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PERCEIVED IMPACT OF COMPASSION FATIGUE AND ITS COPING STRATEGIES AMONG NURSES IN LAGOS STATE UNVERSITY TEACHING HOSPITAL

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ABSTRACT: *Most nurses enter the field of Nursing with the intent of helping others and providing empathetic care for patients with critical physical, mental, emotional, and spiritual needs. However, providing empathetic care can take a tool on them as they navigate through their profession. This study was carried out to investigate the perceived impacts of compassion fatigue among nurses in LUTH, Idi-Araba. Questionnaire was used to gather information from 186 respondents who were selected using multistage sampling technique. Prevalence was measured using the post-traumatic stress scale. Data collected was analysed using SPSS version 22 and the results were represented with frequency tables and charts. Finding from the study shows that 30.1% met the criteria for moderate compassion fatigue while 45.1% and 15% met for high and severe compassion fatigue respectively. Some of the impacts of compassion fatigue as identified by the nurses include burnout (74. 8%), decreased sensed sense of empathy (68.8%), frequent fall-out or relationship breakdown with patients (68.8%) and tendency for the nurse to make medication errors (61.4%). Coping strategies adopted by the nurses are mostly problem-focus and include balancing of work life and home demands (78.5%), finding time to rest (76.4%), and ensuring peace with family members and neighbours (72%). Recommendation for the study included provision of professional counselling, elongation of annual leave duration and employment of more nurses.*

KEY WORDS: perceived impact, compassion fatigue, coping strategies

INTRODUCTION

Nurses are saddled with the responsibilities of caring for patients and their families in a manner that is expected to be humane, responsive, empathetic, collaborative, and culturally informed (Ezenwaji et al., 2019). The expectation to provide such quality care for patients with severe emotional and physical distress with limited resources predisposes nurses to compassion fatigue (O'Callaghan et al., 2019; Ezenwaji et al., 2019). Many nurses are faced with the challenge of heavy workload and are exposed to acutely and chronically ill patients (O'Callaghan et al., 2019). Nigerian nurses in particular are exposed to greater physical demand due to high patient-nurse ratio resulting from mass exodus of nurses to the developed nations and high expectations from patients and family in the midst of poor working environment.

It has been reported that the quality of life of professional nurses has two opposing aspects. This include compassion satisfaction which refers to the positive feelings derived from helping others going through a traumatic experience and compassion fatigue which refers to a combination of physical, emotional and spiritual depletion associated with caring for such

individuals (O'Callaghan et al., 2019; Cross, 2019). It is important for nurses to maintain a balance between these two aspects to sustain their morale.

According to Boyle (2011) despite the fact that caring and compassion are at the core of relationships between nurses and patients, there is always a cost to caring. Compassion fatigue can affect how nurses care for their patients; hence there is need for its better understanding to foster appropriate intervention (Barnett, Hays & Cantu, 2019; Cross, 2019). Nurses may incorporate the emotions, fears, and grief of their patients following extended exposure to traumatic experiences resulting into increase psychological trauma.

Compassion fatigue has been described as the combination of emotional, physical, and job-related outcomes of expending one's energy in the provision of compassionate, empathic care to others over any period of time (Aycock & Boyle, 2009; Adimando, 2017). This phenomenon has been vicariously referred to as secondary traumatic stress; vicarious trauma, burnout and victimisation, among others but the overarching features, predisposing factors, and potential consequences remain somewhat consistent (Nolte et al., 2017).

Irrespective of specialty or discipline, carers of patients with chronic illness and their families have been reported to be at highest risk for experiencing compassion fatigue (Figley, 2012; Maytum, Heiman, & Garwick, 2014; Yoder, 2010). Those caregivers who work with traumatized patients have also been identified as high risk for compassion fatigue (Boyle, 2011; Lombardo & Eyre, 2011; Stewart, 2009). The continuing and on-going contact with grief and medically poor outcomes also lead to a long-term sense of hopelessness or compassion fatigue (Wentzel & Brysiewicz, 2018).

Studies have shown that most nurses experience moderate to high compassion fatigue (Teresa-Anne et al., 2016; Shahar, Asher & Ben Natan, 2019). According to Rossi et al. (2012), nurses are exposed to an exorbitant amount of patient trauma and workplace stressors that leave them at a heightened risk for the development of compassion fatigue. The stress level increases from helping or wanting to help the traumatized person and it continue to rise especially in the absence of available or reduced help or when the individual dies (Aycock & Boyle, 2009; Hiçdurmaz & Inci, 2015). In a meta-synthesis by Nolte et al (2017) on compassion fatigue in nurses, unbearable workplace weight and lack of support were identified as the two major factors that triggered compassion fatigue among nurses.

Compassion fatigue may have untoward effects in different facets of a caregiver's professional and personal life. These effects range from physical effects to emotional effects, and work-related effects, all of which can have adverse consequences on the quality care rendered to the patients (Meyer, Li, Klaristenfeld, & Gold, 2015; Rossi et al., 2012; Sarafis et al., 2016). The physical effects may include somatic complaints, such as headache, sleep disturbances, lack of concentration, fatigue, and muscle tension, all of which can contribute to missed work days, increased accident proneness and errors, and decreased performance and/or endurance for job-related activities (Coetzee & Klopper, 2010; Jenkins & Warren, 2012; Lombardo & Eyre, 2011). Emotional effects of compassion fatigue may include anxiety, depression, labile mood, resentment, anger, and poor judgment all of which can predispose nurses to emotional outbursts, and tendency to shift blame on others (Coetzee & Klopper, 2010; Smith, 2009). These combined effects can also have implication for job satisfaction for the nurse.

Nurses cope with compassion fatigue and respond to stressful situations by employing different coping styles. Some nurses may take actions to solve the situation, some use emotion-oriented coping styles such as self-blame and anxiety), while others try to avoid the situation. Different coping styles with compassion fatigue have been documented. Prayer, humour, exercise, venting, distraction, withdrawing, continuing education, job change, and creation of boundaries have been reported by nurses as their common coping mechanisms: (Berger, Polivka, Smoot & Owens, 2015; Yoder, 2010). It is important to understand the coping responses of nurse so as to develop resilience-promoting interventions that will help to better resolve the compassion fatigue (Jarrad et al., 2018).

Identification of compassion fatigue will help to promote nurses' awareness, monitor and improve nurses' working conditions and inform policy in this direction. Thus this study is aimed at investigating the perceived impacts of compassion fatigue among nurses working in Lagos University Teaching Hospital (LUTH), Idi-Araba and to assess their coping mechanisms

METHODS

Design
A descriptive cross-sectional study design was used for the study. The method allows for the collection of data from the respondents in their natural environment without having to manipulate them.

Ethical Consideration
Ethical approval to conduct study was obtained from the research committee of LUTH, Idi-Araba Informed consent was gained from every participant, and their right to privacy and confidentiality was maintained throughout the study as all information derived from participants was made confidential

Study Population
This study was carried out among nurses in Lagos University Teaching Hospital, Idi-Araba. The hospital has 350 nurses who are distributed across different departments. Nurses from the adult emergency unit, intensive care unit, children emergency, orthopaedic, dialysis and cardio renal departments, male and female medical wards, male and female surgical wards and children's ward were involved in the study

Sample size determination
The number of nurses who participated in the study was determined using Taro Yemane's formula which is given as: $n = \frac{N}{1+N\,(e)^2}$

Where n = sample size
N= total population = 350
e= error margin = 0.05
Hence $n = \frac{350}{1+350\,(0.05)^2}$
n= 187
n≈ 208 adding 10% attrition rate

Sampling
A multistage sampling technique was adopted. This involved the clustering of all nurses in LUTH, and then the respondents were selected proportionately from the cluster given consideration to the number of nurses on each of the wards selected randomly. Simple random technique was then employed in the selection of the respondents

Instruments
Self-administered questionnaire was used to collect data for the study and was divided into 5 sections. Section A elicited information on the socio-demographic data of the respondents. Section B contained yes or no 9 items that was designed to assess the perceived impacts of compassion fatigue on the respondents. Section C assessed the prevalence of compassion fatigue among the nurses with the aid of the Secondary Traumatic Stress Scale (STSS), also known as the Compassion Fatigue Measuring Scale. The STSS measures the frequency of symptoms and the existence of compassion fatigue unlike other similar instruments that measure the respondent's risk of developing compassion fatigue now or in the future. This scale was developed by Bride et al. (2004) and contains 17 items with responses rated on a Likert scale ranging from 1 (never) to 5 (very often). The items fall into subscales of intrusion (items 2, 3, 6, 10, 13), avoidance (items 1, 5, 7, 9, 12, 14, 17), and arousal (4, 8, 11, 15, 16). These subscales stem from the DSM-IV criteria for post-Traumatic Stress Disorder (PTSD) as the wording of the items was taken into account to investigate symptomology among those secondarily exposed to trauma (Bride et al., 2004). A higher score on the STSS is indicative of a greater compassion fatigue experience. Section D consists of 6 items to determine the coping styles of the respondents with yes or no responses. The internal consistency of the STSS and its subscales has been reported and are all at or above 0.8 (Kotula, 2015). The reliability of the other parts of the instrument was ensured through the test-retest method by distributing the questionnaire to 20 nurses from General hospital, Gbagada, Lagos twice at 2 weeks interval. Correlation between the two set of questionnaire was determined and was deemed suitable for the study

Data Analysis
Data collected was analysed using SPSS version 22 and the results were represented with frequency tables and charts. The total score on STSS was obtained by summing the responses to all items while the subscale scores were obtained by summing the responses to items from each respective subscale. The compassion fatigue experienced was classified as little to none= 28; mild= 28-37, moderate= 38-43, High= 44-48 and severe= > 48.

RESULTS

The total number of questionnaire distributed was 208, but only 186 were completed by the respondents. This gives an approximate response rate of 90%. Most of the nurses are less than 40 years (67.74%) and 46.28% had 1-10 years working experience while 30.13% had 11-20 years working experience. The sample consisted of 63.45% female with majority of them in a marital union (73.1%). Junior nurses make up the majority of the respondents with NOII, NOI and SNO constituting 25.80%, 30.00% and 20.43% of the respondents respectively.

In table 2, the expression of compassion fatigue among the respondents was depicted. None of the respondents was totally without compassion fatigue symptoms. Approximately 39.8% of

the respondents met the criteria for mild to moderate compassion fatigue while almost half of the respondents (45.15%) met the criteria for high compassion fatigue, and 15.05% were in the category of severe compassion fatigue.

The manner in which the nurses' express the impact of compassion fatigue on them is captured in figure 1. More than two-third of the respondents identified frequent complaints of burnout as the greatest impact of compassion fatigue on them. Decreasing sense of empathy and impaired commitment to patients were respectively identified by 67.8% and 66.9% of the respondents as impact of compassion fatigue on them. Other impacts of compassion fatigue on the respondents that are worthy of mention are incessant fall out with patients and high rate of absenteeism from work as identified by 65.2% and 64.7% of the respondents respectively.

Table 1. Demographic Characteristics of the Respondents (n= 186)

Variables	Categories	n	%
Age (in Years)	Less than 30	52	27.96
	31-40	74	39.78
	41-50	48	25.80
	Above 50	12	6.45
Years of Experience	1-10	86	46.28
	11-20	56	30.13
	21-30	36	19.36
	Above 30	08	4.30
Sex	Male	68	36.55
	Female	118	63.45
Marital Status	Married	136	73.10
	Single	34	18.28
	Widowed	4	2.15
	Divorced	12	6.45
Rank	NOI	48	25.80
	NOII	62	33.33
	SNO	38	20.43
	PNO	24	13.00
	ACNO	14	7.53
	CNO	16	8.60

Table 2. Prevalence of Compassion Fatigue (n= 186)

STSS	Little or No	Mild	Moderate	High	Severe
n (%)	0 (0)	18 (9.68)	56 (30.10)	84 (45.15)	28 (15.05)

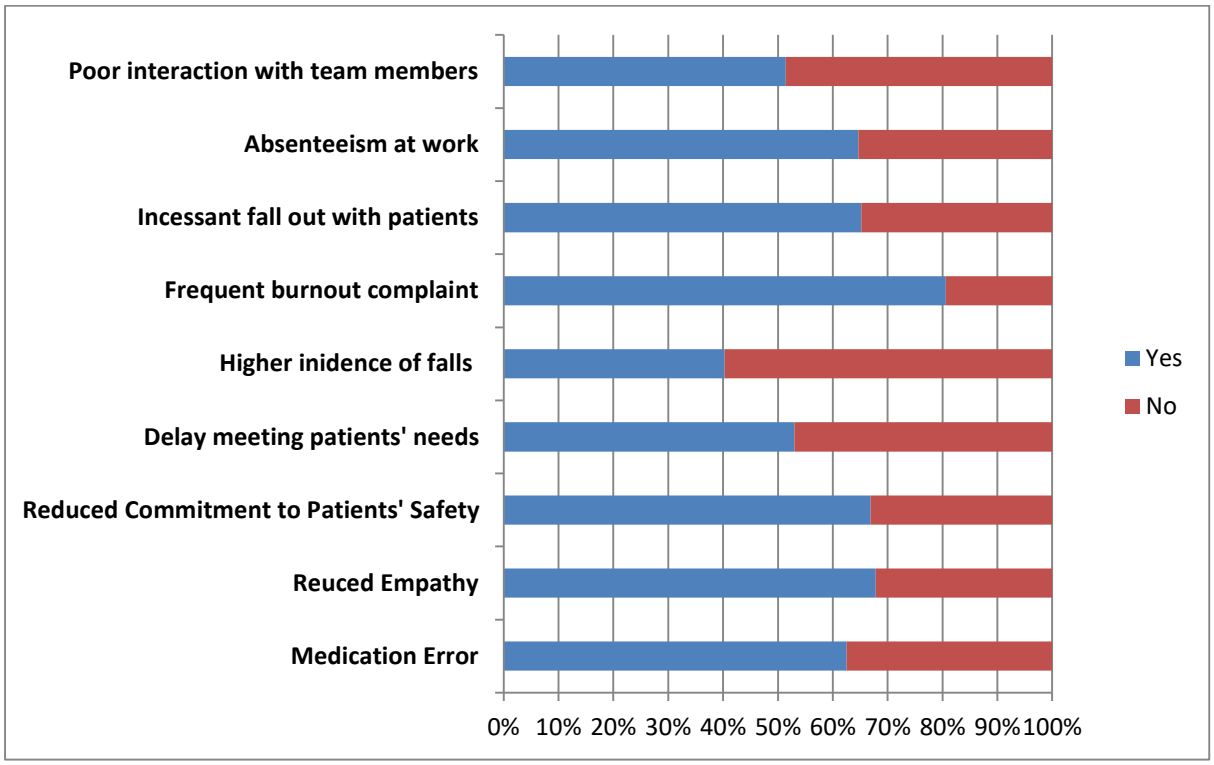

Figure 1. Influence of Compassion Fatigue (n= 186)

Table 3 displayed the frequency of coping methods adopted by the respondents to address compassion fatigue. The coping strategies with the highest frequencies are finding balance between work and home demand (78.5%), having good resting period (76.35%) and settling personal disputes between families and significant orders (72.05%). The least coping strategies adopted by the respondents include alcohol drinking and smoking (12.38%) and avoidance of work (19.15%).

DISCUSSION

It is important for nurses to be at optimal level physical, mental and emotional health for them to be able to render optimal care and ensure safety of their patients. This implies that allowing compassion fatigue to fester among nursing professionals can hamper quality care and lead to compromised patients' care. On the reality of this enormous harm, all the respondents in this study expressed varying categories of compassion fatigue symptoms. More than a third of the nurses had mild to moderate compassion fatigue; about half of the nurses had high compassion fatigue, while 15.05% of them had severe compassion fatigue.

Table 3. Respondents Coping Strategies (n= 186)

Variables	Yes n (%)	No n (%)
Having a good resting period	142 (76.35)	44 (23.65)
Seeking counsel and support when necessary	74 (39.8)	112 (60.2)
Settling all interpersonal disputes with husband, wife and others	134 (72.05)	52 (27.95)
Balancing work and home demands	146 (78.5)	40 (21.5)
Avoiding work	32 (19.15)	154 (80.85)
Drinking alcohol and smoking	10 (12.38)	176 (87.63)
Others specified (exercise, meditation, praying)	76 (40.85)	110 (59.15)

This finding is consistent with similar studies among mental health service providers in Nigeria where majority of the respondents were reported to be high risk for compassion fatigue (Adeyemo et al., 2015; Omoaregba et al., 2016). It also corroborates the findings from other studies outside Nigeria (Jarrad et al., 2018; Hooper et al., 2010; Shahar, Asher & Ben Natan, 2019; Upton, 2018; Wang et al., 2019) where moderate to high level of compassion fatigue was reported among nurses. This finding revealed that compassion fatigue is a serious problem among nurses in this setting contrary to what was reported by other authors (Al Barmawi et al.; Barnett, Hays & Cantu, 2019; O'Callaghan et al., 2019).

In O'Callaghan et al., (2019) one-third (31.4%) reported low levels, two-thirds (68.6%) had average levels and none had a high level in a study conducted among emergency nurses. Al Barmawi et al., (2019) and Barnett et al., (2019) also reported low level of compassion fatigue among critical care nurses and hospice nurses respectively. A possible explanation for this may be due to higher percentage of relatively young nurses in the O'Callaghan et al., sample (more than half are less than 30 years) compare to the present study where just about 28% are less than 30. This reflect the submission of Wang et al. (2019) who reported that increasing age and being married positively influence compassion satisfaction. Another point that is worthy of note is that the sample's years of nursing experience in O'Callaghan et al., study ranged from one to 48 years which is longer than in the present study. This suggests that years of experience may play a role in nurses' burnout experience. This is also consistent with the finding among nurses with few years of experience in maternity wards in South Africa where more that three-quarter had moderate to high compassion fatigue (Teresa-Anne et al., 2016). Furthermore, the reference studies were carried out in high income countries with better health care facilities compare to Nigeria. In addition, majority of the nurses are females and married. Married women have additional responsibilities in African setting; hence the stress of balancing work and home may contribute to compassion fatigue among the nurses. This observation is supported by a findings from similar studies conducted among nurses (Hee & Kyung, 2012; Jarrad et al., 2018; Wang et al., 2019). It was reported that married nurses were more prone to compassion fatigue than their unmarried counterparts.

There is no doubt that the high incidence of compassion fatigue among the nurses will impact the nurses adversely and affect the quality of care they render. They frequently complain of burnout which led most of them to have decreasing sense of empathy and impaired commitment to patients care. This is in line with the remarks of other authors (Al Barmawi et al., 2019; Figley, 2012) who posit that nurses' high level of compassion fatigue can result into poor judgment, loss of empathy, and decreased productivity. All these can rub the patients off the opportunity to receive quality nursing care.

Despite the respondents' fatigue level, they found ways to cope with the compassion fatigue. Two major coping styles have been identified in literature namely problem-focus and emotion-focus coping styles. The problem-focus coping style adopts problem solving approach which offers a better way of coping than emotion-focus (Omoaregba et al., 2016). In this study, the nurses mostly used problem focus coping mechanisms. More than three-quarter try to find balance between work and home demand. Considering the fact that most of the nurses are married and will need to find balance between home and work related stress, it is not surprising that this becomes the most adopted coping style by the nurses. Most of the nurses also reported finding adequate time to rest as a means of coping. Another problem-focus coping style adopted by the nurses is to settle whatever personal disputes they have with families and significant orders. This shows that the nurses are personally engaging in helpful coping styles as oppose to emotion-focus coping styles which has been found to predict compassion fatigue independently (Omoaregba et al., 2016). Despite the helpful coping styles developed by the nurses, the level of compassion fatigue is still high an indication that the compassion fatigue is beyond the coping capacity of the nurses.

Implication for Nursing Practice

The study strongly reveals that compassion fatigue among nurses in LUTH is high which has implication for patients' care and safety. The findings from this study have provided insights on how compassion fatigue affects the well-being of nurses. It is a critical issue that has to be given critical attention that it deserves by all concern. The nurses are engaging in problem-focus coping to address the issue, however, personal effort by the nurses need to be corroborated by government and hospital management. This may be achieved by employment of more nurses and provision of necessary equipment to aid nursing care delivery. Incentives should also be given to motivate the nurses. Provision of professional counselling and elongation of annual leave duration may also be needed.

CONCLUSION

Compassion fatigue is a menace that cuts across all cadre and specialties of nursing, and LUTH nurses are not left behind. The study found high level of compassion fatigue among the nurses which is express in varying degree of negativity such as reduce empathy towards patients, frequent burnout complain and reduced commitment to patients' care and safety. Although the coping strategies adopted by majority of them are ideal, there is the need for the management of Nigeria public hospitals to reduce the factors that can worsen the incidence of compassion fatigue among its nursing workforce.

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