy and compassion are necessary in obtaining positive patient outcomes. Mental health nurses care for complex individuals with severe and persistent mental illness and are exposed to stories of trauma and workplace violence (Hanrahan, 2009). Compassion fatigue is a devastating phenomenon among health care workers. The act of caring for others in empathetic and compassionate ways along with high demands for patient satisfaction, increased workloads and lack of resources contribute to compassion fatigue (Edwards & Burnard, 2003; Figley, 2002). Mental health nurses are at risk for development of compassion fatigue.

Compassion fatigue can be defined as a combination of burnout and secondary traumatic stress (Kelly, Runge & Spencer, 2015). Compassion is a driving factor in nursing practice. Compassion fatigue depletes the nurse of their ability to provide empathy and compassion to their patients. Compassion satisfaction among healthcare professionals is directly related to development of compassion fatigue. Compassion satisfaction is the positive reinforcement felt by the nurse when the holistic needs of the patient are met. Low compassion satisfaction is a contributing factor to compassion fatigue (Smart et al., 2014).

Compassion fatigue is often times misunderstood and overlooked by the individual and the organization as a whole. Little support is available to combat compassion fatigue (Harris & Griffin, 2015). However, with self-care and support, compassion fatigue can be prevented and treated. Untreated compassion fatigue results in physical and psychological difficulties of the

individual, financial impacts for the organization and negative outcomes for patients (Bao & Taliaferro, 2015; Lombardo & Eyre, 2011).

This independent study researched the cause and effect of compassion fatigue, symptoms and potential interventions that can be utilized to educate and raise awareness to psychiatric-mental health nurses. The literature was searched for best evidence and analyzed. This independent study provided an educational handout to psychiatric nursing staff. This handout helps staff to recognize compassion fatigue and offer resources for coping.

Purpose

The purpose of this paper is to increase awareness of compassion fatigue for psychiatric mental health nurses and provide education on prevention and related interventions. This paper aims to define compassion fatigue and how it impacts the mental health nurse, the patient and the organization and to identify evidenced-based solutions to this problem. Specific factors regarding mental health nursing and compassion fatigue are explored. Untreated compassion fatigue produces devastating physical and psychological symptoms for the nurse that result in poor quality care for patients and financial burdens for organizations.

Education and awareness is crucial to preventing compassion fatigue. There is a clear lack of understanding among nurses about what compassion fatigue is because it has not been accurately defined in practice (Coetzee & Klopper, 2010). This impacts the ability of the nurse to identify symptoms and seek help. With education and resources the prevalence of compassion fatigue may be reduced (Harris & Griffin, 2015). This can contribute to increased positive outcomes for patients, less nurses leaving the field, and less turnover rates for organizations. Self-care techniques are identified to encourage nurses to participate in activities that promote

renewal of self and increase compassion satisfaction. In addition, organizational strategies are examined in an effort to reduce and treat compassion fatigue.

Significance

With the increasing expectations of psychiatric nurses to deliver compassionate care despite increased workloads, risk of workplace violence, lack of psychiatric resources and organizational problems, compassion fatigue needs more attention (Hanrahan, 2010). Mathieu (2007), found that nearly every health care provider will develop some form of compassion fatigue during their career, with many nurses taking time off work for physical and mental related illnesses. Mathieu (2007), found that compassion fatigue also contributes to a large number of nurses leaving the field.

Compassion fatigue is an increasingly growing phenomenon, yet is rarely discussed in healthcare. Lack of education regarding prevention will result in more and more nurses exposed to compassion fatigue, resulting in an inability to care for patients (Houck, 2014). At a time when mental health professionals are needed most, nurses cannot afford to ignore the cost of compassion fatigue.

Hanrahan (2009), reports a lack of psychiatric nurses to meet the mental health needs of the United States and that approximately 25% of mental health nurses leave the field every year. In addition, Hanrahan (2009), found that 66% of psychiatric nurses work in hospitals or acute care have over 26 years of experience. With the aging nurse population and lack of new hires, this already scarce specialty will be further depleted.

Lauvrud, Nonstad and Palmsteima (2009), found that length of experience and low compassion satisfaction can result in symptoms of post-traumatic stress in psychiatric nurses and that nurse who have more experience are often exposed to more risk factors of compassion

fatigue. Education should be provided to all nurses regarding compassion fatigue to ensure we have strong, empathetic, compassionate nurses in the field. If nurses are struggling, support should be easily accessible and utilized (Harris & Griffin, 2015).

Theoretical Framework

Jean Watson's Theory of Caring was utilized in discussing compassion fatigue. This theory emphasizes the relationship of nurses to care for self and others and focuses on heart centered healing, which is doing for and being there for others in need (Wagner, 2010). This theory focuses on holistic care of the individual's physical, emotional and spiritual needs. Empathy is a large component of this theory, and the nurse must practice empathy when providing care. In addition, the nurse must care for oneself in order to care for others.

With compassion fatigue there is generally a lack of self-care by the nurse and a dysfunction in ability to empathize or have compassion for a patient (Figley, 2002). Nurses are expected to be compassionate to others at all times, to show empathy and address all physical and emotional needs of patients. This theory emphasizes the importance of compassionate and empathetic caring from nurses for positive patient experiences (Wagner, 2010). This level of care is possible when compassion fatigue is not present. When nurses become affected by compassion fatigue, the ability to provide safe, quality and compassionate care is diminished (Lanier, 2012).

The theory also states that caring changes the self, others and the environment (Wagner, 2010). Knowing this is an important part of recognizing the nurses' ability to comprehend, absorb and cope with the suffering of others and how reactions to these events might influence the self, the patient and the organization. Based on this statement, nurses need to recognize the potential for how caring will affect different aspects of their personal and professional lives. Nurses who do not maintain a balance between empathy and objectivity are at greater risk to

develop compassion fatigue (Lanier, 2012). Watson's theory states that caring impacts the self, the patient and the environment, and so does compassion fatigue. When compassion fatigue develops, the nurse becomes impaired, the patient is at risk for treatment errors and there are financial consequences for the organization (Bao & Taliaferro, 2015).

Another theory utilized in discussion of compassion fatigue is Mary Koloroutis's relationship based care model. This model is based on three central relationships: the care provider and patient relationship, the care provider's relationship with one self, and the care provider's relationship with colleagues (Koloroutis, 2004). Koloroutis (2004), states that compassion and care, where one seeks to understand the experiences of others, is essential for a healing relationship. Compassion fatigue disrupts these relationships. The nurse becomes unable to provide compassionate and empathetic care to the patient, develops low compassion satisfaction in self and may have conflicts with colleagues (Aycock & Boyle, 2009; Lombardo & Eyre, 2011; Smart et al., 2014).

Koloroutis (2004), describes the care provider and patient relationship in where the care provider makes the patient the central focus. The care provider is expected to convey respect and personal concern for the patient.

Koloroutis (2004), believes that the care provider must have a strong sense of self, or self-knowing, in order to achieve emotional maturity and the ability to empathize. If this is not met, emotional reactions could interfere with the level of care provided and places the nurse at risk for compassion fatigue. Koloroutis (2004), also believes that self-care is essential for managing the caregiver's own stress, and the ability to manage work related issues and their own emotional and physical health. This relationship with self is crucial in developing and maintaining empathy, which is a core competency for psychiatric nurses. Figley (2002), states

that there is a correlation between lack of self-care and development of compassion fatigue. Nurses who do not find separation from work and life are at increased risk for compassion fatigue (Braunschneider, 2013).

The third relationship involves the caregiver and colleagues or organization. Koloroutis (2004), states that all members of the organization should expect compassionate, quality care from all team members and that a culture of education, respect and support for one another should be created. This is important, as organizational issues contribute to the development to compassion fatigue. Colleague conflicts, lack of quality supervision, and structural changes within the organization all contribute to development of compassion fatigue (Edwards & Burnard, 2003). Nursing administration should be aware of ways to promote healthy work environments in which employees are supported and respected (Harris & Griffin, 2015).

Definitions

A psychiatric mental-health nurse is a nurse is a registered nurse who specializes in working with individuals suffering from mental disorders. There is a strong emphasis for relationship-based care within this specialty and a focus on person-centered, interpersonal relationships to understand complex patient circumstances, emotions, beliefs and actions (Kane, 2015).

Compassion fatigue is a phenomenon that occurs in healthcare after exposure to witnessing the trauma or suffering of others in which the affected person is unable to feel empathy or compassion over time. This results in emotional and physical disturbances for the care provider, risk for poorer outcomes for patients and organizational issues as well. Symptoms can worsen with repeated exposure (Figley, 1995).

Self-care refers to the ability of nurses to care for their own personal physical, mental and emotional needs in order to effectively care for others (American Holistic Nurses Association, 2016).

Compassion satisfaction is the ability of the nurse to feel satisfaction from caregiving. It is the positive side of caring (Bao & Taliaferro, 2015). Often low compassion satisfaction is related with high levels of compassion fatigue. Compassion satisfaction is increased through caring moments (Smart et al., 2014).

Burnout is considered a state of exhaustion, both mentally and physically, and is characterized by disengagement. Feelings of hopelessness and lack of motivation accompany burnout and it has direct effects on the nurse and patient alike (Erickson, 2015).

Secondary traumatic stress is considered the emotional distress caused from listening to someone's firsthand experience with trauma. This can result in symptoms that are similar to post-traumatic stress disorder such as anxiety, hyperarousal and thought disruptions for the care provider. In addition, if the caregiver has a personal history of trauma this can trigger the care provider to re-experience the trauma (National Child Traumatic Stress Network, 2011).

Literature Review

Figley (1995), defined compassion fatigue as a state of dysfunction experienced by those who care for the suffering, which can result in secondary traumatic stress. It is the result of prolonged, continuous, and intense contact with patients and exposure to stress (Smart et al., 2014). Detrimental effects of this phenomenon on the care provider include varying degrees of physical, emotional and work related symptoms (Lombardo & Eyre, 2011). Nurses experience burnout and indirect stress from the constant expectations to deliver high quality and compassionate care while meeting the needs of an ever-changing environment.

Compassion fatigue is considered a combination of burnout and secondary stress (Kelly, Runge & Spencer, 2015). Burnout is the number one reason psychiatric nurses are leaving the field (Hanrahan, 2009). Effects of burnout include frustration, powerlessness and work related issues. Secondary stress results from exposure to patients' trauma through empathy (Figley, 2002).

Bao and Taliaferro (2015), state that hospital nurses are at increased risk for compassion fatigue due to long hours of direct patient contact where nurses are expected to provide empathetic relationships during times of stress or trauma. Health care professionals who observe or listen to experiences of suffering and do not maintain healthy balance between empathy and objectivity are also at higher risk for developing compassion fatigue (Lanier, 2012). In addition, caregivers that personally absorb the indirect trauma or give high levels of compassion over extended periods of time are also at risk (Lanier, 2012).

Compassion is a core competency of nursing. Nurses receive personal and professional satisfaction when they provide compassionate, empathetic care (Smart et al., 2014). Compassion satisfaction is a measurement of these positive interactions (Smart et al., 2014). When nurses effectively treat patients with compassion and empathy resulting in positive patient outcomes compassion satisfaction is high. When the nurse is unable to feel empathy or compassion towards patients this can result in low satisfaction and negative patient outcomes. When nurses do not have the resources to meet the needs of patients this also results in low compassion satisfaction. There is evidence to show a direct correlation to low compassion satisfaction scores and increased risk for compassion fatigue. High compassion satisfaction may actually be preventative against development of compassion fatigue (Smart et al., 2014). Strategies to raise compassion satisfaction among nurses should be explored.

Psychiatric nurses are exposed to patients suffering from severe and persistent mental illness including post-traumatic stress disorder (PTSD), as well as workplace violence which are considerable factors in the development of compassion fatigue among mental health providers. Lauvrud et al. (2009), states that psychiatric nurses are particularly susceptible to low compassion satisfaction and development of compassion fatigue and secondary stress symptoms. When a mental health nurse is a victim of violence this not only affects the nurse but those witnessing the event. In a study of 70 psychiatric nurses, Lauvrud et al. (2009), found that 67 reported exposure to threats of severe physical violence, witnessed others exposed to violence, or had been exposed directly to physical violence themselves over a period of 30 days.

Approximately 23-44% of psychiatric nurses experience some degree of psychological stress (Lee, Daffern, Ogloff & Martin, 2015). In addition, up to 90% of psychiatric nurses report verbal aggression and threats (Nijman, 2005). Seventy-six percent have reported experiencing mild physical violence and 16% reported severe physical violence (Nijman, 2005). Because of these interactions, mental health nurses are at risk to develop PTSD. Caregivers are also at risk in developing secondary stress where symptoms of PTSD arise though indirect trauma and sharing in the suffering of others.

Not only does contact with trauma or indirect trauma, risk of workplace violence and high expectations for care contribute to compassion fatigue, there are organizational factors as well. Mental health nurses report that increased workloads, lack of resources, colleague conflicts, staffing concerns, quality of supervision, work-life balance and internal structural changes as high sources of stress (Edwards & Burnard, 2003).

Coetzee and Klopper (2010), also state that aging nurses contribute can contribute to nursing staff stress. Hanrahan (2009), reports that the average age among psychiatric nurses is 50

years old and that four percent of nurses in the field are 30 years or younger. In addition, lack of support from managers, poor working environment, lack of career or educational opportunities and unstable work environments all impact the emotional health of the nurse on a daily basis (Coetzee & Klopper, 2010).

Compassion fatigue impacts the organization and has a direct impact on patient satisfaction, increased turnover rate, poor quality care and decreased productivity (Bao & Taliaferro, 2015). If compassion fatigue is untreated, patient outcomes suffer. Nurses are unable to provide the high standards of compassionate and quality care if these symptoms are present. This results in ineffective nursing performance, medical errors, and lower patient satisfaction (Harris & Griffin, 2015). Organizations suffer from staff turnover, absenteeism, performance issues and interpersonal issues (Aycock & Boyle, 2009).

The cost of compassion fatigue goes beyond the nurse. Harris and Griffin (2015), state that compassion fatigue in nurses causes patients to report negative responses on satisfaction surveys which directly impacts the organization in loss of financial reimbursement. In addition, compassion fatigue related to poor job and professional dissatisfaction, and lack of support causes increased turnover rates which is another financial burden for organizations (Harris & Griffin, 2015). Other impacts of compassion fatigue on the organization include direct impact on patient care and patient satisfaction, increased turnover rate and decreased productivity (Bao & Taliaferro, 2015).

Recognizing the condition exists it the first step in combating compassion fatigue. Harris and Griffin (2015), state that normalizing compassion fatigue as a response to stressful or difficult events may help nurses to open up about their symptoms or fears, and be more open in seeking out help. If nurses feel supported and listened to they may be more willing to discuss

feelings. If compassion fatigue is discovered early the severity and duration of the symptoms can be reduced (Houck, 2014).

Awareness of symptoms and risk factors is crucial. Symptoms generally develop over a period of time and include irritability, sleep disturbances, anger, intrusive thoughts, avoidance and being tired before going to work. Additionally, lack of interest or enjoyment may occur as well as compulsivity, blaming, and excessive complaints may be evident. Depression, low self-esteem, anxiety, hopelessness, loss of control, negative thoughts and restlessness may develop. Physical symptoms include gastrointestinal problems, fatigue and headaches (Lanier, 2012).

Nurses suffering from compassion fatigue may be disorderly, accident prone, indifferent, and use poor judgment (Coetzee & Klopper, 2010). Some symptoms are similar to post traumatic stress disorder such as anxiety, insomnia and flashbacks (Houck, 2013) and can be identified as secondary traumatic stress. Nurses who suffer from compassion fatigue may also turn to drugs and alcohol as a way to cope with their symptoms (Mathieu, 2007).

Risk factors for compassion fatigue include individual factors, organizational factors, and workplace factors. Mathieu (2007), states that the care provider's ability to cope, personality style, and personal life circumstances contribute to the development of compassion fatigue. Having a personal history of trauma is another identifiable risk factor (Bao & Taliaferro, 2015). Being exposed to trauma and traumatic events and having direct, prolonged contact with patients experiencing stressful life events contribute as well (Kelly, Runge, & Spencer, 2015). Working with individuals who have complex issues, suicidal threats or behaviors and hostile transference can also contribute to compassion fatigue (Pierson, 2009). Prolonged exposure to caring with individuals who are suffering or experiencing high levels of stress is another risk factor for compassion fatigue.

Hanrahan (2009), found that psychiatric nurses work on average 39 hours per week of primarily direct patient care and have typically fewer on call hours than other types of nurses. Psychiatric nurses work with severely ill patients and that unit census is often run at full capacity.

There are many steps that can be taken in prevention of compassion fatigue. Lauvrud et al. (2009), indicates that higher patient/staff ratios and emotional distance may be preventative factors in combating compassion fatigue. These factors may be unattainable as staffing levels are often inadequate and the nurse may find difficulty with detaching emotionally from their patients. However, collaboration with colleagues and peers may be helpful.

Discussions at staff meetings regarding specific patient situations, nurses response to these situations and actual or potential interventions could be addressed. Managers can guide the discussion and offer support and education as needed. Managers can also boost compassion satisfaction by acknowledging the nurses efforts and accomplishments (Harris & Griffin, 2015). Education is an important part of prevention and education regarding compassion fatigue should be implemented in all facilities for all nurses.

The concept of using *time-outs* can be effective in reducing stress when working in high acute areas such as mental health. Time-outs can be necessary when working with difficult or very ill patients. Time-outs should be a priority when nurses are expressing lack of empathy or difficulty caring about a patient, and the team should work to support this, allowing the nurse time to rejuvenate (Harris & Griffin, 2015).

Nurses can also consider rotating patient assignments as needed to offer one another a break from a challenging patient. This break helps to alleviate the constant, intense interaction

which can contribute to compassion fatigue (Harris & Griffin, 2015). Organizations should facilitate use of time-out rooms and access to chapels.

Allowing nurses to debrief on prolonged, stressful events and challenging patients, and encouraging discussion of processing these events aids in coping with the stressful situation. Nurses can also be encouraged to journal as a way to express thoughts and feelings (Harris & Griffin, 2015).

Self-care is another way to prevent or decrease symptoms of compassion fatigue. Figley (2002), states there is evidence to support lack of self-care and development of compassion fatigue. Strategies for identifying, preventing and intervening with compassion fatigue are needed. Finding activities that rejuvenate and satisfy the self should be explored (Houck, 2013). The nurse must practice self-care techniques and be aware of their capacity to care. In order to care for others, nurses need to care for themselves.

Bush (2009), states that exercising, proper sleep and nutrition, and utilizing relaxation practices are effective self-care techniques. Berry (2012), adds that getting social support is crucial as it nurtures the self. Exercise is effective, but must be considered a pleasure and something enjoyable. Yoga, meditation and walking are effective stress relievers.

Activities that allow the mind to detach from stress are encouraged and could be as simple as cooking a meal or interacting with a pet (Berry, 2012). Spiritual practices may be helpful for some nurses to assist in self-healing through meditation, journaling, prayer, quiet time and pastoral care services (Houck, 2013). Positive psychology such as being optimistic, using humor, being thankful, kind and generous can contribute to building resilience to stress in an effort to combat compassion fatigue (Berry, 2012).

Finding outlets to voice frustrations outside of the workplace are essential. Braunschneider (2013), adds that there must be a separation from work and life for nurses. This separation allows the nurse to have enjoyment outside of work.

When symptoms persist and self-care and prevention are no longer appropriate, different measures should be taken. Mathieu (2007), states that symptoms can perpetuate into depression, anxiety and even suicidal thoughts. Access to resources such as pastoral care and counseling services are warranted to those who are struggling with compassion fatigue. Employee Assistance Programs (EAP) should be utilized (Mathieu, 2007). Organizations need to recognize the problem of compassion fatigue and offer resources for nurses to debrief and discuss work related issues without fear of retaliation and offer support as needed.

Methodology

A comprehensive literature review was conducted using the CINAHL, Medline, Psych Info and PubMed databases. Search terms such as *compassion fatigue, compassion satisfaction, secondary stress, mental health nurses* AND *compassion fatigue* and *self-care* AND *compassion fatigue* were used. The literature was analyzed for pertinence to the research. A total of 15 articles were utilized. Limitations were found regarding searches specifically related to mental health professionals and compassion fatigue which could identify a need for further research. The literature was reduced to focus on articles of various specialties that might be exposed to trauma, or stressful patient contact or situations. There was limited research available on compassion fatigue and psychiatric mental-health nurses specifically.

An educational handout was developed, using the evidence-based data from the research. The handout consists of education and support resources for compassion fatigue. Risk factors and symptoms of compassion fatigue were identified and self-care techniques are offered, along

with numbers for resources such as pastoral care and counseling services. This information was provided to the psychiatric nursing staff on an inpatient psychiatric unit. This will help increase awareness and recognition of compassion fatigue in this unit and offer support for those in need, potentially increasing positive patient outcomes and more satisfied staff. The inpatient director found this to be an appropriate intervention for the unit.

Results

This paper identified that psychiatric mental-health nurses have an increased risk for developing compassion fatigue. The increased risk for witnessed or experienced physical or emotional violence, working with high need populations, lack of resources and increased demands impact the nurses ability to provide compassionate and empathetic care (Edwards & Burnard, 2003; Lauvrud et al., 2009) . Aging psychiatric nurse populations will increase these risk factors substantially resulting in further decline in resources (Coetzee & Klopper, 2010).

Psychiatric nurses work with patients who experience severe and persistent mental illness which is often accompanied by histories of trauma, abuse and suffering for extended periods of time. Prolonged exposure to others' suffering is a cornerstone of compassion fatigue (Lanier, 2012). Compassion satisfaction is directly related to compassion fatigue and efforts should be made to educate and provide outlets for caring and satisfying experiences for nurses (Smart et al., 2014).

Psychiatric nurses have higher levels of work stress and lower compassion satisfaction (Lee et al., 2015). Compassion fatigue is increasing in today's healthcare system and causing nurses to leave the field. There are high turnover rates for organizations where compassion fatigue is not addressed and financial consequences arise from low patient satisfaction (Bao & Taliaferro, 2015; Harris & Griffin, 2015).

Compassion fatigue can have severe physical and psychological effects on caregivers (Lanier, 2012). These effects have multiple consequences for the nurse, the patient and the organization. Without compassion and empathy, patient outcomes suffer and patients become less satisfied. Nurses have more sick time and turnover rates if compassion fatigue is not addressed (Aycock & Boyle, 2009). Patient safety becomes a concern when nurses develop symptoms of compassion fatigue such as inattentiveness, avoidance and accident prone behaviors (Bao & Taliaferro, 2015; Harris & Griffin, 2015).

There is evidence to support that lack of self-care is related to the development of compassion fatigue (Figley, 2002). There are effective self-care techniques that reduce or decrease symptoms of compassion fatigue. Awareness of compassion fatigue is lacking and many individuals and organizations do not address this problem. Education in high acute, stressful areas should be mandated. Efforts should be made by administration to support and educate nurses on identifying and combating compassion fatigue (Harris & Griffin, 2015).

Implications for Nursing

Compassion fatigue has many implications for practice. In order to deliver safe, quality care nurses must be healthy and stable. Compassion fatigue reduces the nurses' ability to have empathy and can even develop into avoidance of certain patients (Lombardo & Eyre, 2011). There is a direct correlation with compassion fatigue and patient satisfaction (Smart et al., 2014).

Research is limited regarding direct patient safety concerns and compassion fatigue. However, there is some evidence showing that compassion fatigue increases the risk for accident-prone behaviors, inattentiveness and impaired concentration from the nurse (Pfennings, 2013). These factors put patients at risk for treatment errors and negative outcomes. There is growing evidence to support that compassion fatigue has a direct correlation with increased

medication errors (Maiden et al., 2011). To increase patient safety and satisfaction, nurses need the tools to combat compassion fatigue and efforts need to be initiated through self-care and organizational strategies.

A recommendation for access to time out or quiet rooms should be provided to nurses and resources should be readily available for support services such as pastoral care and employee assistance programs. There should be an open-book policy regarding discussions about compassion fatigue and written education should be readily available on nurse units. Nurse support groups should be offered to allow debriefing and support. Managers and administration should increase compassion satisfaction through acknowledgment and support of nurses' skills, talents and achievements (Harris & Griffin, 2015).

Recommendations for research include increasing studies in specific areas such as mental health settings. Because nurses in different settings experience different trauma and events, more research is needed to determine exact causes of compassion fatigue in certain areas. More research is needed in respect to specific patient safety concerns such as medication errors, wrong procedures or even lack of care provided. Overall, more research is needed to truly appreciate the role of compassion fatigue in nursing, as there is a lack of evidence in differentiating compassion fatigue from other work stress that is not related (Adams et al., 2006). Boyle (2011), states that research regarding compassion fatigue should be a priority for all nurses.

Recommendations for education regarding compassion fatigue should begin during school and provided throughout the career of the nurse. Compassion fatigue became more recognized in the 1990's and older seasoned nurses may not be aware of the dangers. Nurse educators should provide an overview of compassion fatigue during schooling to ensure a strong

foundation of knowledge to increase awareness so prompt attention can be taken if the symptoms develop.

Educators can help to diminish the stigma of nurses feeling shame or guilt, as compassion fatigue can be a normal reaction to the challenges new nurses will face. In addition, since lower rates of compassion fatigue are associated with more effective management (Hanrahan et al, 2010), managers should partake in training to develop leadership skills to promote and support the needs of nurses. In addition nurses must take on the challenge to educate themselves and others about the risk factors and treatments for compassion fatigue (Houck, 2014).

Recommendations for health policy could include requiring hospitals to utilize 12-hour shifts for nurses. According to Portnoy (2011), research shows a correlation with increased compassion fatigue in 8-hour shifts. Working 12-hour shifts might allow nurses more actual days off to re-energize and rejuvenate, thus reducing the risk of compassion fatigue. Other policies to consider would be mandated yearly education regarding the risk factors, symptoms and treatment for employees who might be susceptible to developing compassion fatigue in areas such as mental health, oncology and emergency room caregivers.

Conclusion

In conclusion, compassion fatigue has been identified as a growing problem among health care providers. Compassion fatigue is a state of dysfunction from prolonged exposure to witnessing the trauma or suffering of others coupled with the symptoms of burnout such as disengagement and exhaustion that results in psychological and physical distress in nurses (Bao & Taliaferro, 2015; Kelly, Runge & Spencer, 2015; Lombardo & Eyre, 2011). The symptoms of compassion fatigue generally develop over time and can be severe. Symptoms range from irritability, lack of empathy, lost sense of accomplishment, isolation and depersonalization to

insomnia, gastrointestinal disturbances and anxiety. If left untreated compassion fatigue can progress to feelings of depression, drug abuse and suicidal thoughts (Lanier, 2012; Mathieu, 2007).

Compassion fatigue can happen to any nurse at any time. However, psychiatric nurses may be even more susceptible to developing compassion fatigue over time from direct and indirect trauma, workplace violence, low staffing levels, severely ill patients, aging workforce and lack of resources. Intense workloads, increased demands of the healthcare system and lack of support add to this risk. Ineffective management and lack of education are also important factors (Coetzee & Klopper, 2010; Hanrahan, 2009; Lauvrud et al., 2009).

Another important aspect of compassion fatigue is compassion satisfaction. This is the satisfaction a nurse feels when the emotional, physical and spiritual needs of the patient are met. This occurs when the nurse has the capacity to show compassion and empathy. Compassion satisfaction is also increased through recognition and support for caring actions. When the nurses compassion satisfaction is low due to ineffective management, stressful work environments, or lack of resources this directly correlates with an increased risk of developing compassion fatigue (Smart et al., 2014).

Despite the prevalence of compassion fatigue among nurses, the symptoms can be decreased or even prevented. Not every nurse will develop compassion fatigue during their career and personal factors such as learned coping skills and effective self-care techniques can help (Mathieu, 2007). Conversely, nurses with a personal history of trauma themselves are at a higher risk for developing compassion fatigue (Bao & Taliaferro, 2015). Self-care practices such as exercise, meditation and having a good balance between work and life can be effective (Bush, 2009). The nurse should be able to detach from work when at home and participate in activities

that reduce stress and provide enjoyment (Berry, 2012). The nurse should have proper rest and nutrition to assist in replenishing energy. Self-care practices should be individualized and the nurse must commit to these practices in an effort to reduce the likelihood of developing compassion fatigue (Berry, 2012).

Organizational factors also play a significant role in compassion fatigue. Many mental health nurses report that unsafe work environments, short staffing, lack of management support and conflicts with colleagues as significant factors (Edwards & Burnard, 2003). These issues can be managed through conversations regarding their needs and support from managers. Managers and organizations should recognize the detrimental effects of compassion fatigue on the nurse, the patient and the organization as a whole, as they are all interrelated (Harris & Griffin, 2015). When a nurse suffers from compassion fatigue, the patient may have more negative outcomes and have negative perceptions of their care resulting in dissatisfaction (Smart et al., 2014). Because many hospitals are reimbursed dependent on satisfaction surveys, this directly impacts the financial stability of the organization. Organizations are also at risk of staff turnover and nurses missing work (Aycock & Boyle, 2009). This puts strain on other staff and again increases the risk of low satisfaction in the nursing staff. Education and open discussions regarding compassion fatigue should be addressed. Rooms should be provided to staff to debrief and collect themselves if needed. Support groups should be encouraged and access to pastoral care and employee assistance programs should be provided (Harris & Griffin, 2015).

There is more research needed in regards to compassion fatigue and factors related to psychiatric mental-health nurses as this is a specialized area with specialized concerns. More studies should be conducted regarding the psychiatric nurse shortage, psychiatric work environment and psychological and behavioral issues that affect this sector of nurses. There is a

clear lack of psychiatric nurses in this country that are already unable to meet the mental health needs of the population (Hanrahan, 2009). If compassion fatigue is not combated in these nurses it will have a devastating effect on the mental health services as more nurses will leave the field.

Compassion fatigue needs to be discussed. Support is needed to ensure a strong, compassionate nurse population (Harris & Griffin, 2015). With continued awareness and education, this phenomenon can be decreased. Through theory, nurses are taught to give of themselves, to make the patient the first priority and to put the patient's needs first before their own (Kolorourtis, 2004; Wagner, 2010). Nurses are taught to be empathetic and compassionate, to be strong and brave in the face of tragedy. Nurses are human and compassion fatigue is a human response to caring too much. With education and support this phenomenon can be decreased in the nursing community.

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COMPASSION FATIGUE IN MENTAL HEALTH NURSES

What is Compassion Fatigue?

Compassion fatigue is a state of emotional and physical dysfunction in healthcare providers caused by prolonged exposure to working with individuals experiencing suffering and trauma (Figley, 1995). It is a combination of burnout (frustration, powerlessness, work related issues), and secondary traumatic stress (absorbing the trauma of others)(Smart et al., 2014). Compassion fatigue causes a decreased ability for the care giver to have compassion and empathy when providing care.

Who is at risk?

Any care provider who works with traumatized or suffering individuals is at risk. Mental health nurses have an increased risk in developing compassion fatigue due to risk of workplace violence (verbal and physical threats or actual attacks), lack of resources to care for patients and prolonged exposure to patients suffering from PTSD and other severe and persistent mental health and behavioral issues (Lauvrud et al.2009). Other factors such as increased workloads, highly acute patients, short staffing and unsafe working environments also contribute to the development of compassion fatigue.

What are the symptoms?

Symptoms of compassion fatigue develop over time. They are both physical and emotional in nature and can be severe. Some of the symptoms include:

Physical Symptoms	Emotional Symptoms
Gastrointestinal complaints	Depression/Anxiety
Headaches	Feelings of worthlessness
Exhaustion/Fatigue	Anger/frustration
Nausea	Depersonalization
Frequent illness	Avoidance
Sleep disturbances	Loss of interest
Restlessness	Irritability
Loss of control	Feelings of hopelessness
Accident prone behaviors	Negative thoughts
Concentration difficulties/ poor judgment	Suicidal Thoughts
Use of drugs and alcohol as coping mechanism	Lack of empathy and compassion/indifferent

Why should we care?

Left untreated, compassion fatigue can have devastating physical and emotional effects on the nurse and permanently affect the nurses' ability to provide quality, empathetic and compassionate care. This results in negative consequences for patients including errors in treatments and medications (Bao & Taliaferro, 2012). Patients have lower satisfaction scores which impacts the financial reimbursement for organizations (Harris & Griffin, 2015). If nurses do not practice self-care techniques they are at a higher risk to develop compassion fatigue. Compassion fatigue is also related to nurses leaving the field, contributing to the psychiatric nursing shortage.

What can be done?

Many things can be done to prevent and treat compassion fatigue and recovery is possible. Self-care practices and organizational factors have been identified as effective strategies in combating compassion fatigue.

Self-Care Practices	Organizational Interventions
Proper diet, rest and exercise	"Time-out" areas to rejuvenate
Medication, Yoga, Journaling, walking	Rotating assignments for difficult patients
Social support	Supportive and effective management (recognize skills and accomplishments of nurses)
Deep breathing, relaxation techniques	Offer nurse support groups
Participate in activities outside of work that allow the mind to detach from work.	Provide easy access to pastoral care and employee assistance programs for counseling
Know your limits of caring, be aware of symptoms or changes in behaviors	Managers can address feelings of compassion fatigue and allow nurses to debrief difficult events or patients, allow discussion of what was done, what could be done to help.
Talk to colleagues and managers, counseling	Offer mandatory training related to compassion fatigue and how to get help.
Practice work/life balance	
Positive psychology (use of humor, optimism, kindness and generosity)	

If you notice any of these symptoms in yourself or others, please get help. Reach out to your colleagues and talk to nurse managers. Compassion fatigue is a serious concern among health care providers. With education, awareness and support it can be recognized and treated.

RESOURCES:

Pastoral Care Services at Winona Health Services (507) 457-4382

Employee Assistance Programs at Winona Health Services (507) 454-2606

More information on compassion fatigue is available at www.compassionfatigue.org

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