

# Compassion satisfaction, compassion fatigue, compassion fatigue, and vicarious trauma A descriptive study of the impact of the COVID-19 pandemic on non-direct care nurses

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urse leaders in acute care hospitals are responsible for planning, implementing, and assessing healthcare services and training individuals who provide these services.<sup>1</sup> These individuals are pivotal for the development and maintenance of the healthy working environment necessary to provide quality and effective patient care while achieving organizational goals.<sup>2</sup> Nurse leaders routinely provide direct patient care less than 50% of the time. Although stress and burnout among nurses who provide direct patient care has been well documented, there's a correlation between nurse leader responsibilities and stress, fatigue, and professional satisfaction.<sup>3-5</sup> Survey results conclude that 62% of nurse leaders plan to quit their jobs due to burnout and stress within the next 3 to 5 years.<sup>6</sup> Hevezi posits that distress adversely impacts nurse leaders' well-being and their decision-making processes, which may affect staff, patients, and healthcare outcomes.<sup>7</sup> Having a positive and supportive work environment helps ensure a healthy work atmosphere for nurse leaders. Although the original intent

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of this research was to describe compassion satisfaction (CS) and compassion fatigue (CF) among non-direct care nurses, the study aim was broadened in response to COVID-19 to include vicarious trauma (VT).

Specifically, the study addressed the following research questions:

1) How do nurses in leadership positions self-describe their CS and CF, as assessed by the Professional Quality of Life (ProQOL) tool, and what was the impact of COVID-19 on these constructs?<sup>8</sup>

2) How do nurses in leadership positions self-describe their VT, assessed by the Vicarious Trauma Scale (VTS) as reported 13 months after COVID-19 was declared a global pandemic?<sup>9</sup>

#### **Theoretical frameworks** *Compassion*

Compassion was identified as a virtue by Florence Nightingale.<sup>10</sup> Compassion is "...the sensitivity

shown in order to understand another person's suffering, combined with a willingness to help and promote the well-being of that person, in order to find a solution to their situation."10 CS means the positive, altruistic feelings of self-appreciation achieved when caring for and helping others.11 CF is the psycho-emotional distress that occurs as sequela to long-term self-sacrifice and prolonged exposure to difficult situations.12 Research has determined that, although the relationship between CS and CF is weak, there's an inverse relationship between CS and burnout.13 There's a correlation between high levels of nurse caring and compassion to patient satisfaction and intent to stay.14,15 When viewed linearly, CS and CF serve as conceptual anchors.

CS is determined by the work environment, one's role requirements, and personal character-

#### **Research box**

**Purpose:** The aim of this longitudinal survey study was to obtain data from nurses who aren't required to provide direct patient care, such as nurse leaders, that describes their CS, CF, and VT.

**Location and description:** Survey data were obtained electronically from non-direct care nurses employed at three acute healthcare facilities located in the midwestern US. The facilities included a safety-net academic medical center, a community-based acute care facility, and a children's hospital.

**Time frame:** Data were collected pre-COVID-19 and repeated 13 months after the start of the pandemic.

**Population:** Study participation was solicited from nursing personnel whose job category didn't require more than 50% direct patient-care activities.

**Collection tool:** Study data, at the initial data collection interval, consisted of responses on the ProQOL Scale version 5. The VTS was added to the second data collection in response to COVID-19 experiences reported anecdotally at the study sites and in the media.

**Sample size:** Responses from each study site were combined prior to analysis. Initially, there was a 52.8% response rate (409/774), which decreased to 35.2% (180/512) at the second data collection interval.

**Results:** Comparative analyses identified a decrease in CS and a trend toward greater levels of CF. Clinically based nurse leaders also reported greater levels of VT.

istics.<sup>16</sup> Professional experiences associated with helping others promote CS, which "occurs when empathy drives altruistic behaviors on the part of the helper and results in the alleviation of patient suffering."17 Thus, CS provides a coping mechanism for the negative aspects of caregiving while experiencing hope and optimism. Although CS has been weakly linked to CF, the feelings of satisfaction and fulfillment when providing care assure that the care provided is appropriate and valued.18

CF is the result of long-term exposure to stressful, chaotic situations, where there's dissonance between the role demands and the available resources as well as an inability to control the outcome.19 This results in reduced empathy and inhibits the ability to remain engaged when providing care.12 Results from a concept analysis describe CF as "... the final result of a progressive and cumulative process that is caused by prolonged, continuous, and intense contact with patients, the use of self, and exposure to stress. ... It evolves from a state of compassion discomfort."20 These authors posit that CF occurs when the compassionate energy expended by nurses surpasses their restorative processes, at which point recovery power is lost and physical, social, emotional, spiritual, and intellectual challenges increase.20 Maslach and colleagues identified depersonalization; reduced output, endurance, or diminished performance; loss of empathy; and poor judgment as precursors to CF.<sup>21</sup> Specific CF outcomes include increased loss of workdays due to physical complaints

such as stomach pains, headaches, fluctuations in weight, accident proneness, and emotional breakdown.<sup>18,19</sup> Finally, decreases in CS and incidences of CF are higher among nurses in the presence of continued physical and psychological stress associated with providing care to seriously ill patients who may be traumatized.22 Although nurse leaders don't have the same clinical responsibilities as those who provide direct care, routine exposure to those with CF has transference risks.

#### Vicarious trauma

VT is defined as a detrimental alteration in the manner one understands and interprets traumatic events when the exposure has been second-hand.<sup>23</sup> Although distinct from posttraumatic stress disorder, VT has similar symptomology, including reexperiencing, avoidance of similar situations, and generalized depression.<sup>23</sup> VT assessment was added to the second data collection set in response to the COVID-19 pandemic.<sup>9</sup>

#### **Methods**

The first and second studies were determined to be exempt under 45 C.F.R 46.101(b)(2) by the study site's Institutional Review Committee.

#### Study design

The study design was guided by the concepts of compassion and VT, which impacted nurse leaders as they experienced profound challenges to ensuring a safe working environment. To collect study data, researchers used psychometrically validated tools that assessed compassion and VT.

## Table 1: Roles of nurses who responded to the second survey

	Frequency	Percent	Valid Percent	Cumulative Percent
No response	19	10.7	10.7	10.7
Case management	5	2.8	2.8	13.5
Employee health	6	3.4	3.4	16.9
Infection prevention	1	.6	.6	17.3
Informatics	11	6.2	6.1	23.5
Nurse leader	69	38.8	38.8	62.5
Nurse researcher	24	13.5	13.5	75.7
Other (please specify)	3	1.7	1.7	77.4
Professional development - educator, education specialist, faculty	33	18.5	18.5	95.9
Quality/performance improvement	4	2.2	2.2	97.1
Risk management	1	.6	.6	97.6
APRN nurse manager	1	.6	.6	98.9
Clinical practice and quality	2	1.2	1.1	100.00
Total	178	100.0	100.0	

#### Inclusion criteria

Participation was limited to nurses whose job duties didn't routinely require more than 50% direct patient care. At the study site, nursing roles that generally don't have at least 50% direct patient care included but weren't limited to case management, employee health, informatics, leadership, research, performance improvement, and professional development specialists (see Table 1). These individuals in non-direct patient care roles received a study invitation via email with an embedded link for accessing the study materials.

#### **Exclusion** criteria

Before providing access to the study survey tools, each potential

participant was asked to validate that they met the study inclusion criteria and acknowledge that the submission of a completed survey implied study consent. If the potential participant responded negatively to any items, the individual was thanked for their time and access to the study surveys was denied.

#### Study settings

Once research approvals were secured, data collection commenced. All study sites were Magnet<sup>®</sup>-recognized by the American Nurse Credentialing Center and included a safety-net academic medical center, a community-based healthcare facility, and an urban pediatric hospital.<sup>24</sup> Data were collected in fall 2019 and spring 2021. Pandemicrelated demands on the nursing staff prevented the safety-net academic medical center from participating in the second data collection. A contact person at each study site coordinated sitespecific study activities.

#### Sample size

The study had two separate 4-week data collection intervals. These occurred prior to the onset of, or even knowledge about, the impending pandemic. The second data set was collected 13 months after the World Health Organization announced that COVID-19 was officially a pandemic. Both studies were determined to be exempt by the study site's IRC (Institutional Review Committee). Employment data survey, the invitation distribution lists were similar. However, there was some attrition at each site during the time period between the two studies.

#### Study instruments

Data were collected using the ProOOL scale version 5, a 30-item 5-point Likert survey.8 The ProQOL, which has three subscales (CS, secondary traumatic stress, and burnout), was developed specifically for identifying the positive and negative aspects of those employed in a helping profession, including nurses.<sup>25</sup> Responses on the latter two subscales were summed to determine a CF score. The reported reliability, calculated as alpha scores, are .90 for CS, .84 for secondary trau-

#### Data analysis

Once data collection ended, responses were transferred to a study-specific SPSS program. Responses were analyzed using descriptive techniques and missing data were retained. Responses missing 10% or more of the data were deleted from the study data files.

#### Results

After data cleaning was completed, there was a total of 409 of a possible 774 respondents within the initial data set, or a 52.8% response rate. The response rate decreased to 35.2% at the subsequent data collection interval (180/512). Results are provided using percentile data to compensate for the variance in study participant size.



At the second data collection, 94.8% of participants reported average burnout, reflecting a marked increase (40.4%) in burnout.

were obtained from the human resources department at each study site, and specific employment codes were used to identify potential participants.

Initially, there was a total of 774 possible participants from all three sites but because the safetynet academic medical center couldn't participate in the second data collection interval, that number decreased to 512. Although it couldn't be determined if the individuals who responded to the initial survey also participated in the second matic stress, and .80 for burnout subscales.<sup>8,25</sup>

VT was assessed using the VTS.<sup>26</sup> This eight-item sevenpoint Likert scale was administered at the second data collection interval. Item responses range from strongly disagree (1) to strongly agree (7), which are summed to describe the VT experienced by the participant; higher scores correlate to higher levels of trauma. Reliability of the VTS, determined by a Cronbach's alpha, is between .84 and .88.<sup>9,26,27</sup> Demographically, these participants have either a bachelor's (47.5%) or a master's (45.1%) degree with 45.7% having a specialty certification. The largest group (44.7%) had 20 or more years of experience, and 46.4% were in their current position between 1 and 5 years. Sixty-three percent of participants used the terms *nurse leader, educator, education specialist,* or *faculty* to describe their positions.

Analysis of research question #1 Responses on the ProQOL tool were analyzed as instructed by

the author.8 Theoretically, professional quality of life contains a negative and a positive concept. CS is used to describe positive concepts and CF illustrates negative aspects. CF encompasses burnout and secondary traumatic stress. The author scored each subscale separately and then interpreted the scores.<sup>28</sup> Table 2 provides a summary of these scores; black responses are from the initial data collection, and red scores are from the second data collection.

CS includes the pleasant feelings associated with performing one's role satisfactorily, specifically helping others and having a positive contribution to managing the workload.8 Higher scores (greater than or equal to 42) in this subscale correlate to satisfaction specific to being effective in one's role. Scores less than or equal to 23 indicate the presence of job-related problems, or a situation in which satisfaction is

derived from non-work-related activities. Initially, CS responses were split between average (52.6%) or high (46.4%). At the secondary data collection, 62.2% reported an average and 30.4% earned a high CS score. Therefore CS, or perceiving oneself as being effective in one's role, decreased.

Burnout, as a negative construct of CF, is the hopelessness correlated to difficulties coping, or being ineffective in one's role. Burnout may have a gradual onset, either with the feeling that one's efforts make no difference, or a consequence of a high workload or non-supportive work environment. Initially, low and average burnout scores were similar (45.1% and 54.4%). Scores shifted at the second data collection. No one had a low burnout score, whereas average burnout was reported by 94.8% of the participants. This reflects a marked increase (40.4%) in burnout.

Secondary traumatic stress is the second construct encompassed by CF. This is workrelated exposure to people who've experienced traumatic events. Although the participant hasn't personally experienced these events, the exposure may cause sleep or thought disturbances as well as the desire to avoid scenarios reminiscent of the event. Initially, 61.3% of the study population reported low secondary traumatic stress scores. Low secondary traumatic stress scores were reported by 58.2% of the population at the second data collection interval. representing a 3.1% increase in secondary trauma.

#### Analysis of research question #2

Responses on the VTS were analyzed as directed by the authors.9 Responses were recoded into numerical data from 1 (strongly disagree) to 7 (strongly agree). The mean score of all participants

Table 2: Summary of ProUUL scores						
Compassion satisfaction sum scores	Frequency/percent of total population		<b>Compassion satisfaction level</b>			
22 or less	2 (0.10%)	0 (0%)	Low			
Between 23 and 41	123 (52.6%)	84 (62.2%)	Average			
42 or more	108 (46.4%)	51 (30.4%)	High			
Burnout scale sum scores	Frequency/percent of total population		Burnout level			
22 or less	102 (45.1%)	0 (0%)	Low			
Between 23 and 41	123 (54.4%)	127 (94.8%)	Average			
42 or more	1 (.5%)	7 (5.2%)	High			
Secondary traumatic sum scores	Frequency/percent of total population		Secondary traumatic stress level			
22 or less	141 (61.3%)	78 (58.2%)	Low			
Between 23 and 41	88 (38.2%)	56 (41.8%)	Average			
42 or more	1 (.5%)	0 (0%)	High			
Kov: Black scores are the initial data collection, and	rad source are the response	s from the second data collect	ion			

was 31.5. The mean score for those in nurse leader positions was 38.7. This outcome aligns with the changes in ProQOL results.

#### Discussion

Data from the initial data collection describe average CS, average burnout scores, and low secondary trauma scores. At the subsequent data collection interval, the overall scores didn't change, but the participant percentage within CS, burnout, and secondary trauma differed. Responses on the burnout subscale changed the most, from an average of 54.4% to 94.8%. Although these participants, for the most part, continued to experience workprovides the ability to describe CF. The change in secondary trauma scores describes a scenario where CF is emerging. Scores on the VTS, when separated by role, highlight the effects of secondary exposure to traumatic events. Study participants responsible for providing direct patient care reported higher experiences of VT.

When comparing the responses to the ProQOL over time to the responses on the VTS, two outcomes emerge. First, COVID-19 has had an effect among nurses who aren't required to provide direct patient care. This change,

#### Limitations

Data for this study were obtained from midwestern acute healthcare settings in an urban area, which limits generalization to other settings and geographical locations. The ongoing COVID-19 pandemic and its impact on nurses is ever-changing, and CS, CF, and VT assessments will fluctuate.

#### Leadership implications

The literature does describe interventions aimed at preventing burnout specific to nurse leaders. Nurse leaders with high levels of CS can reduce the personal CF and burnout of their direct staff.<sup>29</sup> High levels



Nurse leaders with high levels of CS can reduce the personal CF and burnout of their direct staff.

place CS with a minimal change in secondary trauma, there was an increase in burnout. Exposure to VT situations occurred more frequently among those participants in self-described nurse leader positions.

The ProQOL Manual states that high burnout scores, regardless of other scores, describe at-risk persons who increase the chances for at-risk workplace scenarios.<sup>28</sup> The trend from low to average correlates to an increased feeling of inefficacy as the result of personal or organizational factors.<sup>28</sup> Linking burnout scores to secondary trauma scores as indicated by scores on the ProQOL, represents an increase in secondary traumatic stress, placing the population at risk for burnout. Secondly, responses on the VTS among the subgroup whose role responsibilities require them to be in a clinical setting with those providing direct care reveal VT.

In conclusion, COVID-19 has had a negative effect on nurses who aren't direct care providers, especially those who are routinely in a clinical setting. Because of COVID-19, the CF and burnout experiences go beyond the nurse who provides direct patient care.

of CF and burnout have been linked to low productivity and adverse effects on professional performance, along with poor decision-making.30 Organizational practices, such as scheduling and workload structures to ensure work-life balance, access to needed resources, and assuring competency in all domains of practice, should be in effect. Training in personal coping skills, relaxation techniques, and mindfulness or spirituality should also be available.30,31 Personal life choices, including sleep hygiene, a healthy diet, routine exercise, and moderating alcohol intake, may improve efficacy

in one's position.<sup>30</sup> Although they're not new, these variables tend to be ignored when work situations become stressful or persistent. Healthy peer support provides a mechanism for the nurse leader to remain compassionate, which may increase their sense of altruism and improve their sense of CS, especially when clinical situations are uncertain, stressful, and unrelenting. This, in turn, allows the nurse leader to identify CF among direct care providers and intervene early, if not proactively. Patient care depends on the professional well-being of direct and non-direct providers, and the ability to retain nurses has been correlated to CF and burnout.

Research results from Prochnow and colleagues identified low levels of burnout among nurse leaders with availability of resources as the most frequent stressor pre-COVID-19.30 The results of the present study support these findings, and add CS, CF, and VT as additional challenges. The challenge is complex, and it's doubtful that universal intervention(s) are appropriate. Organizations should initiate interventions aimed at improving the workload or workflow to stave off attrition, with longitudinal data to assess their effectiveness.<sup>30</sup> They should explore institutional support for personal stress-reducing interventions and monitor these programs for use and perceived value.31

#### Performance potential insight

There exists in the nursing profession the ability for fulfillment in caring for others (CS), and the risk of giving too much of ourselves (CF). For nurse lead-

ers, the care of "others" is generally transferred from caring for patients to caring for those providing direct care. There's a parable ascribed to the Cherokee Nation in which a young boy is told that there's battle between two "wolves" that goes on inside all of us.<sup>32</sup> One wolf is evil and represents such things as anger, regret, self-pity, guilt, resentment, and inferiority. These correlate to CF experiences. The other wolf is good and represents joy, peace, love, hope, serenity, humility, kindness, benevolence, empathy, generosity, truth, compassion, and faith. These describe CS experiences. The boy ponders this and asks, "Which wolf wins?" and the reply is, "The one you feed." Choosing to attend to CS, finding meaning and fulfilment in work, is critical to the resilience and retention of non-direct care nurse leaders. CS is an intrinsic reward and therefore is an intrinsic practice and reflection. Satisfaction doesn't come *from* others but through caring for others. NM

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