

NURSES' COPING STRATEGIES WITH COMPASSION FATIGUE

A Literature Review

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<p>Abstract</p> <p>The need for more research to answer the question, "Which of the strategies nurses use in coping with compassion fatigue are most helpful?" has been identified (Yoder 2010). The purpose of this study was to find out helpful strategies that are being employed in coping with compassion fatigue among nurses of different areas of speciality.</p> <p>Three research questions were formulated and answered: What are the strategies that are being employed among nurses in coping with compassion fatigue? In which specialities of the nursing profession have these coping strategies been reported as helpful? What are nurses' perceptions of the helpfulness of the strategies used among them in coping with compassion fatigue?</p> <p>A predefined review plan guided the implementation of the study. Seven articles were selected based on predefined inclusion and exclusion criteria from electronic articles published within the last decade. Data was extracted, analysed and synthesised using a narrative approach.</p> <p>A total of twenty distinct coping strategies were identified: Seven personal coping strategies (e.g. self-care and introspection) and thirteen work-related coping strategies (e.g. debriefing and developing supportive professional relationships). The coping strategies were being employed by nurses in paediatric, adult, and geriatric settings.</p> <p>There is an overall insufficiency of research investigating the ways nurses can cope with the insidious phenomenon of compassion fatigue. The key to combating compassion fatigue lies in the incorporation of the most helpful strategies into a single easy-to-do interventional programme that can fit into nurses' already busy schedules. More understanding of compassion fatigue coping strategies must be sought after in order to help nurses acquire the resilience they need in their job, and to flourish in compassionate care.</p>		
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1 BACKGROUND

Compassion is a basic attribute at the bedrock of any act of true caring; it is a core ingredient in the formation and sustenance of the proper relationship between care providers and their clients which is needed in order to administer beneficial and effective care. It would be practically impossible to provide patient-centred and humane care without compassion. (Price 2013; Ballantyne 2013.)

Care providers' exposure to clients who are experiencing or recovering from a traumatic event, or their materials, such as health history, may trigger an upset of psychological reactions which have detrimental effects on care providers' ability to carry out their professional duties, as well as their personal lives (Ainsworth & Sgorbini 2010). Exposure to trauma materials may result in the care provider exhibiting symptoms of traumatization, the level of which usually depends on the proximity, intensity and duration of the exposure (American Psychiatric Association 2002). Such a care provider is said to experience secondary traumatization. Meadors & Lamson (2008) expounded that these symptoms tend to have a continuing effect on care providers' personal relationships, social networks, professional lives, and other aspects of life.

Compassion fatigue is a secondary-trauma-related phenomenon that has increasingly been investigated in caring professions in the recent couple of decades. Some have referred to it as a "cost of caring" (Figley 1995b, 1). It refers to a condition in which a care provider experiences an exhaustion of their compassionate energy in doing their work as a result of feeling overburdened by the care situations pulling on their energy resources (*see* Coetzee & Klopper 2010).

Proponents of the concepts of secondary traumatisation have proposed an increase in the resources for raising awareness and implementing preventive measures,

following the argument that care providers of individuals with trauma-related distress commonly experience secondary traumatisation (Elwood, Mott, Lohr & Galovski 2010). The need for care providers to engage in adequate self-care and for healthcare agencies to limit caseloads, increase trauma specific supervision, increase clinician leave time, and provide opportunities for clinicians to receive mental health services has been emphasized (Salston & Figley 2003). A review made by Sabin-Farrell and Turpin (2003) highlighted the concern that following the recommendations to use more resources in the prevention and treatment of secondary traumatisation (though they used the term “vicarious traumatization” in their write-up) might lead to unnecessary expenses due to the insufficiency of data proving the efficacy of some of these strategies. Several research works have since followed to this effect.

Interventions have been introduced towards the management of compassion fatigue, involving the equipping of care providers with personal coping strategies, as well as empowering healthcare managers and policy decision makers. Some findings have questioned the effectiveness of some of these interventions; for example, among intensive care providers for children, supervision or debriefing time with a supervisor did not seem to affect the care provider’s level of stress (Meadors & Lamson 2008, 28; cf. Pickett, Brennan, Greenberg, Licht & Worrell 1994). There is therefore the need to investigate the effective areas of these interventions.

The choice of topic was influenced by the reviewer’s observations of how nurses’ display of compassionate care changed over time, during nurse clinical training in a variety of hospital wards. The purpose of this study was to find out helpful strategies that are being employed in coping with compassion fatigue among nurses. The specialities of nursing in which these coping strategies have been reported as beneficial were discussed. This study aimed at providing an information base for decision making.

2 THE CONCEPT OF COMPASSION FATIGUE

Collins English Dictionary (2011) defines compassion as “a feeling of distress and pity for the suffering or misfortune of another, often including the desire to alleviate it”, and defines fatigue as “the temporary inability to respond to a situation or perform a function, because of overexposure or overactivity”. One may loosely say that compassion fatigue involves the temporary inability to respond compassionately to a situation that requires it, because of previous overexposure to such situations, or the temporary inability to provide compassionate care due to previously overly spending one’s compassion energy.

2.1 Origin and Nature of the Concept

Joinson (1992) was first to use the term *compassion fatigue* in describing situations where nurses had either turned off their own feelings or experienced apathy, depression, ineffectiveness, and anger in response to the stress they feel watching patients go through devastating illnesses or trauma. Figley (1995a), building on the foundation of Joinson’s findings, argued that compassion fatigue is a natural consequence of working with those who have experienced a trauma or another stressful event. Employing the term *secondary traumatic stress*, he defined compassion fatigue as “the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person” (*op. cit.* p. 10). He suggested that the term *compassion fatigue* can be used interchangeably with the term *secondary traumatic stress*, stating that the earlier is the “most friendly term for the phenomenon” since some professionals have found the term *secondary traumatic stress* derogatory (*op. cit.* p. 17). Other researchers have since pointed out differences between Joinson’s original idea about compassion

fatigue and Figley's concept of secondary traumatic stress, stressing that the terms are not interchangeable (Coetzee et al. 2010, 235; Ochberg 2011).

Due to the lack of clarity between the nature of the concept of compassion fatigue and other secondary-trauma-related concepts such as secondary traumatic stress, vicarious traumatization and burnout, researchers, especially over the last decade, have endeavoured to clarify these concepts (Collins & Long 2003; Beck 2010; Coetzee & Klopper 2010). Some have even argued the validity of some of the constructs, for example, in discussing their findings, Devilly, Wright, and Varker (2009) showed that the measures of secondary traumatic stress and vicarious traumatization showed no construct validity (p. 381). This lack of clarity between these constructs has hampered the progress in the research of the concept of compassion fatigue. In this study, the concept of compassion fatigue is differentiated from *secondary traumatic stress*, *vicarious traumatization* and *burnout*.

Secondary Traumatic Stress

The anxiety disorder suffered from by people who have experienced a traumatic event such as war is termed *post-traumatic stress disorder* (PTSD); its symptoms can be grouped into three major areas: 1), re-experiencing of the traumatic event, including intense fear, nightmares, horror and intrusive recollections of the event 2), avoidance of trauma-related events and emotional numbing and 3), chronic psychological arousal (Diagnostic and Statistical Manual of Mental Disorders 2000). Secondary traumatic stress incorporates the concepts of compassion fatigue and vicarious traumatization, but the emotions and behaviours that follow result in an acute stress disorder namely *secondary traumatic stress disorder* (STSD). In defining STSD, Figley (1995a) referred to it as "the natural, consequent behaviours and emotions resulting from knowledge about a traumatizing event experienced by a significant other..." rather than the first-hand victim, as in case of PTSD. He went

ahead to describe that the symptoms of STSD were similar to those of PTSD except that the sufferer is not the direct victim of the traumatic event. (p. 8.)

Vicarious Traumatization

Citing McCann and Pearlman (1990), Baird and Kracen (2006) referred to their argument that changes in therapists' cognitive schema of self, other, and the world are pervasive, cumulative and permanent. The psychological need areas of safety, trust, intimacy, esteem, and control of a care provider may be challenged after being empathically engaged with traumatic materials of their clients, negatively transforming their inner experience and disturbing their self-identity, spirituality, world view, and cognitive frame of reference (Baird *et. al.* 2006; Beck 2010). Such caregivers vicariously suffer from their client's trauma, hence the term *vicarious traumatization*.

Burnout

While Burnout may be experienced by people in other professions than healthcare, compassion fatigue is peculiar to care providers due to the nurturing nature of caregiving. Compassion fatigue has been referred to as "a form of caregiver burnout" (Figley 2002b). One can be burned out but not experiencing compassion fatigue. Ward-Griffin, St-Amant, and Brown (2011) defined burnout as the inability to cope with job stress, adding that Maslach, Schaufeli, and Leiter (2001) pointed out that it displays symptoms such as emotional exhaustion and reduced personal and professional accomplishments. Referencing the works of Stewart (2009) and McHolm (2006), they differentiated burnout from compassion fatigue stating that while burnout is cumulative and has a predictable course, compassion fatigue is acute, more devastating, and results from direct exposure to the suffering care recipient rather than to a stressful work environment. Referencing the works of Valent (2002) and Stamm (2002, 2005), Yoder (2010) stated that both compassion fatigue and burnout arise from separate failed survival strategies; compassion fatigue arises

when one cannot rescue or save an individual from harm while burnout results when one cannot achieve their work goals and results (p. 191). Some quantitative studies have also found a correlation between compassion fatigue and burnout that suggests that they both measure overlapping concepts (Yoder 2010, 193; Maytum et al. 2004, 174).

Furthermore, Devily et al. (2008) found that the constructs of secondary traumatic stress, vicarious traumatization, and burnout mainly appear to measure the same phenomenon, that is burnout, and that exposure to traumatic materials had no significant impact on the three constructs, supporting the findings of some other researchers (pp. 381 – 382). One may understand that the difference between the explicit meanings of secondary traumatic stress and burnout seems to be one of perspectives; from an occupational stress and job performance point of view, the phenomenon is called *burnout*, while from a psychopathological perspective, it is referred to as *secondary traumatic stress*.

The distinguishing characteristics between compassion fatigue, secondary traumatic stress, vicarious traumatization and burnout can be identified in the aspects of their risk factors, triggers/antecedents, symptomology, and process (TABLE 1).

TABLE 1. Distinguishing characteristics of burnout, compassion fatigue, secondary traumatic stress, and vicarious traumatization

	BURNOUT (Bo)	COMPASSION FATIGUE (CF)	SECONDARY TRAUMATIC STRESS DISORDER (STS)	VICARIOUS TRAUMATIZATION (VT)
RISK FACTORS	Any kind of demanding and stressful work environment [Bo1]	<ul style="list-style-type: none"> • Contact • Use of self • Stress [CF1]	Caregivers who work with people suffering from PTSD [STS1]	Caregivers who empathically engage with trauma clients and their materials, e.g. therapists [VT1]
TRIGGERS/ ANTECEDENTS	Results from cumulative build-up of stress [Bo2]	Prolonged, continuous, intense exposure to risk factors (see CF1 above) [CF2]	Exposure to a single acute traumatic event [STS2]	Single exposure to a trauma materials [VT2]
SYMPTOMOLOGY	Lack of job satisfaction and motivation displayed as: <ul style="list-style-type: none"> • Emotional exhaustion • Depersonalization towards patients • Lack of personal accomplishment [Bo3]	Work-related (social), physical, and emotional disruptions leading to inability express compassionate care [CF3]	<ul style="list-style-type: none"> • Intrusion: re-experiencing the survivor's trauma • Persistent arousal • Avoidance of reminders or numbing in response to them. [STS3]	Change in inner experience, cognitive schema and world-view which are: <ul style="list-style-type: none"> • Cumulative • Pervasive • Permanent [VT3]
PROCESS	<ul style="list-style-type: none"> • Progressive stages in the order: <ol style="list-style-type: none"> 1. Enthusiasm 2. Stagnation 3. Frustration 4. Apathy [Bo4]	<ul style="list-style-type: none"> • Cumulative process in the order: <ol style="list-style-type: none"> 1. Compassion discomfort 2. Compassion stress 3. Compassion fatigue [CF4]	Sudden emotional response [STS4]	Sudden emotional response [VT4]

Note. Sources for the findings in this table are found in Appendix 1.

2.2 The Compassion Fatigue Process

Based on the assumption that empathy and emotional energy are the main factors needed to foster proper therapeutic relationship between a care provider and the suffering patient, an etiological model to help those who are most susceptible to compassion fatigue was introduced by Figley in 1995. The model has since been revised to include other factors that influence the progression of stress responses into compassion fatigue. The knowledge that this model provides can help understanding how to stop the development of compassion fatigue. (Figley 2002a.)

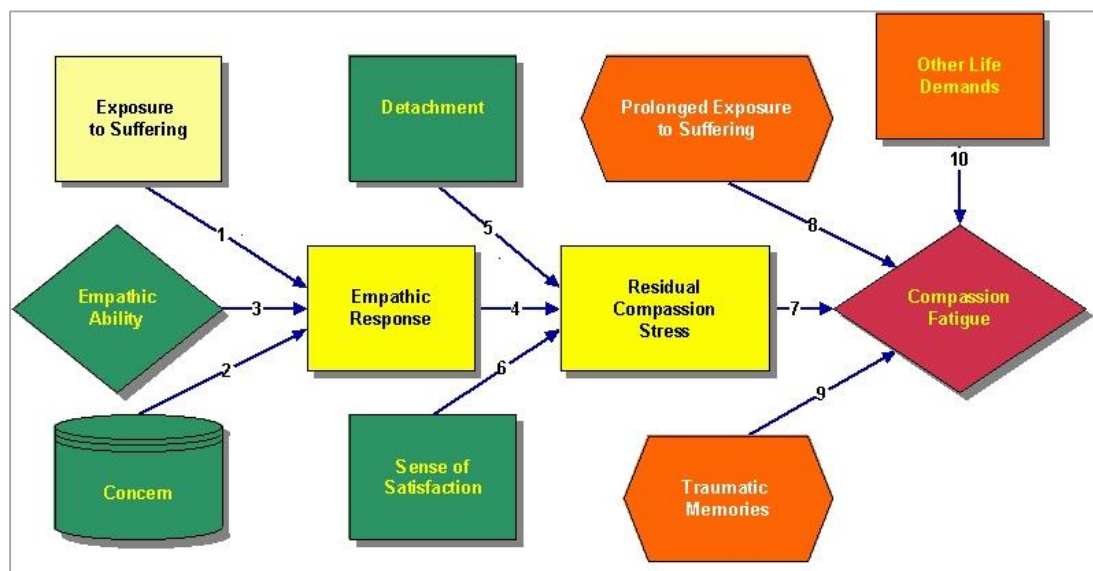


FIGURE 1. The compassion fatigue process (Figley 2001)

Empathic ability is the aptitude for noticing the pain of others. *Empathic concern* is the motivation to respond to people in need. *Exposure to suffering* is experiencing the emotional energy of the suffering of a client through direct exposure. *Empathic response* is the extent to which effort is made to reduce the suffering. *Residual compassion stress* is the residue of compassion energy after emotional response to the suffering of a client; it may be affected by the caregiver's *sense of satisfaction*, and *detachment*, which both can help lower or prevent compassion stress. *Sense of*

satisfaction/achievement is the extent to which the care provider is satisfied with the response to the suffering of the client. *Detachment/disengagement* is the extent to which the care provider can distance himself or herself from the misery of the client when he or she is not working with the client. If compassion stress is not mitigated, prolonged exposure to suffering, traumatic memories, and other unexpected disruptive occurrences may lead the care provider into a state compassion fatigue. (Figley 2001; 2002a.) Note. The arrows and numbers in the figure indicate the measurable relationship between any two variables.

2.3 Compassion Fatigue in Nursing Context

While all care providers are at risk for emotional exhaustion applicable to all levels or degrees of their work (Bush 2009, 26), the nature of nurses' job leaves them regularly exposed to empathically demanding situations. According to Yoder (2010), this phenomenon is not only present in caregivers that deal with catastrophic situations but also in common hospital nurses (p. 196). Compassion fatigue has been found in several specialities of the nursing profession: hospice nurses (Abendroth & Flannery 2006), oncology nurses (Potter, Deshields, Divanbeigi, Berger, Cipriano, Norris & Olsen 2010), trauma nurses (Townsend & Campbell 2009), paediatric nurses (Maytum, Heiman & Garwick 2004; Meadors & Lamson 2008), etc.

In investigating the concept of compassion fatigue from a nursing standpoint, Coetzee et al. (2010) defined it as a progressive and cumulative process, from a temporary state of compassion discomfort which causes can be removed by having adequate rest, to a more intense state of compassion stress in which the stress increases and endurance level decreases, and then to the state of compassion fatigue in which the power of recovery is lost. They also outlined the empirical indicators or manifestations of these three stages physically, emotionally, socially, spiritually, and intellectually. (See Appendix 2.)

The unique empathic engagement of nurses with their patients is clearly observable from their day-to-day work life. According to Bush (2009), Stebnicki (2008) stated, “In Native American teaching, it is said that each time you heal someone you give away a piece of yourself until, at some point, you will require healing”. The fatigue that arises from the continuous giving of oneself without proper healing may lead to early retirement or quitting the nursing profession. Yoder (2010) stated,

An understanding of compassion fatigue, trigger situations, and coping strategies in nursing may help prevent negative effects on the nurse's personal life and on the ability to perform his or her job and help prevent nurses from leaving the profession at a time when the need for nurses is great. (p. 191.)

2.3.1 Trigger Situations

A number of studies have reported the situations that nurses have indicated as triggers of compassion fatigue. Maytum et al. (2004) identified work-related and personal triggers of compassion fatigue among nurses who work with children with chronic conditions. Under work-related triggers, they broadly grouped their findings into three areas: a) caring for children with chronic conditions and their families, (b) professional roles, (c) work overload, and (d) broader system issues.

Seeing painful procedures done to children, too much sadness, and too much death topped the list of work-related triggers. They also found seeing kids unable to have a “normal” life, being the sounding board for too many sad situations, unreasonable policies, staffing shortages, insurance frustrations, and a feeling of general healthcare system dysfunction, lack of support and a feeling of being on your own as triggers. Personal triggers included over-involvement in patient’s situation, unreasonable self-expectations and personal commitments, and personal problems. (pp. 174 – 176.) Additionally, Yoder (2010) found personal limitations, and personal

experiences as triggers of compassion fatigue, stating that, “Difficult past personal events made dealing with similar patient situations more stressful”.

2.3.2 Interventions and Coping Strategies

A healthcare intervention is any type of treatment, preventive care, or test that a person could take or undergo to improve health or to help with a particular problem (Effective Health Care Program). Coping strategies are learned behaviours that promote survival and adaptation when encountering challenging events, in order to remain functional or effective. A healthcare intervention may be geared towards empowering nurses to become more capable of protecting themselves. In other words, interventions may be aimed at equipping nurses with coping strategies. Aycock and Boyle (2009), among others, have emphasized the need to identify interventions for compassion fatigue, warning that the lack of skill development to manage compassion fatigue may impact retention and staff engagement in the work setting (p. 185).

Just as compassion fatigue is overlapping and interrelated with other secondary-trauma-related pathological conditions (see 2.1 above), the remedies or coping strategies for these conditions tend to be overlapping as well (Ochberg 2011); for example, Yoder (2010) who investigated nurses’ coping strategies with compassion fatigue found results very similar to those of Maytum (2004) who investigated coping strategies with compassion fatigue jointly with those of burnout.

Research suggests that the coping process of newly graduated inexperienced nurses with stress differs from that of nurses who have had one year or more work experience (Hinds, Quargnenti, Hickey & Magnum 1994). In this study, the duration of experience of the nurses was not considered a selection criterion since the idea was to pool as many coping strategies as possible.

2.4 Resilience and Coping Responses

Resilience is the ability to effectively cope and adapt when faced with loss, hardship or adversity. It is a dynamic process that minimizes the negative results of exposure to an adverse situation. (Tugade & Fredrickson 2004, 320; Fergus & Zimmerman 2005.) One of the objectives of Zander and Hutton (2012) was “to use the findings to develop strategies that can be implemented at an organizational level to support the development of resilience in nurses”. They found seven major aspects that the nurses used in forming resilience: the nurses’ individual conceptualization of resilience, the issues and challenges they face that help “stretch their limits”, techniques and strategies they use to develop resilience, the need to acknowledge their need for support and awareness of available support, good insight into their own personality and behaviour, processing situations through reflection, and personal and professional experience. (pp. 20 – 22.)

According to Bush (2009), Lazarus and Folkman (1984) asserted that it is rather how an individual responds to stressors that influences stress and coping responses, and not the stressors themselves. They either respond in an action-oriented and problem-solving manner (adaptive coping response), or resort to ineffective coping responses and defensive mechanisms like substance abuse and withdrawal. (p. 26.) There are several styles with which an individual may respond in coping with stressful situations. For example, the Coping Inventory for Stressful Situations (CISS), pioneered by Endler and Parker (1990) identifies three coping styles: task-oriented coping (i.e. taking actions to solve the situation), emotion-oriented coping (e.g. self-blame, anxiety and worry), and avoidance-oriented coping. An understanding of the coping responses of nurses working in different healthcare settings can help understand how to develop resilience-promoting interventions for the nurses. In this study, the term “coping strategy” is differentiated from “coping responses” (see paragraph 1 of 2.3.2 above; cf. Adriaenssens, De Gucht & Maes 2012).

3 PURPOSE, AIM, AND RESEARCH QUESTIONS

The purpose of this study was to find out helpful strategies that are being employed in coping with compassion fatigue among nurses of different areas of speciality. This purpose goes in line with the recommendation of Yoder (2010) to find which coping strategies are most helpful (p. 196). How widely the coping strategies are used was also discussed. Nurses' own perceptions of the helpfulness of these strategies were also considered. This was done by extracting and synthesizing information from relevant electronic research articles.

This study was aimed at producing a structured collation of information on the coping strategies that may be most helpful in different specialities of the nursing profession, which could be utilized by nurses as well as healthcare policy decision makers.

The following research questions were developed to help achieve these goals.

- 1. What are the strategies that are being employed among nurses in coping with compassion fatigue?**
- 2. In which specialities of the nursing profession have these coping strategies been reported as helpful?**
- 3. What are nurses' perceptions of the helpfulness of the strategies used among them in coping with compassion fatigue?**

4 IMPLEMENTATION OF THE STUDY

This study was conducted as a *narrative literature review*, though some principles of *systematic literature review* were incorporated, for instance in the strictness of the inclusion and exclusion criteria, and in the explicitness of the search protocols. This was done to somewhat minimize errors and improve transparency.

4.1 The Principles of Literature Review Method

A literature review is a comprehensive summary of the ideas, issues, approaches and research findings that have been published on a particular subject area or topic (Kiteley & Stogdon 2014). It is a thoroughly and objectively done summary and critical analysis of relevant research and non-research literature on a particular topic (Hart 1998). Jones (2008) reveals that in healthcare field, literature review can aim to assess current knowledge on the efficacy or helpfulness of an intervention, for instance, to provide evidence base for the preferred treatment method of a particular disease (p. 32). This goes in line with the purpose of the current study, which will be achieved by answering research questions 2 and 3.

Narrative (or traditional) literature review focuses on identifying the conceptual and theoretical approaches used by several authors to understand a phenomenon, and offering a critique of the authors' contributions in their study. Assessment and interpretation of the findings are then offered. (op. cit. p. 33.) The assessment and interpretation primarily provides comprehensive understanding of the subject matter and highlights the significance of new research (Cronin, Ryan & Coughlan 2007). Narrative literature review is viewed as less rigorous than systematic literature review (Kiteley & Stogdon 2014, 11).

Systematic literature review aims to provide a comprehensive list of all published and unpublished studies on a subject matter. It uses explicit and rigorous criteria to search out, systematically assess, and synthesize studies that are relevant to the subject matter. (Cronin et al. 2007.) The large number of studies that are included in systematic reviews makes the evidence base and generalisations more reliable. A strict pre-defined protocol is followed in a systematic literature review. (Systematic Reviews: CRD's Guidance for Undertaking Systematic Reviews in Health Care 2009.) According to Lappalainen (2010), Kääriäinen and Lahtinen (2006) said that the systematic review protocol must be repeatable and bias should be minimised. Systematic literature review, in health and social care, aims to improve clinical practice by assessing the efficacy of a healthcare intervention. In other words, it facilitates evidence-based clinical practice. For this reason, emphasis is placed on judging the quality of the evidence provided in each one of the literature included in the review. (Jones 2008.)

4.2 Electronic Article Search and Selection

A multi-stage article search and selection process was conducted in this literature review. The search, which included only scientific articles in electronic format, was first conducted on 10th of October, 2013. The same search was conducted again in January 2014 to include any new articles published in the end of 2013. The search was conducted in the CINAHL, Elsevier ScienceDirect, OVID, and PubMed databases for articles which contain the phrase "compassion fatigue" with regards to nurses of any specialization, and also include the interventions used to treat, prevent or cope with compassion fatigue. Four databases were surveyed in accordance with the proposition of Kitchenham, Brereton, Turner, Bailey, and Linkman (2009), as stated by Järvinen (2012, 4–5), that in a good systematic literature review at least four electronic databases are surveyed.

The keywords chosen for the search were “compassion fatigue”, “nurse”, “cope”, “coping”, “intervention”, “prevention”, and “treatment”. These words were chosen by examining a sample of articles on the subject matter to find which words were often used. The words *nurse*, *intervention*, *prevention* and *treatment* were truncated as *nurs**, *interven**, *prevent**, and *treat** respectively. The search phrase combination deduced was as follows: **“compassion fatigue” AND nurs* AND (cope OR coping OR interven* OR prevent* OR treat*)**.

First, an all-text-field search was made in the four chosen databases and was limited to articles published from 2003 to 2013. Additional search limits were set to retrieve only articles written in English language, and only those available as free full-text. The search settings were done according to the available options on each database as describe in TABLE 2. The available search options were not uniform for all four databases. In this stage, the CINAHL, Elsevier ScienceDirect, OVID and PubMed databases produced 28, 109, 59, and 9 articles respectively, totalling 205 articles.

TABLE 2. Description of search settings used for the chosen databases

	Search Setting Description	Result (n)
CINAHL	Search Field: TX All text Limiters: Linked Full Text Publication Date: 2003 – 2013	28
Elsevier ScienceDirect	Search Field: Full Text (Advanced search) Limiters: Refine your search: Journals Science: Nursing and Health Professions Publication Date: 2003 – 2013	109
OVID	Search Field: Keyword (Advanced search) Limiters: Publication Date: 2003 – 2013	59
PubMed	Search Field: TX All text Limiters: Free full text available Publication Date: 2003/01/01 – 2013/12/31	9

Following the recommendation of the University of York Centre for Reviews and Dissemination (Systematic Reviews: CRD's Guidance for Undertaking Systematic Reviews in Health Care 2009, 24), a pilot selection was conducted on a sample of the retrieved articles based on predetermined inclusion criteria. This helped to further refine the inclusion and exclusion criteria to ensure that the selected articles would answer the research questions. The final inclusion and exclusion criteria are listed in TABLE 3.

The titles and abstracts of all two-hundred-and-five (205) articles were then assessed against the inclusion criteria to determine whether they were suitable for the study; duplicated articles were singularized. This stage gave a total of eighteen (18) articles.

In the final stage of the selection process, taking into account the relevance of the conceptual, theoretical and methodological approaches used in the studies (Jones 2008), the eighteen full articles were read and assessed against the inclusion and exclusion criteria to see if they clearly answered any of the three research questions. *Seven* articles were chosen for the study. *Eleven* articles were excluded: *seven* articles only suggested or mentioned coping strategies with compassion fatigue but did not conduct a first-hand research to back it; *two* articles examined coping strategies with respect to stress in general; *one* article examined the availability of compassion fatigue mitigating interventions to a sample of nurses; *one* article used the phrase "coping strategies" but actually studied coping responses (see sub-section 2.3.2 and section 2.4 above). Illustration of the stages of the article search and selection process is found in FIGURE 2.

TABLE 3. Inclusion and exclusion criteria

<p>Inclusion criteria</p> <ul style="list-style-type: none"> • Scientific articles in electronic format and available as free full-text within JAMK University of Applied Sciences' database resources • Articles that reported strategies and interventions in coping with compassion fatigue used by healthcare professionals including, but not necessarily restricted to, nurses. • Articles that mentioned or discussed the nurses' own perception of the helpfulness of coping strategies with regards to compassion fatigue <p>Exclusion criteria</p> <ul style="list-style-type: none"> • Articles that only suggested coping strategies with compassion fatigue, without the backing of research data • Editorials, Letters to the Editor, book reviews and commentaries which only reviewed or made reference to other studies that investigated nurses' coping strategies with compassion fatigue • Articles that reported compassion fatigue in veterinary caregivers

Although the studies done by Kravits, McAllister-Black, Grant and Kirk (2010), and Mackenzie, Poulin & Seidman-Carlson (2005), did not focus on compassion fatigue specifically but on stress and burnout in general, one of the instruments used in their evaluations, the Maslach Burnout Inventory-Human Services Survey (MBI-HSS), has an *emotional exhaustion* (EE) component which reflects the degree of compassion fatigue experienced (Kravits et al. p. 133). Hence, they were included in the review.

The reference list of each of the selected articles was scanned through for any potential source of required data. Sources found did not fulfil all the inclusion criteria and were hence left out.

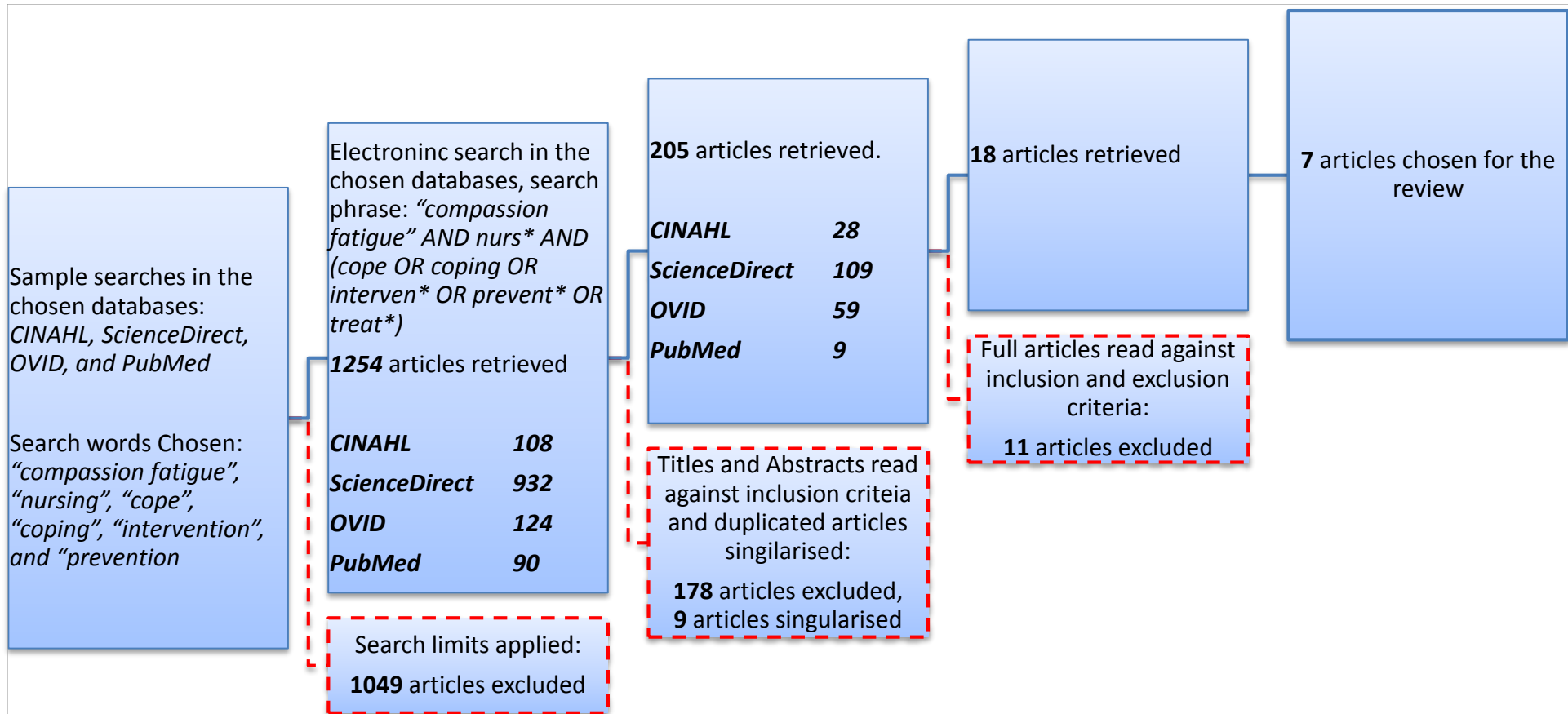


FIGURE 2. Flowchart of article search and selection process

4.3 Analysis and Synthesis

The checklist provided by the critical appraisal skills programme (CASP) was employed to help guide the reviewer's thought process in understanding and appraising the chosen literature (10 questions to help you make sense of qualitative research). The questions were modified to suit the purpose of each study as advised by Cronin et al. (2007).

The selected studies were carefully read through, with special attention being paid to the findings and discussions sections. The contents and structure of the interventions used in the studies were also examined. Data relevant to the purpose of the current study was extracted and tabulated to facilitate comparative overview. The data was then categorised and organised into themes. A summary of the basic characteristics of the selected articles including the purpose of each study, participants and settings, and the method used to conduct the study is presented in Appendix 3.

Narrative synthesis was the choice method in this study. It adopts a textual approach in analysing the patterns and relationships between and within the studies. It is used for working with diverse data. It also provides an overall assessment of how robust the evidences that the studies present are. (Kiteley & Stogdon 2014, 17; Systematic Reviews: CRD's guidance for undertaking systematic reviews in health care. 2009.)

5 RESULTS

The results of this study showed that in the past decade, a few studies have investigated how nurses cope with compassion fatigue. The coping strategies employed by nurses, the specialties of nursing in which they have been reported as helpful, as well as the evaluation of the helpfulness of the interventions/coping strategies were synthesised.

The selected studies (n = 7) had been published in English language and were all North-American: United States (n = 6) and Canadian (n = 1). Each selected study fell into one of two categories: **A.**, studies in which strategies used by nurses to cope with compassion fatigue were explicitly reported (n = 2) and **B.**, studies in which interventions to improve the coping ability of nurses were tested and evaluated (n = 5). To analyse articles of the second category, the nature of each intervention used in the studies was examined to identify which coping strategies it provided the participants with. This was based on the reviewer's thinking that all healthcare interventions for combating compassion fatigue aim at equipping nurses with coping strategies. *Note.* The works of Maytum (2004) and Yoder (2010) were the foundation for the themes used to categorise the identified coping strategies.

5.1 Multi-Strategy Intervention Programmes in the Selected Studies

Interventions were viewed as incorporating multiple coping strategies including arts, teaching, and exercise, to help nurses cope with compassion fatigue.

A Mindfulness-based stress reduction (MBSR) programme

Mindfulness is the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally, to the unfolding of experience moment

by moment (Kabat-Zinn 2003). Henry and Henry (2003) stated that practicing the tenets of mindfulness is one way nurses can achieve sensitivity and understanding, both of self and co-workers, they need to protect themselves from compassion fatigue. The study done by Mackenzie et al. (2005) tested a shortened version of the traditional MBSR programme (see Appendix 4. for overview of programme content), which better fits into nurses' work schedules, on a sample of nurses and nurse aides. The coping strategy that was identified here falls under the theme *introspection or self-analysis* (see Yoder 2010). To differentiate MBSR exercises from simple introspection, the term *structured/guided introspection* was employed. In addition to this, the intervention was identified as a self-care activity which falls under the theme *engaged in self-care activities*.

Psycho-educational interventions

Psycho-education or psycho-educational intervention is a professionally delivered treatment modality that integrates and synergizes psychotherapeutic and educational interventions (Lukens & McFarlane 2004). This can be used with an individual or a group. Kravits et al. (2010) taught self-care behaviours to nurses using a single 6-hour class of discussions and interactions. The interventions they used included relaxation and guided imagery training, art exploration of proactive coping strategies, and creation of a personalized wellness plan (see Appendix 5. for overview of programme content). One theme that was identified from these is *engaged in self-care activities*. Another theme was *guided introspection (reflection)* as indicated by the authors to be the aim of the explorative art and guided imagery practice that concluded the programme (Kravits et al. 2010, 132–133).

The study conducted by Potter et al. (2013) employed a psycho-educational approach to teach nurses about compassion fatigue in a thorough discussion. The interventions that were integrated in the programme were to promote resilience by self-regulation, intentional living, self-validation, social support connection, and self-

care. A four-hour offsite retreat for debriefing and self-care practice, including a healing arts programme, was also integrated. The themes identified were *engaged in self-care activities, debriefed formally with colleagues, and developed a personal philosophy of nursing care.*

Transformational Leadership “Prosperity-Planning” Coaching

Transformational Leadership was defined as leadership that identifies and communicates vision and values, and asks for the involvement of the workgroup to achieve the vision (The Magnet Recognition Program® Application Manual 2008, 23). The project undertaken by Rivers et al. (2011) aimed to assist nurses in developing resilience to the effects of compassion stress, a precursor of compassion fatigue, by means of life coaches partnering with nurses in a thought-provoking and creative process which will inspire them to maximise their potentials in all areas of life. The theme identified was *developed supportive professional relationships.*

A bereavement support programme

Fetter (2012) reported the use of an integration of methods to form a program that will support both the caregivers and families of those receiving end-of-life care. A remembrance tree helped the staff openly discuss memories of patients who recently passed away; journals and bereavement cards helped provide the nurses self-reflection and self-care, and closure; a picture on the door to patients’ rooms helped improve mindfulness and courtesy. Themes identified were *debriefed informally with colleagues, introspection, engaged in self-care activities, and increased participation in patient support.*

5.2 Coping Strategies

A total of twenty (20) distinct coping strategies were identified: Seven (7) personal coping strategies and thirteen (13) work-related coping strategies (TABLE 5). The

various coping strategies identified from the analysis of selected studies were categorised into work-related coping strategies, and personal coping strategies, using the works of Maytum et al. (2004) and Yoder (2010) as foundation. Among the selected studies, there was not a wide variation between the types of coping strategies identified. Most of the identified themes fit into those of the foundational studies. One exception was the theme *increased participation in patient support*. One other one that slightly varied from the theme of *introspection* was the theme of *engaging in structured/guided introspection* (e.g. MBSR programmes). Another slight variation was a form of debriefing not found in the themes of the foundational studies: *Debriefing formally with non-collegial professional*. Both Maytum et al. (2004) and Yoder (2010) described the coping strategies based on the length of time in which they were used, i.e. long term and short term.

Engaging in self-care activities was the most used personal coping strategy, appearing in five of the seven selected studies. *Structured/guided introspection* and *“personal” introspection* (or reflection) were also prominent personal coping strategies. Although Yoder’s (2010) study was based on the themes developed by Maytum et al. (2004), she found the use of spiritual or religious methods to be one personal coping strategy that was reported by Maytum et al. (2004) study participants.

Debriefing topped the list of work-related coping strategies, appearing in four of the seven selected studies. This included formal and informal debriefing, with colleagues or a non-collegial professional. TABLE 4 shows a summary of the results of this study.

A noticeable pattern is the rise in the amount of research focused on interventions to combat compassion fatigue from 2010 to 2013. The interventions tested during this period had two noticeable ingredients that seem to form their basis: psycho-education and support.

TABLE 4. Identified Coping Strategies from Selected Studies

AUTHOR(S)/YEAR	INTERVENTION/ SPECIALITIES	IDENTIFIED COPING STRATEGIES	
		PERSONAL	WORK-RELATED
<p>Maytum, J. C., Heiman M. B., & Garwick, A. W. (2004)</p>	<p>No Intervention.</p> <ul style="list-style-type: none"> • Paediatrics <ul style="list-style-type: none"> ▪ Inpatient tertiary care ▪ Ambulatory care ▪ Community health ▪ Home care ▪ Hospice care 	<p>Short-term coping strategies</p> <ul style="list-style-type: none"> • Engaged in self-care activities (e.g. exercise, meditation, journaling, recreation) • Enjoyed non-work relationships • Maintained sense of humour • Maintained positive thinking and positive attitude <p>Long-term coping strategies</p> <ul style="list-style-type: none"> • Developed a personal philosophy of nursing care • Engaged in self-analysis including: <ul style="list-style-type: none"> ▪ Learned awareness of triggers ▪ Developed stress management techniques ▪ Developed new coping strategies • Developed supportive personal relationships 	<p>Short-term coping strategies</p> <ul style="list-style-type: none"> • Took time away from work • Engaged in self-assertive behaviours • Debriefed informally with colleagues following a stressful day • Debriefed formally with colleagues following codes, deaths, or incidents • Changed patient work assignment • Enrolled and attended in-service sessions and professional conferences <p>Long-term coping strategies</p> <ul style="list-style-type: none"> • Developed supportive professional relationships • Developed a conceptual framework of personal nursing practice • Developed an awareness of personal triggers for compassion fatigue and burnout • Developed an awareness of personal boundaries specific to nurse-patient relationships • Developed rituals for situations dealing with loss, grieving, or death • Chose a work environment congruent with personal philosophy; changed jobs when necessary • Enrolled in coursework for advanced training and nursing education

Note. The table continues on the next page.

Note. The table has been continued from the previous page.

Mackenzie, Poulin & Seidman-Carlson (2005)	MBSR. <ul style="list-style-type: none"> • Geriatrics <ul style="list-style-type: none"> ▪ Long-term and complex continuing care. 	<ul style="list-style-type: none"> • Engaged in structured/guided introspection (e.g. MBSR programmes) • Engaged in self-care activities 	NIL
Yoder E. A. (2010)	No Intervention. <ul style="list-style-type: none"> • Home care • Emergency Department • Intensive care • Progressive care • Oncology unit • Medical–surgical 	<ul style="list-style-type: none"> • Life outside work • Used spiritual or religious methods • Used Introspection or self-examination • Modified attitude toward stressful situation. Taking a positive perspective. 	<ul style="list-style-type: none"> • Changed personal engagement (disengaged or increased engagement) • Changed nature of work involvement • Debriefed informally • Took action to change/manage current situation • Developed ritual
Kravits, McAllister-Black, Grant & Kirk (2010)	Psycho-education. <ul style="list-style-type: none"> • Oncology 	<ul style="list-style-type: none"> • Engaged in self-care activities • Engaged in structured/guided introspection (e.g. exploratory art, guided imagery practice) 	NIL
Rivers, R., Pesata, V., Beasley, M. & Dietrich, M. (2011)	Life Coaching. <ul style="list-style-type: none"> • UNSPECIFIED 	NIL	<ul style="list-style-type: none"> • Developed supportive professional relationships • Debriefed formally with non-collegial professional
Fetter (2012)	A bereavement support programme. <ul style="list-style-type: none"> • Oncology 	<ul style="list-style-type: none"> • Engaged in self-analysis/introspection • Engaged in self-care activities 	<ul style="list-style-type: none"> • Debriefed informally with colleagues • Increased participation in patient support
Potter, Deshields, Berger, Clarke, Olsen, & Chen (2013)	Psycho-education. <ul style="list-style-type: none"> • Oncology 	<ul style="list-style-type: none"> • Engaged in self-care activities • Developed a personal philosophy of nursing care. 	<ul style="list-style-type: none"> • Debriefed formally with colleagues

5.3 Assessment of the Helpfulness of Coping Strategies

Category-A studies, which did not involve an intervention, gave the nurses' self-report on the coping strategies which worked for them. It was understood to also be a self-report that the coping strategies are helpful, at least, for the investigated sample. Other studies used qualitative methods (questionnaires and interviews) to evaluate the effectiveness of the interventions. This gives an insight into the helpfulness of the coping strategies that were incorporated in forming the intervention programme.

5.3.1 Instrument-based Assessment

A number of instruments were used to evaluate the interventions in the selected studies, some of which indicate the levels of compassion fatigue. Mackenzie et al. (2005), Kravits et al. (2010), and Potter et al. (2013) all used the Maslach Burnout Inventory-Human Services Survey (Maslach & Jackson 1981) as part of their assessment instruments. All three studies recorded a significant decrease in emotional exhaustion immediately after the intervention, which indicates the effectiveness of the coping strategies incorporated into their interventions: *self-care*, *structured/guided introspection*, and *developing a personal philosophy of nursing care*.

Although the Professional Quality of Life (ProQOL) scale also includes a measure of compassion fatigue, it was not considered suitable because the definition of compassion fatigue, which was used in the creation of the instrument, follows Figley's (1995a) definition i.e. *secondary traumatic stress*, which, in the reviewer's point of view, is different from compassion fatigue (see section 2.1 above). However, the *compassion satisfaction* component of the ProQOL, which is the pleasure one gets from helping others, was taken into consideration. (see Stamm 2005.) Besides Potter et al. (2013), Rivers et al. (2011) used the ProQOL. Their study indicated such coping strategies as *developing supportive professional relationships*, and *debriefing*

formally with non-collegial professional. Potter et al. (2013) did not record any statistically significant increase in compassion satisfaction, but Rivers et al. (2011) reported otherwise.

5.3.2 Narration-based Assessment

Rivers et al. (2011), Fetter (2012), and Potter et al. (2013) additionally used other means than assessment instruments. Rivers et al (2011) individually interviewed the participants. The participants all viewed their participation as a positive experience, stating that they acquired more self-awareness. Fetter (2012) both observed and discuss with the participants who verbalised that they were better able to talk about their thoughts or debrief. She also used a questionnaire to which 88% of the respondents gave positive responses. Indicated coping strategies included *increased participation in patient support*. Potter et al. (2013) used weekly questionnaires, which the overall response of the participants was positive. The coping skills that were indicated in these studies were *engaged in self-analysis/introspection, engaged in self-care activities, developed a personal philosophy of nursing care, developed supportive professional relationships, debriefed formally with non-collegial professional, and increased participation in patient support*.

5.3.3 Specialties of Nursing in Which Studies Were Undertaken

Three of the selected studies were conducted in oncology settings. One other included an oncology unit, in addition to home care, emergency department, intensive care unit, progressive care unit, and medical–surgical units. One other study was conducted among paediatric nurses in different settings, one in a gerontology setting, and one was unspecified.

6 DISCUSSION

The purpose of this study was to find out helpful strategies that are being employed in coping with compassion fatigue among nurses by answering three questions about these strategies and their helpfulness. The first question was to find out the strategies that are being employed among nurses in coping with compassion fatigue. The re-categorised list of coping strategies is presented below (TABLE 5).

TABLE 5. Nurses' Coping Strategies with Compassion Fatigue

PERSONAL COPING STRATEGIES	WORK-RELATED COPING STRATEGIES
<p>Short-term</p> <ul style="list-style-type: none"> • Engaging in self-care activities/life outside work (e.g. exercise, meditation, journaling, recreation) • Enjoying non-work relationships • Modifying attitude toward stressful situation. (Taking a positive perspective using humour, positive thinking and positive attitude) <p>Long-term</p> <ul style="list-style-type: none"> • Engaging in self-analysis or structured/guided introspection (e.g. MBSR, exploratory art, guided imagery practice) including: <ul style="list-style-type: none"> ▪ Learning awareness of personal triggers ▪ Developing stress management techniques ▪ Developing new coping strategies • Developed a personal philosophy of nursing care • Using spiritual or religious methods (e.g. prayer) • Developing supportive personal relationships 	<p>Short-term</p> <ul style="list-style-type: none"> • Debriefing formally or informally with colleagues or non-collegial professional following codes, deaths, or incidents • Changing personal engagement in patient care (disengaged or increased engagement) • Changing nature of work involvement (e.g. changing patient work assignment, taking time away from work) • Took action to change/manage current situation (e.g. Increasing participation in patient support) • Engaging in self-assertive behaviours • Enrolling in and attending in-service sessions and professional conferences <p>Long-term</p> <ul style="list-style-type: none"> • Developing supportive professional relationships • Developing a conceptual framework of personal nursing practice • Developing an awareness of personal triggers for compassion fatigue and burnout • Developing an awareness of personal boundaries specific to nurse-patient relationships • Developing rituals for situations dealing with adverse events e.g. loss, grieving, or death • Chose a work environment congruent with personal philosophy; changed jobs when necessary • Enrolled in coursework for advanced training and nursing education

The second question was to find out the specialities of the nursing profession in which these coping strategies have been reported as helpful.

The results of this study show similar coping strategies with compassion fatigue across an extensive range of nursing specialties, and in paediatric, adult, and geriatric care settings. One common characteristic among these specialties is the challenging and critical nature of their job. This suggests that nurses' experiences of compassion fatigue are similar whatever the speciality or setting.

The third question was to find out nurses' perceptions of the helpfulness of the strategies used among them in coping with compassion fatigue.

The evaluation of the helpfulness of these coping strategies puts self-care and self-reflection or introspection on top of the list of preferable coping strategies.

Debriefing and developing supportive professional relationships were also evaluated as very helpful. This information can serve as a pointer to nurses as to a good starting point, when they are looking to develop their coping strategies with compassion fatigue.

It is no doubt that a nurse needs more than one strategy. A combination of strategies will ensure that the different kinds of challenging events nurses encounter in their work are well combated from all perspectives known. Interventions like psycho-education and MBSR, as seen in some of the selected studies, cleverly combine a number of coping strategies to form a compact programme. The use of life coaches by Rivers et al. (2011) seems to take a "back-door" approach. It seems, although the life coaches might not necessarily know much about nurses' work environment and experiences, as they help the nurses in other aspects of life, they realised more work–personal life balance leading to improvements in the nurses' resilience. Maytum et al. (2004) also discussed the nurses' indication that a work–personal life balance is essential to managing compassion fatigue.

In discussing their findings, Maytum et al (2004) attributed the similarity in the pattern of coping strategies to the fact that all their participants cared for children with chronic conditions who required the care of nurses in different roles and from various settings. The finding of the current study expands the scope of this thought since nurses of other specialties besides paediatrics were included, and yet the same trend was observed. This suggests that nurses' experiences of compassion fatigue are similar across the spectrum of nursing specialities, leading to similar coping responses and strategies.

Previous studies have reported nurses themselves indicating that past experiences have helped them cope with subsequent episodes of compassion fatigue (Maytum et al. 2004, Yoder 2010). In their study of paediatric acute care nurses, Cook et al. (2012) found out that the nurses' experience level was critical to their process of coping (p. e11). Furthermore, Hinds' et al. (1994) suggestion that the coping process of newly graduated inexperienced nurses with stress differs from that of nurses who have had one year or more work experience might help put this into perspective. None of the studies included in this review reported the effect of work experience on how nurses cope with compassion fatigue, but, perhaps, experienced nurses can help mentor inexperienced ones on the job. This could be a cost effective strategy if a well-planned programme is developed to that effect.

6.1 Limitations to the Study

The findings of this study are not generalizable to all nurses in all healthcare settings. One reason being the selected studies were all North-American. Furthermore, only articles written in English and in electronic format were included. Other forms of publication were not included. The use of different research methods and assessment instruments in the selected studies also restricted data extraction and

synthesis. In spite of these limitations, the findings gives valuable insight into the kinds of coping strategies nurses use with compassion fatigue, and the helpfulness of these strategies.

An area of bias was the use of the themes reported by Maytum et al. (2004) and Yoder (2010) as the foundation for this study. This might have significantly limited the scope of the reviewer's reasoning, and perhaps more themes might have been revealed than those of the foundational studies.

6.2 Conclusion

There is an overall insufficiency of research investigating the ways nurses can cope with the insidious phenomenon of compassion fatigue. With constant reports of severe shortage of nurses and the loss of nursing workforce ravaging the healthcare sectors of different western countries, we cannot afford to overlook the quota compassion fatigue contributes to these issue. The key to combating compassion fatigue lies in the incorporation of the most helpful strategies into a single easy-to-do interventional programme that can fit into nurses' already busy schedules. This will be made possible only by acquiring more understanding on the coping strategies that are involved. How do the coping strategies work? What is the relationship between them? Such questions must be answered to a good extent in order to help nurses acquire the resilience they need in their job, and to flourish in compassionate care.

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APPENDICES

Appendix 1. Sources for the distinguishing characteristics of burnout, compassion fatigue, secondary traumatic stress disorder, and vicarious traumatisation

Bo1: *Maslach (1982b); Leiters et al. (1996); Salston et al. (2003, 168).*

Bo2: *Maslach et al. (2001).*

Bo3: *Maslach (1982a, 3); Maslach et al. (1986, 1); Maslach et al. (2001).*

Bo4: *Edelwich et al. (1980).*

CF1, CF2, CF4: *as compiled by Coetzee et al. (2010, 243).*

CF3: *Coetzee et al. (2010).*

STS1, STS2: *Figley (1983).*

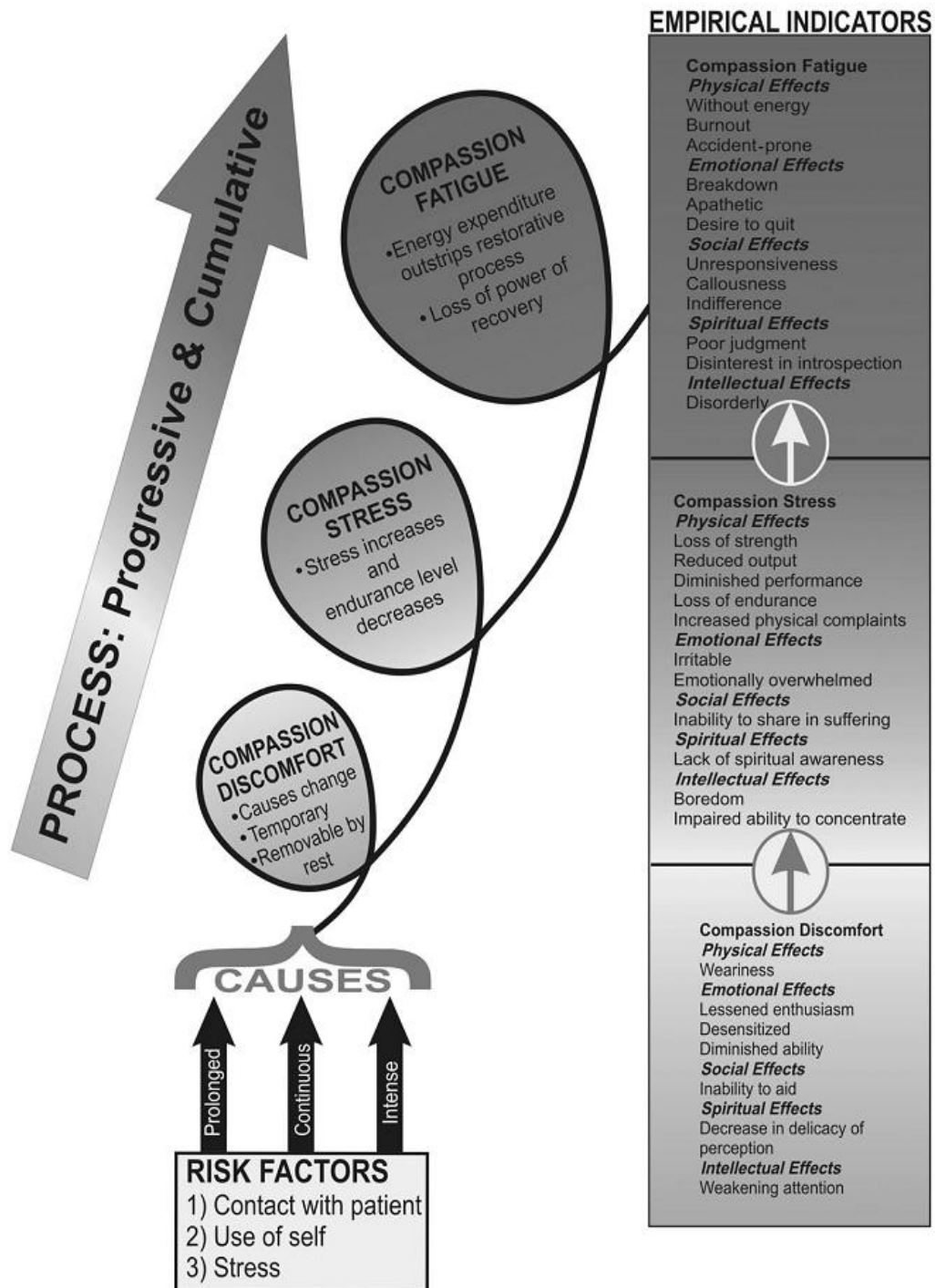
STS3: *Figley (1995c).*

STS4: *Figley (1995a).*

VT1, VT2: *Pearlman et al. (1995).*

VT3, VT4: *McCann et al. (1990); Baird et. al. (2006); Beck (2010).*

Appendix 2. Definition of the categories, characteristics, and empirical indicators of compassion fatigue (Coetzee et al. 2010, 240)



Appendix 3. Summary of Reviewed Articles

AUTHOR(S)/YEAR	PARTICIPANTS AND SETTING	PURPOSE	METHODOLOGY
Maytum, J. C., Heiman M. B., & Garwick, A. W. (2004)	Paediatric nurses with extensive experience working with children with chronic conditions from a variety of healthcare settings, including inpatient tertiary care, ambulatory care, community health, home care, and hospice care.	To identify the range and types of coping strategies used to manage compassion fatigue and prevent burnout.	A qualitative descriptive methodology (interview) was used to obtain data which was analysed using qualitative content analytic methods.
Mackenzie, Poulin & Seidman-Carlson (2005)	30 Nurses and nurse aides (16 underwent intervention, 14 were control participants) recruited from long-term and complex continuing care units in a large urban geriatric teaching hospital.	To address the relative dearth of research on mindfulness training with nonclinical populations and practicing nurses and nurse aides specifically, and to describe and evaluate the efficacy of a brief version of the traditional Mindfulness-Based Stress Reduction (MBSR) programme.	16 nurses and nurse aides completed the brief MBSR programme and provided pre-intervention and post-intervention evaluations (Maslach Burnout Inventory, Smith Relaxation Dispositions Inventory, and Intrinsic Job Satisfaction subscale from the Job Satisfaction Scale, Satisfaction With Life Scale, and the Antonovsky's Orientation to Life Questionnaire). The 4-week training programme consists of four 30-minute group sessions of instruction and experimental mindfulness exercises, and homework exercises to practice at least 10 minutes per day, 5 days per week. 14 control participants from the same care units completed outcome measures while on a wait-list for the programme.

Note. The table has been continued from the previous page.

Yoder E. A. (2010)	A broad spectrum of RNs (n = 106) employed in home care, emergency department, intensive care unit, progressive care unit, oncology unit, and medical–surgical units of a community hospital.	To describe the prevalence of compassion fatigue and to investigate the situations that lead to compassion fatigue and methods of coping.	Questionnaire with both quantitative and qualitative components: Demographic information, Professional Quality of Life Scale (ProQOL R-IV), and two narrative-response-inviting questions which answers were analysed using content analysis.
Kravits, McAllister-Black, Grant & Kirk (2010)	248 RNs, 51% of which were new-graduates and new-hire nurses experienced in nursing with or without experience in oncology, and 49% nurses who had been employed by their current employer for more than 1 year.	To develop and evaluate a psycho-educational programme that assists nurses to develop stress management plans.	A psycho-educational intervention; a single 6-hour class of relaxation and guided imagery training, art exploration of proactive coping strategies, and creation of a personalized wellness plan. Pre- and post-evaluations done using the Maslach Burnout Inventory—Human Services Survey (MBI-HSS), “Draw-a-Person-in-the-Rain” art technique, and the developed wellness plans. A course evaluation was also received from the participants afterwards.
Rivers, R., Pesata, V., Beasley, M. & Dietrich, M. (2011)	30 nurse managers and staff nurses.	To create a coaching model for assisting nurses in developing resilience to the effects of compassion stress/fatigue.	A 20-week partnership with a life coach to develop an individualized plan to help the participants prosper in all areas of their life. Participants had three face-to-face meetings and weekly telephone calls with their life coach. Participants completed pre-test and post-test assessments, comprising both a quantitative and qualitative instruments, as well as a brief interview.

Note. The table continues on the next page.

Fetter (2012)	Health care staff of an oncology unit (n = 50); 25 staff members which were nurses responded to the evaluation questionnaire.	To create a bereavement support intervention which will better support nursing staff, patients, and families throughout end-of-life care and, ultimately, significantly reduce compassion fatigue in the hospital unit by providing the inpatient oncology team with methods to combat it.	A bereavement support programme involving a) creation of a remembrance tree diagram on which the names and obituaries of patients who recently passed away were placed to help staff discuss openly about them and, hopefully, find peace and closure, b) helping the staff self-reflect and remember the impact they had on the deceased by means of journals and bereavement cards, and c) giving the nurses opportunity to take part in palliative care with the family by placing a symbol at the door of the patient's room to signify the need for privacy and silence, and the use of a bereavement package containing helpful materials that may be giving to the family members of the patient cope with the end-of-life care.
			Evaluation of the effectiveness of the programme was done by observing the participants and also by means of a questionnaire that required a descriptive response
Potter, Deshields, Berger, Clarke, Olsen, & Chen (2013)	13 oncology nurses employed in an outpatient chemotherapy infusion centre of a United States National Cancer Institute-designated comprehensive cancer centre	To evaluate a compassion fatigue resiliency programme designed to educate oncology nurses about compassion fatigue.	Nurses attended a five-week programme involving five 90-minute sessions on compassion fatigue resiliency. A pre- and post-test design, using repeated measures, was conducted over six months. The measuring tools were the MBI-HSS, Professional Quality Of Life scale (ProQOL IV), Impact of Event Scale –Revised (IES-R), and the Nursing Job Satisfaction Scale.

**Appendix 4. Overview of Shortened MBSR Intervention contents
(Mackenzie et al. 2005, 106)**

Program Component	Week 1	Week 2	Week 3	Week 4
Theme	Disengaging the automatic pilot	Dealing with barriers	Attachment and aversion	Developing and maintaining your own practice
Exercises	Mindful eating	Mindful stretching	Mindful sitting with awareness of thoughts	Body scan
	Body scan	Mindful sitting with awareness of the breath	Three-minute breather	Mindful sitting with awareness of breath and thoughts
Homework	Body scan	Mindful stretching	Mindful sitting with awareness of thoughts	Continuing mindfulness practice
	Mindfulness of an everyday activity	Mindful sitting with awareness of the breath	Three-minute breather	
		Paying attention to practice barriers	Paying attention to likes and dislikes	

Appendix 5. Overview of the Content and Structure of Psycho-Educational Intervention (Kravits et al. 2010)

Topic	Intervention(s)	Concept
Significance of self-care	<ol style="list-style-type: none"> 1. Psycho-education 2. Introduction to stress diary and wellness plan 3. Poem and art reflection 	Successful coping and adaptation can be promoted by stimulating belief in the personal power to control life circumstances, creating achievable goals and generating a positive mood (Folkman & Greer, 2000)
Stress and the stress response	<ol style="list-style-type: none"> 1. Psycho-education 2. Guided deep breathing and positive intention practice 	
Creation of a wellness plan	<ol style="list-style-type: none"> 1. Art directive exploring coping strategies 2. Initiate writing wellness plan 3. Grounding exercise practice 	
Coping options	<ol style="list-style-type: none"> 1. Art directive exploring challenges and options for managing challenges 2. Progressive muscle relaxation practice 	Cultivation of meaning-based resilience supports positive adjustment to risk or threat, expansion of coping options and promotion of prosocial interactions (Haase et al., 1999)
Completion of the wellness plan	<ol style="list-style-type: none"> 1. Refine and complete the wellness plans 2. Guided imagery practice 	