

## COMPASSION FATIGUE AMONGST HEALTH CARE PROVIDERS

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### ABSTRACT

**Objective:** To find out the frequency of compassion fatigue in health care providers in military hospitals.

**Study Design:** Cross sectional comparative study.

Place and duration of study: Armed Forces Post Graduate Medical Institute (AFPGMI), CMH Rawalpindi, MH Rawalpindi and CMH Sialkot from December 2013 to July 2014.

**Patients and Methods:** Two hundred and fifty four health care professional participated in the study. The participants included doctors, nurses and male nursing assistants. The instrument for collecting data consisted of 'Professional Quality of Life Measure version 5' (Pro QOL-5) questionnaire. Data was analysed by using IBM SPSS version 22. The alpha value was set at  $< 0.05$  for significance.

**Results:** There were 128 male and 126 female participants with mean age of  $31.72 \pm 8.28$  years. Reliability of the questionnaire was determined by Cronbach's alpha which was calculated to be 0.81. Seventy nine participants (31.1%) showed low compassion fatigue, 168 (66.1%) showed average compassion fatigue whereas only 7 participants (2.8%) showed high compassion fatigue scores. The difference in frequency of three compassion fatigue levels was significant ( $p$ -value  $< 0.001$ ). Compassion fatigue was significantly different amongst doctors, nurses and nursing assistants ( $p$ -value = 0.049). There was no effect of gender on the compassion fatigue score ( $p$ -value  $< 0.01$ ).

**Conclusion:** Compassion fatigue is higher in doctors as compared to para medical staff irrespective of gender.

**Keywords:** Burn out, Compassion fatigue, Compassion satisfaction, Secondary traumatic stress, Vicarious trauma.

### INTRODUCTION

Compassion fatigue is a condition characterized by a gradual lessening of compassion over time<sup>1</sup>. It is also called vicarious trauma and secondary traumatic stress. Compassion fatigue was first diagnosed in nurses in the 1950s. It is common among individuals who work directly with trauma victims such as doctors and nurses specially the first responders. Compassion fatigue has been labeled as, "Cost of Caring" for others in emotional pain<sup>2</sup>. It has been defined as "A debilitating weariness brought about by repetitive, empathic response to pain and sufferings. It is a result of absorbing and internalizing the emotions of clients and, sometimes, coworkers. It is a deep physical, emotional and spiritual exhaustion accompanied by acute emotional pain<sup>3</sup>. Compassion fatigue is a term generally applied to health care providers those who work in the fields of trauma, mental illness, surgery,

emergency medicine, obstetrics, and rural general practitioners are particularly at risk<sup>4</sup>.

Health care professionals who are first hand responders to the traumatized patients internalize their stress and get affected by compassion fatigue<sup>5</sup>. Patients of compassion fatigue express symptoms like hopelessness, lack of pleasure, anxiety, stress, sleeplessness and a negative attitude towards life. This decreases self-efficacy and confidence leading to deterioration in performance and work output<sup>6</sup>. Multiple factors are involved in the pathophysiology of compassion fatigue. These may pertain to the personality of the sufferer or to external world. Both the factors have been claimed to be equally important. Personal factors are level of sympathy and compassion, age, gender, ideology and personality type. External or environmental factors are job related stress, support from society, family and friends, ethnicity and training. Anyone having both the sets of predisposing factors can be considered to be at high risk of developing compassion fatigue<sup>7</sup>.

There is a limited amount of literature focusing on compassion fatigue. A study conducted in nurses showed that they felt as

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they have become pessimistic, anergic, and less sympathetic towards their patients<sup>8</sup>. They realized as they were distancing from patients and even from their colleagues. Many studies showed that speciality has a profound impact on developing compassion fatigue<sup>9</sup>. Specialities in which health care providers encounter terminally ill patients are more likely to be affected by compassion fatigue. Various factors have been identified which trigger compassion fatigue and burn out. These 'triggers' have been grouped into three categories like sympathy for patients, organizational issues and personal problems<sup>10</sup>. Organizations and treating physicians should focus upon the triggering factors while dealing with compassion fatigue patients.

The most insidious aspect of compassion fatigue is that it attacks the very core of what brought us into this field, our empathy and compassion for others. Being a doctor or other helping professional is the perfect compassion fatigue formula. Caring for others with difficult, often chronic illnesses can be a draining emotional experience leading to substantial drop in emotional bank account<sup>11</sup>.

Maximum research on this subject has been conducted in the western world and inferences drawn from their data may or may not be relevant to us due to our own socio cultural peculiarities and other factors. To tackle the problem of compassion fatigue and to protect our people from CF, sound planning parameters need to be established which require basic data from our own set up. The current study was planned to find out the frequency of compassion fatigue in health care providers i.e. doctors and para medical staff in military hospitals.

## **PATIENTS AND METHODS**

It was a cross sectional comparative study conducted at Armed Forces Post Graduate Medical Institute (AFPGMI) in collaboration with CMH Rawalpindi, MH Rawalpindi and CMH Sialkot. Before starting the study, official approval was obtained from the concerned hospitals through AFPGMI. Written informed consent was also taken from all the participants before commencement of the study. Duration of

the study was from Dec 2013 to July 2014. A total of 281 participants were recruited in the study through non-probability purposive sampling. However, 27 respondents could not complete the questionnaire leaving a sample size of 254. The participants included doctors, nurses and male nursing assistants. Other health care related personnel, not directly related to patient care, were excluded from the study.

The instrument for collecting data consisted of 'Professional Quality of Life Measure version 5' (Pro QOL-5) questionnaire 12'Pro QOL-5' is a standardized instrument that has been adapted to measure symptoms and behaviors reflective of secondary stress. The Pro QOL-5 is the latest version launched in 2009. This is a closed ended and self-administered questionnaire having three parts. There are 30 items in Pro QOL-5 having responses on a 5 point Likert scale. Pro QOL-5 is made up of three subscales: low score for compassionate satisfaction (CS), high score for compassionate fatigue (CF) and high score for burnout.

Data was analysed by using IBM SPSS version 22. Descriptive statistics were used to calculate mean and standard deviation for continuous variables whereas frequency and percentage for the categorical variables. Inferential statistics were used for comparisons and associations amongst different variables. Response rate was calculated in terms of percentage. Reliability of the questionnaires was determined through internal consistency by applying Cronbach's Alpha test. Item analysis was performed by calculating mean  $\pm$  standard deviation of each item along with reliability analysis through 'item deleted' process. The alpha value was set at  $< 0.05$  for significance at confidence level of 95%. The data was presented as tables and graphs.

## **RESULTS**

Two hundred and fifty four health care professionals participated in the study at a response rate of about 90%. There were 128 male and 126 female participants with mean age of  $31.72 \pm 8.28$  years. Reliability of the questionnaire was determined by Cronbach's

alpha which was calculated to be 0.81, showing high reliability.

Seventy nine participants (31.1%) showed low CF, 168 (66.1%) showed average CF whereas only 7 participants (2.8%) showed high CF scores. One sample Chi square test showed that difference in frequency of three CF levels

insignificant. Cross gender tabulation showed that the difference was slight at moderate levels of CF but at high CF scores males were three times more affected as compared to females. This is inconsonant with International studies which suggest more vulnerability of women to CF as compared to men<sup>13</sup>. This difference may be due to the cultural effect as female health

**Table-1: Frequency, percentage and comparison of different levels of CF in three professional categories.**

CF level	Professional category			p-value
	Doctors (113)	Nurses (92)	Nursing assistants (49)	
Low	32 (28.3%)	32 (34.8)	15 (30.6%)	0.049*
Average	74 (65.5%)	60 (65.2)	34 (69.4%)	
High	7 (6.2%)	0	0	

**Table-2: Frequency, percentage and comparison of different levels of CF in males and females.**

CF level	Male (128)	Female (126)	p-value
Low	33 (25.8%)	46 (36.5%)	0.118
Average	90 (70.3%)	78 (61.9%)	
High	5 (3.9%)	2 (1.6%)	

was significant ( $p$ -value < 0.001)

Compassion fatigue was compared between the three categories of health care professional i.e. doctors, nurses and male nursing assistants as shown in table-1. Chi square test showed significant difference of CF among the three categories ( $p$ -value = 0.049) with high CF level present only in doctors (6.2%).

Table-2 illustrates the comparison of three levels of CF in males and females. Chi Square test revealed that the difference of CF in both the genders was not significant ( $p$ -value < 0.05).

## DISCUSSION

Participants' scores were calculated and categorized into the cut-offs for low, average, and high levels of CF in accordance with Stamm's guidelines. Results of our study demonstrate that compassion fatigue was significantly higher in doctors as compared to nurses and male nursing assistants. Moreover, high CF was only present in doctors being 2.8% of the total study population. Majority of the health care providers scored within the average range for compassion fatigue. Male health care providers were affected more than females although the difference was statistically

care providers in our society seem to be less involved emotionally with patients. Secondly, females in our society are comparatively less exposed to patients as compared to males having less chances of suffering from compassion fatigue.

Abendroth et al conducted a study to find out frequency of compassionate fatigue in health care professionals in America<sup>14</sup>. Their study included 238 participants and they reported that low, average and high compassion fatigue was present in 21.3%, 52.3% and 26.4% of their study population. Another study conducted by Sodeke-Gregson et al in UK reported low, average and high compassion fatigue in 0%, 30% and 70% health care professionals who participated in their study<sup>15</sup>. A similar study was conducted in Israel by El-bar et al who reported that low compassion fatigue was present in 42.2%, average in 11.7% and high compassionate fatigue in 46.1% participants of their study<sup>16</sup>. These findings are quite different from the results of our study. Compassionate fatigue seems to be a multifaceted and complex disorder. In addition to the factors intrinsic to patient, external factors are equally involved in its pathophysiology. The diversity of results

between these studies seems to be associated to the external factors pertaining to job related environment although internal factors cannot be totally ruled out.

Dasan et al studied 681 health care professional providers and reported that high CF scores were associated with the nature of work place and the number of years worked as health care professional<sup>17</sup>. They concluded that the CF scores became worsened over time. The main features differentiating 'satisfied' from 'fatigued' participants were the ability to deal with high work load and having positive view about the team with which they worked.

Ariapooran studied compassion fatigue in nurses and the role of social support in predicting this psychological disorder<sup>18</sup>. They reported that 45.3% and 15.03% of their study population had average and high CF scores respectively. Their study concluded that social support from family, friends and society was negatively correlated with both average and high CF scores ( $p$ -value < 0.01). According to hierarchical multiple regressions, social support from family was found to be the significant predictor of CF ( $p$  < 0.001).

Compassion fatigue is a disorder that generally goes unnoticed, adversely affecting the work output. Studies have reported that compassion fatigue varies amongst various specialities, being higher in the specialities where debilitating, terminally ill or dying patients are more frequently encountered. Health care professional working in such 'high risk' specialities need to be 'strengthened' by the organizations, society and the family so that their emotional bank could not be dried up.

## CONCLUSION

Significantly high percentage of health care professionals suffer from average level compassionate fatigue. It is more frequent in doctors followed by nurses, however unaffected by the gender. This may adversely affect their psychological health leading to decreased efficiency and work out put.

## CONFLICT OF INTEREST

This study has no conflict of interest to declare by any author.

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