COMPASSION FATIGUE AND COPING STRATEGIES AMONG NURSES WORKING WITH TRAUMATISED PATIENTS

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DECLARATION

I declare that the dissertation (in the form of an article) hereby submitted by me for the MAGISTER SOCIETATIS SCIENTIAE degree at the University of the Free State is my own independent work and it has not been previously submitted by me at another university/faculty.

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Beryl V. Thaele

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1. INTRODUCTION

The impact of the emotionally draining nature of the work of nurses and other professionals who work with traumatized patients has drawn a growing body of research to include studies on compassion fatigue or secondary traumatic stress experienced by these nurses. Most researchers who contributed to this field of study have argued that there should be a relationship between compassion fatigue experienced by nurses and the coping strategies they use to combat compassion fatigue (Figley, 1995).

Compassion fatigue is well-illustrated in the following quote by Maslach (1996, p.2):

> "When you have to care for so many people, you begin to suffer from emotional overload – it's just too much. I'm like a wire that has too much electricity flowing through it – I've burned out and emotionally disconnected from others" (Jane J., nurse).

Compassion fatigue (CF) is flourishing today due in part to the consequences of disease, violence, war and political conflict. The nursing profession, like many other health professions, with its tremendous physical and emotional demands, naturally predisposes nurses to compassion fatigue. There are tests like the Self-Assessment for Compassion fatigue which has not been validated but the results should serve as a quick guide check of whether someone is suffering from CF or not (Pfiffering & Gilley, 2000). The authors have also given warning signs of compassion fatigue.

2. PROBLEM STATEMENT

Figley (1995) notes that there is a cost of caring. He goes on to write that professionals like nurses who listen to clients' stories of fear, pain and suffering may feel similar pain and suffering because of this empathy for the patient.

Compassion fatigue manifests in all or some of the five categories of symptoms which were identified by several researchers (Figley, 1995; Pearlman & Saakvitne, 1995; Boss,

1999; Boscarino, Galea, Adams, Ahern, Resnick & Vlahov, 2004):

1. Physical symptoms (fatigue, physical depletion or exhaustion)
2. Emotional symptoms (irritability, anxiety, depression, guilt and helplessness)
3. Behavioural problems (aggression, substance abuse, etc.)
4. Work-related symptoms, e.g. inability to concentrate, communication problems, withdrawal from colleagues, etc.
5. Interpersonal symptoms, for example, ineffective communication, inability to concentrate or focus and withdrawal from clients or co-workers.

Compassion fatigue has a sudden onset of symptoms and there is a sense of helplessness and confusion, a sense of isolation from supporters and the symptoms are disconnected from real causes (Figley, 1995).

Regular exposure to a high incidence of trauma leads to secondary traumatisation manifested by the re-experiencing of traumatic events, avoidance of reminders of traumatic events, avoidance of reminders of traumatic situations and persistent arousal. These are compounded by the cumulative impact of numerous work stressors such as work load, lack of emotional support in the work environment, poor working conditions and prolonged working exposure to traumatized patients. All these factors predispose nurses to burnout and compassion fatigue (James & Gilliland, 2001).

When people start experiencing emotional exhaustion, because they get overly involved emotionally and they overextend themselves, they feel they are no longer able to give of themselves to others. They would like to help but they have compassion fatigue and they cannot motivate themselves to do committed work anymore. This raises the question about the strategies professionals like nurses use when they are overly involved emotionally and are no longer able to do committed work. They have to combat their compassion fatigue, and the type of coping strategies that are used, will determine whether he/she is positively or negatively affected.

3. THE PURPOSE OF THE STUDY

The purpose of the study is therefore to investigate the influence of different types of coping strategies used by nurses working with traumatised patients on the levels of burnout and compassion fatigue they experience. The role of demographic variables such as age, number of years working experience and marital status will also be investigated. The information from this study can make a valuable contribution to future interventions aimed at empowering nurses to develop effective strategies to combat compassion fatigue and burnout.

4. LITERATURE SURVEY: COMPASSION FATIGUE

4.1 Defining Compassion Fatigue

The concept of compassion fatigue has been used since 1992 when Joinson (1992) used it in a nursing magazine. It fits the description of nurses working with extremely difficult and resistant patients. Joinson (1992) noted how and why health professionals lose their compassion as a result of their work with the suffering. The dictionary meaning of compassion is "a feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause" (Webster, 1989, p.229). Some people would argue that it is wrong for a practitioner to have deep feelings of sympathy and sorrow for their client's suffering, and certainly practitioners must understand their limitations in helping to alleviate the pain suffered by their clients (Figley & Nelson, 1989). If this alliance is not present, it is highly unlikely that therapeutic change will take place. The most important ingredients in building a therapeutic alliance include the client liking and trusting his or her therapist. These feelings are directly related to the degree to which the therapist utilizes and expresses sympathy and compassion.

Pearlman and Saakvitne (1995) say that the fundamental aspects of compassion fatigue/vicarious traumatization are:

- It is cumulative - developing over a period of time;
- It is pervasive - affecting all aspects of the therapist's life even outside the therapy situation;
- It is contageous – therapists will act as if they are also experiencing the symptoms experienced by their clients – an emotional contagion passed from client to clinician (Danieli, 1985; Bloom, 1997).
- It is experienced in a unique way by each person;
- It is a new concept – it is different from burnout which is the impact of work on the therapist. Compassion fatigue focuses on the self – leading to changes in meaning in the person. The therapist may start experiencing a different kind of world view, identity and spirituality, hopelessness in the world and even in psychotherapy;
- It is different from counter-transference since it is not specific to any one therapy relationship as counter-transference is;
- The affected therapists may be ashamed to acknowledge vicarious traumatisation, as if they have to emerge unaffected. This leads to isolation and having no way of getting help for their problems.

Compassion fatigue is not "burnout", says Figley (2003). Burnout is associated with stress and hassles involved in your work; it is cumulative and relatively predictable. Compassion fatigue is very different. It is a state of tension and preoccupation with the individual or cumulative trauma of clients as manifested in one or more ways including re-experiencing the traumatic event, avoidance/numbing of reminders of the event and persistent arousal. With CF you are absorbing the trauma through the eyes and ears of the clients (Figley, 2003).

Compassion fatigue refers to a physical, emotional and spiritual fatigue or exhaustion that takes over a person and causes a decline in his or her ability to experience joy or to feel and care for others. Compassion fatigue is a one-way street (Pfiffering & Gilley, 2000) in which individuals are giving out a great deal of energy and compassion to others over a period of time, yet aren't able to get enough back to reassure themselves that the world is

a hopeful place. It is this constant outputting of compassion and caring over time that can lead to these feelings.

4.2 Symptoms of Compassion Fatigue

Thompson (2003) states that compassion fatigue is marked by a gradual disengagement, blunted emotions and exhaustion that affects motivation and drive. The grief engendered by a loss of ideals and hope may lead to a deepening depression, a sense of helplessness and a feeling that life is not worth living. Substance abuse can arise as a form of self-medication. Although symptoms vary, the following may indicate that one may suffer from compassion fatigue (Thompson, 2003):

- Abusing drugs, alcohol or food
-Anger;
-Blaming;
-Chronic lateness;
-Depression;
-Diminished sense of personal accomplishment;
-Exhaustion (physical or emotional);
-Frequent headaches;
-Gastrointestinal complaints;
-High expectations;
-Hopelessness;
-Hypertension;
-Inability to maintain balance of empathy and objectivity;
-Increased irritability;
-Less ability to feel joy;
-Low self-esteem;
-Sleep disturbances;
-Workaholism;

Several researchers agree on the following psychosocial symptoms (Danieli, 1985; Gentry,Baranowski & Dunning, 1997);

- Increased negative arousal;
- Intrusive thoughts/images of clients' situations;
- Difficulty separating work life from personal life;
- Lowered frustration tolerance/outbursts of anger and rage;
- Dread of working with certain clients;
- Marked or increasing transference/countertransference issues with certain clients;
- Depression;
- Perceptive disturbances (i.e. seeing the world in terms of victims and perpetrators, decrease in subjective sense of safety);
- Increase in ineffective and self-destructive, self-soothing behaviour;
- Feelings of therapeutic impotence or de-skilled with certain clients;
- Diminished sense of purpose/enjoyment with career;
- Diminished ego-functioning (time, identity, volition);
- Decreased functioning in non-professional situations;
- Loss of hope.

4.3 Predisposition to Compassion fatigue

Although compassion fatigue affects those working in care-giving professions – nurses, physicians, mental health workers – it can affect people in any kind of situation or setting where they are doing a great deal of care-giving and expending emotional and physical energy day in and day out. It is most prevalent among professionals and personal family members and friends and associates of trauma survivors (Gentry et al., 1997; Beaton & Murphy, 1995). Professionals especially vulnerable to compassion fatigue include emergency care workers, counsellors, mental health professionals (psychologists, social workers, nurses, psychiatrists, medical doctors), crisis phone-in attendants, shelter workers, clergy, advocate volunteers and human service workers among others, are all susceptible to compassion fatigue (Gentry et al.,1997). There are other contributing factors that add to the predisposition of nurses to compassion fatigue (Pearlman & Saakvitne, 1995):

- Context – hospitals may be run by helpful or problematic people who may push one to do the work better. Research has shown that having a more diverse caseload is associated with decreased vicarious trauma (Crestman, 1995);
- Socially – economic restraints may cause institutions to set limits for help for survivors, for example, the number of sessions may be limited for each client by insurance companies and the therapist cannot do the best for the client;
- Social and cultural factors – the validity of the client's problem may be questioned and the therapist seen as a perpetrator;
- The personality of the therapist – psychological needs, coping style and his/her defenses;
- The confidential context of the therapeutic situation – therapists cannot share client information with others, they have to think of themselves as trustworthy. Despite this, clients may have no trust in the therapist (Danieli, 1984);
- Reenactment (unconsciously becoming involved with the experiences of the client – the compulsion to repeat the trauma, revictimisation and masochy). If the therapist does not recognize the meaning of reenactment, it may affect his/her world view – disbelief in what people are capable of doing. The individual would be predisposed to compassion fatigue if they cannot manage their own feelings;
- Personal histories may make therapists vulnerable, for example, childhood abuse or personal trauma history. These may put the therapist at risk of violating boundaries with the client leading to ethical violations such as overinvolvement or even making damaging diagnoses such as borderline personality in a way of discharging their own despair about not being able to change. In the emerging field of traumatology, it is not uncommon to find those who are personally knowledgeable about trauma trying to aid others who are faced with terrible events (Gentry et al., 2002).

In the above context, the researchers referred to clients and therapists. The same issues that apply to clients and therapists, are expected to apply to patients and nurses in our context.

Vicarious traumatisation impacts on the following major realms (Pearlman &

Saakvitne,1995):

- Realm of self-capacities (affect tolerance and ability to manage our own feelings);
- Ability to maintain a sense of inner connection, to keep connected with people who care about you;
- Ability to make sense of self – the self as being viable and possible.

4.4 The effects of compassion fatigue

According to Pearlman and Saakvitne (1995), when compassion fatigue impacts on the individual, the following may be experienced:

- Intrusive images of what clients talked about;
- Sensory responses – bodily sensations paralleling those of the clients, for example, headaches, backaches, sick to the stomach;
- Sense of safety for loved ones disrupted, for example, children's safety heightened;
- Behaviour manifestations, such as, avoiding social contact with people.
- Isolation leading to aleniation;
- Pretending there is no problem and shutting themselves out and watching TV, for example;
- Professional isolation – if we cannot tell our colleagues, we withdraw and move closer to despair;
- Therapists with CF experience a sense of existential aloneness because of the disruption in the person's secure base (comprising of the ability to manage own feelings, ability to maintain a sense of inner connection and the ability to maintain sense of self as viable) with a sense of self that is grounded and a world that is tolerable and safe (Pearlman & Saakvitne,1995).

4.5 Demographic variables' role in the experience of Compassion Fatigue

Demographic variables like age, marital status and years work experience also seem to play a role in the experience of compassion fatigue.

4.5.1 Age

According to Figley (1995) younger workers who are less experienced are more prone to suffer from compassion fatigue than their elder colleagues.

4.5.2 Marital status

Most of the literature support the notion that married workers seem to be more resistant to compassion fatigue than single and divorced workers (Saakvitne & Pearlman, 1995). It is however interesting to note that in other studies (Arzi, Solomon & Dekel, 2000) it was found that married spouses whose mental health had changed , for example, wives of war veterans, disturbs the equilibrium of the marital emotional state. In a study on emotional disturbances suffered by combat soldiers, Arzi found that victims of traumatic events continued to suffer from the anxiety it induced and to relive the experience in nightmares, thoughts and images. Many of the post-traumatic symptoms were found to have a direct impact on marital relations. Anger and hostility, emotional numbness, withdrawal and detachment are some of the symptoms that affect the casualties' ability to maintain intimate and sexual relations, creating a sense of rejection and frustration in their partners. From this it can be hypothesized that there might be a percentage of married people who are actually more prone to compassion fatigue than their single counterparts if their spouses' mental health has been affected. These wives will present a greater sense of burden and higher levels of distress than the wives of healthy spouses.

4.5.3 Years work experience

Research by Maslach (1982) has indicated that compassion fatigue is greatest when people are young and is lower for older workers. Younger people usually have less work experience but it turns out (Maslach, 1982) that the effect of age reflects for more than just the length of time – with increased age, people are more stable and mature and they

have a more balanced perspective on life and therefore are less prone to the excesses of burnout and compassion fatigue.

4.6 Coping Strategies

When they experience compassion fatigue, nurses may use constructive or maladaptive strategies. Coping can occur at several different levels, namely, individual, social and institutional. When people start experiencing emotional exhaustion, because they are overly involved emotionally and they overextend themselves, they feel they are no longer able to give of themselves to others. They would like to help but they have compassion fatigue and cannot motivate themselves to do committed work anymore. Coping strategies used by nurses to try to combat compassion fatigue play a predictive role. The type of coping strategies used will determine whether the nurse will be positively or negatively affected (Thompson, 2003).

Coping strategies are synonymous with the eight survival strategies (SS's) described by Valent (1998). The survival strategies are specific stress responses which include specific adaptive and maladaptive, biological, psychological and social constituents. According to Valent (1998) survival strategies are determined by a person's strengths and vulnerabilities on the three constituents: biological, psychological and social. These will determine how a stressful event will be appraised, what defenses will be used and what they manifest into on the biopsychosocial axis. The eight survival strategies are rescuing, attaching, asserting, adapting, fighting, fleeing, competing and co-operating (Valent, 1998). Each SS follows a certain kind of appraisal made by the person: Rescuing follows from the appraisal "must rescue others"; attaching from "must be rescued by others"; adapting from "must surrender goals"; asserting from "must achieve goals"; fighting from "must remove danger"; fleeing from "must move from danger" competing from "must obtain scarce essentials"; cooperating from "must create scarce essentials"(Valent,1998).

The high incidence of violence in our society calls for helping professionals to continue

being called upon to process emotionally stressful events. Thompson (2003) concluded that to protect their emotional well-being, helping professionals would benefit from five categories of coping strategies: increasing social support such as working within speaking distance of another helping professional and using humor to relieve tension and anxiety; maintaining task-focused behaviours, such as, thinking and planning about what needs to be done and generating solutions; increasing emotional distancing during the stressful event and thinking of it as a temporary event that will be over soon; managing emotions through cognitive positive self-talk, for example, being mentally prepared about what will happen at the scene and reframing interpersonal language to reduce negative impact; feeling better by using altruism – sparing others from doing more work so that others are relieved, sacrificing for others and putting the needs of others as paramount (Thompson, 2003).

McNeely (1995) found from her research that the most significant coping strategies were emotion-focused strategies and spirituality. McNeely (1995) concluded that the main coping strategy used by the nurses was the use of social support in some form (this strategy was used by 82% of her sample and it was listed as the most effective strategy). This ranged from "visiting mum" to use of formal meetings where staff could air any problem. McNeely also came to the conclusion that although some nurses say that their spouses or partners were very supportive, most nurses say that they confide in other nurses because they "understand" since when the ward had experienced a stressful traumatic incident, staff did not go home until they had spent a few minutes together and discussing the incident and working through their feelings.

In a study done in South Africa, Raphela (2001) studied nurses (in the Port Elizabeth and East London areas) who work in terminal care wards. The researcher studied their levels of burnout and their coping strategies. Conclusions made were that multiple healthy coping strategies used by these nurses reduced their stress levels and that the most reported coping strategies were emotion-focussed coping and spirituality. In another South African study, Ngcobo (1998) investigated the stress experienced by nurses in rural areas, the role of demographic variables and social support as a coping strategy. Findings

revealed that the nursing staff reported high levels of satisfaction with the support they receive from family and friends and they reported low stress levels. De Wet (1999) in a similar study concluded that specific salutogenic coping strategies countered the effects of burnout among nurses. The three salutogenic factors being, the sense of coherence, hardiness and learned resourcefulness.

4.7 The relationship between compassion fatigue and coping strategies

Findings of previous and recent research have supported the idea that there is a relationship between compassion fatigue and coping strategies in nurses working in trauma units with traumatised patients. In a study done by Raphela (2002) the researcher found that the majority of participants who reported low levels of stress had multiple healthy coping strategies to reduce stress, the most significant being emotion-focused coping and spirituality. The idea of spirituality is supported by a study by Henke (1994) who found that people's spirituality may be affected when they experience compassion fatigue. He concluded that compassion fatigue is a result of being weakened emotionally, physically and spiritually because of the long strain of long-term involvement in someone else's struggle, causing people to feel alone and to assume that God has abandoned them.

People's spirituality is also useful as a coping strategy. What runs into people's minds when they hear the words "abandoned" and "isolated" ? Henke (1994) says God created people to be with others. Consider what he said after the creation of Adam: "It is not good for the man to be alone" (Genesis 2:18). The old saying that "no man is an island" holds true according to God's plan. The feeling of abandonment, Henke goes on, can be a devastating consequence of compassion fatigue. Feelings of helplessness because of limitations to alleviate the suffering of patients usually accompany the secondary trauma symptoms experienced by helping professionals like nurses (McCann & Pearlman, 1990). The impact of compassion fatigue has been associated with significant deterioration in the job performance and morale, an increased tendency to make mistakes on the job as well as increased conflicts in personal relationships and substance abuse (Figley, 1995).

In a study done on nurses to examine the relationship of work stressors and work climate to long-term care staff's job morale and functioning (Schaefer & Moos, 1996) it was concluded from the findings that relationship stressors (e.g. relationship with supervisors and co-workers, job tasks and how much autonomy they have to carry their jobs out) affect concurrent proximal outcomes (job satisfaction, intent to stay and job-related distress) over time. These stressors also predict declines in more general aspects of functioning as reflected in depressed mood and physical symptoms.

Reports from traumatologists who worked directly in the field with victims and their relatives in the aftermath of September 11, 2001 in New York (White, 2001) indicated how important it is to be supportive of each other as caregivers in disaster scenes. He observed that working directly with victims and survivors of catastrophic events poses psychological threat to the caregiver. Compassion fatigue poses a special problem in that healthcare workers may be reluctant to identify themselves as suffering symptoms of secondary traumatic stress. They see themselves as "there for the victims" and tend not to admit to needing help from the distress of hearing and seeing heart-wrenching stories of suffering, disaster, and ambiguous loss (Boss, 1999). It is necessary for those in leadership positions to attend to the potential for secondary traumatic stress in their workers. What was explained earlier about nurses preferring to confide in other nurses is referred to as the "shared fate" phenomenon by White (2001). To varying degrees caregivers may share the plight of those with whom they work. He goes on to recommend that a volunteer could be selected to be the "Compassion Fatigue Specialist". At the beginning of the disaster week White (2001) selected the compassion fatigue specialist whose sole task was to attend to the other volunteers – doing regular compassion fatigue checks with each health worker, for example, doing hourly compassion fatigue checks, allowing participants to take breaks, to relax and to talk to the compassion fatigue specialist and conducting one hour debriefing at the end of each day. At the end of the week a compassion fatigue analysis was made on his 8-member team in question. The results showed that all participants had compassion satisfaction but three showed high risk of compassion fatigue. White (2001) concluded that it would have been a good idea to have had a pre- and post-trauma compassion fatigue analysis to know if these

individuals were suffering from compassion fatigue prior to their involvement.

McNeely (1995) quoted a study by Kobasa (1982) who studied how Australian secondary school teachers dealt with stress at work during the previous 12 months. She found that people who remain physically healthy after experiencing high life stress have different personality characteristics from those who become ill after similar experiences. Kobasa proposed that the personality characteristics of commitment, in contrast to alienation, promote an optimistic orientation towards the stresses of life and our ability to solve them. Therefore, she went on, the committed persons were more likely to engage in problem-specific behaviours and transformational coping to resolve the stressful situation, instead of employing regressive-coping behaviours.

5. HYPOTHESES

From the abovementioned it is clear that many factors play a role in the development of compassion fatigue. The coping strategies used by the nurses who work with traumatized patients are important as predicting factors about whether a person will develop compassion fatigue or not. The general signs mentioned earlier are the endpoints of gradual erosion of one's beliefs and of reference, that is, changes in identity, worldview and spirituality (McCann & Pearlman, 1990). Therefore, the following hypotheses will be investigated:

5.1 Coping strategies used by nurses play a role in determining the outcome in their adjustment to the demands of their careers.

5.2 Active, problem-focused strategies like planning and implementing lifestyle changes, as well as some emotionally-focused coping strategies can be used effectively to combat compassion fatigue.

5.3 Nurses using problem-focused coping strategies as well as some emotionally-focused coping strategies are expected to experience less compassion fatigue than those using other types of coping strategies.

6. RESEARCH METHOD

6.1 Introduction

As was stated in section 3, the purpose of this study is to investigate the influence of different types of coping strategies used by nurses working with traumatised patients on the levels of burnout and compassion fatigue they experience. In order to reach this goal, the following research method was used.

6.2 Subjects and sample size

An availability sample of 150 female nurses working in state hospitals in the Bloemfontein area participated in the study. Individual questionnaires were given to voluntary nurses in the different wards in the four state hospitals, namely, Free State Psychiatric Complex, Pelonomi, National and Universitas. A total of 175 questionnaires were distributed, of which 150 were completed and returned. This provides a good response rate of 85.7%. Nurses from various wards with a high percentage of traumatized patients such as the victim support wards (treating victims of sexual violence), wards that manage patients for termination of pregnancy, wards with terminally ill patients, casualty wards and some psychiatric wards were involved in the study. The nurses were informed of the voluntary nature of participation and they were made to sign an informed consent letter. Permission to conduct the study was obtained from the administrators of the participating hospitals.

6.2.1 Gathering information

The questionnaires were handed out to nurses in groups during their lunch breaks. They were assisted by the researcher to fill them in. Those who did not have enough time to fill them in took the questionnaires home and brought them back to the researcher.

The self-report questionnaire consisted of batteries compiled by the researcher. The battery consisted of a biographical section, as well as a short Quality of Life Scale (QLS), the Experience of Work and Life Circumstances Scale (WLQ), a Fortitude Scale (FS), the Compassion Fatigue Self Test for Psychotherapists (CFST), and a Coping Scale (CS).

6.2.2 Sample Characteristics

As can be seen from Table 1, the largest proportion (61.4%) of the respondents had been in their current positions for more than 10 years. When taken with Table 2, it is evident that the sample possessed a high degree of experience in their work – more than 69% of the sample had been with their current employer (the state) for more than 10 years.

Table 1 Years in current position

Years	**N**	%
< 2 yrs	7	4.8
2-5 yrs	18	12.4
6-10 yrs	31	21.4
> 10 yrs	89	61.4
Total	145	100.0

Table 2 Years with current employer

Years	**N**	**%**
< 2 yrs	3	2.0
2-5 yrs	12	8.1
6-10 yrs	31	20.8
> 10 yrs	103	69.1
Total	149	100.0

It is evident from Table 3 that the sample was quite well qualified (as should be expected from professional nurses with such long experience): A full 40.3% of the respondents had more than 3 years of post-school training, with only 34.2% having only Std. 10 or less.

Table 3 Highest qualification

Qualification	N	%
Std. 8-9	24	16.1
Std. 10	27	18.1
Std. 10 + 1-3 yrs training	38	25.5
Std. 10 + >3 yrs training	60	40.3
Total	149	100.0

Table 4 shows the various language groups included in the study. The spread across the language groups is quite varied, with a number of the indigenous African languages included in the sample.

Table 4 Home Language

Language	N	%
Afrikaans	9	6.2
English	5	3.4
Ndebele	1	.7
N-Sotho	16	11.0
Tswana	45	31.0
Xhosa	27	18.6
Zulu	1	.7
Other	41	28.3
Total	145	100.0

The marital status of the sample is shown in Table 5. More than half (52.7%) of the sample were married, with only 14.9% being divorced and 23.6% still being single.

Table 5 Marital Status

Marital Status	N	%
Single	35	23.6
Married	78	52.7
Divorced	22	14.9
Widow	13	8.8
Total	148	100.0

6.3 Measuring instruments

In order to reach the goals for the study, the following instruments were used:

6.3.1 *The Work and Life Questionnaire (WLQ)*

The Work and life Questionnaire (Van Zyl & Van der Walt, 1991) consists of 40 items, all beginning with the preamble "How often do you feel…".
The items are measured on a five-point Likert scale. All the items are negatively worded, and a high score indicates negative work circumstances. The total score of the scale indicates the level of stress experienced by the respondent, and the scale also identifies two causes of stress – those external to the work situation, and those arising from within the work situation (Van Zyl & Van der Walt, 1991, p. 14). The former scale is merely the sum of items 8 to 23, while the latter is computed as the sum of the remaining items. The scale was used to measure both work-related and non-related stress. The stress scales indicate the degree to which the participants' needs and expectations are satisfied. The alpha-coefficient for reliability on this instrument is 0.87 and a coefficient of 0.82 was found for test-retest reliability. The test was developed in South Africa, and reliability and validity have been proven to be acceptable in all South African studies (Van Zyl & Van der Walt, 1991).

6.3.2 *The Fortitude Scale (FS)*

The Fortitude Scale (Pretorius, 1997) is a four-point Likert scale consisting of twenty items, the last of which is the only negatively worded item in the scale. The total score provides an indication of fortitude experienced by the respondent. A high score is indicative of high fortitude. The scale was used to measure self-appraisal, family appraisal and general support in order to ascertain the participants' sense of belonging, satisfaction with relationships and self-appraisal. Three scores are obtained by adding the responses for the respective subscales. The reliability of the scale is 0,85 for the total

score and between 0,74 and 0,82 for the subscales in South African participants (Pretorius, 1997).

6.3.3 *The Compassion Fatigue Self-test for Psychotherapists (CFST)*

The CFST (Figley, 1995) is a self-rating scale, in which respondents have to score themselves – using a scale ranging from 1 (Rarely/Never) to 5 (Very Often) – on 40 negatively worded items. Here a high score indicates a large degree of compassion fatigue. Specifically, 23 items measure compassion fatigue (1-8, 10-13, 17-26, 29) and 17 items measure risk of burnout (9, 14-16, 27-28, 30-40). The scale yields scores on three subscales: (1) compassion satisfaction, which is a measure of satisfaction with care-giving ability, pleasure in helping, making a contribution, etc. (2) compassion fatigue, and (3) burnout, a measure of hopelessness and unwillingness to deal with work, gradual onset as a result of feeling one's efforts make no difference, very high workload, etc. The scale has been found to have good reliability and validity coefficients. Researchers like Figley (1995), Stamm (1997) and White (2001) reported reliability coefficients between 0,86 and 0,94.

6.3.4 *Cope Scale (CS)*

The CS (Carver, Scheier & Weintraub, 1989) is a four-point Likert scale, consisting of 53 items, all positively worded. It measures a variety of constructs, specifically problem-focussed coping (active coping; planning; suppressing competing activities; restraint coping; seeking social support – instrumental reasons); emotion-focussed coping (seeking social support – emotional reasons; positive reinterpretation and growth; acceptance; religious coping; focussing on and venting of emotions); and ineffective coping strategies (denial; behavioural disengagement; mental disengagement; alcohol and drug disengagement). The test was found to have high reliability and validity co-efficients (Figley, 1995; Stamm, 1997) when used by previous researchers.

The three effective coping strategies are the problem-focussed coping, emotion-focussed coping and religious coping. The ineffective coping strategies are denial, behavioural

disengagement, mental disengagement and alcohol and drug disengagement.

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6.3.5 *Quality of Life Scale (QLS)*

The QLS is a short five-item seven-point Likert Scale, with all the items worded positively, and a high score indicating a high quality of life. Although no information could be obtained concerning previous use of the instrument, the results obtained in the present study showed that the scale is reliable (alpha coefficient 0,745). The scale measures the person's appraisal of the quality of his/her life, whether they experience it as high or low.

6.3.6 *Biographical Questionnaire*

This section contained information regarding the participants' age, marital status, qualification and years work experience.

6.4 Statistical Analysis

The following statistical technique was used to analyse the data:

6.4.1 Regression Analysis

Regression analysis is a very useful technique for examining the combined influence of a number of independent variables (called predictors) on a dependent variable (known as the criterion). Specifically, regression analysis, depending on the exact technique used, is able to cancel out shared variance between the predictors and the criterion, so that only the unique influence of each predictor on the criterion can be determined. This allows the research to weigh up the various predictors against each other, not only in terms of their relationship with the criterion, but also in terms of their own interrelationships. As such, variables which might correlate less well with the criterion might still function as better predictors, merely because they might have a greater proportion of unique variance in

common with the criterion.

In this study, regression analyses were conducted with two different criterion variables: Compassion fatigue and Burnout. The predictor variables were the Quality of Life (as measured by the QLS), Work and Life Circumstances (measured with the WLQ), Fortitude, and the various Coping Strategies. Hierarchical regression analyses were conducted, with the coping strategies being introduced simultaneously in the first step, then the remainder of the self-report predictors in the next step, and lastly some possible biographical predictors in a third step. These biographical predictors were: Work experience, marital status and highest qualification. Within each step, the variables were selected according to the stepwise method.

Furthermore, the regression analyses were repeated with first the total scores of the various scales as the predictors, and then with the various subscale scores as predictors. It would obviously not make sense to include both the subscale scores and the total scores, as it could be assumed that they shared a large proportion of variance. For the CS, the 'total' scores were the three larger groupings of coping strategies (problem-focussed coping, emotion-focussed coping, and ineffective coping strategies), while the subscale scores were the five examples each of problem- and emotion focussed coping strategies, and the four examples of ineffective coping strategies – thus fourteen coping strategies in total.

7. RESULTS

7.1 Reliabilities

The reliabilities of the various scales were assessed using listwise deletion of all missing data. The results of these various analyses are summarised in Table 6. Although it is troubling that the N's were sometimes so small (e.g., the CS which could only be computed using data from 99 of the 150 respondents), it should be noted that this is because of the stringent requirements imposed by the listwise deletion. Nevertheless, the

reliabilities of all the scales seemed quite good, with the QLS having the lowest reliability of .745, which is quite acceptable for such a short social psychological scale.

Table 6 Summary of Reliability Analyses

Scale	N	Cronbach's Alpha
QLS	148	.745
WLQ	101	.940
FS	137	.897
CFST	124	.929
CS	99	.920

7.2 Compassion fatigue

7.2.1 Total scores

The regression analysis for compassion fatigue using the total scale scores derived a model with three significant predictors. Specifically, one predictor (Problem-focused coping) was selected in the first step, two (Work and Life Circumstances and Fortitude) in the second step, and none of the demographic predictors in the last step.
The summary of the various models formed after the addition of each variable is shown in Table 7. This model was able to account for 18.5% of the variance of the criterion. The analysis of variance for the final model is shown in Table 8. The results of this analysis indicate that the model is highly significant, and may thus make an important contribution to the understanding of compassion fatigue. The coefficients for the various predictors are shown in Table 9. It is evident that each of the three predictors is highly significant, and thus makes a significantly large contribution to the variance of the criterion variable.

Table 7 ***Model Summary for Compassion Fatigue with Total Scores***

Model	Predictors	R	R Square	Adjusted R Square	Std. Error of Estimate
1	(Constant), Problem-focused coping	.201	.040	.033	13.79392
2	(Constant), Problem-focused coping, Work and Life Circumstances	.375	.140	.128	13.10236
3	(Constant), Problem-focused coping, Work and Life Circumstances, Fortitude	.431	.185	.168	12.80052

Table 8 ***Anova for Final Model: Compassion Fatigue with Total Scores***

	Sum of Squares	Df	Mean Square	F	Sig.
Regression	5145.312	3	1715.104	10.467	.000
Residual	22611.765	138	163.853		
Total	27757.077	141			

Table 9 ***Coefficients for Final Model: Compassion Fatigue with Total Scores***

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta		
(Constant)	27.847	8.519		3.269	.001
Problem-focused coping	.383	.105	.315	3.653	.000
Work and Life Circumstances	.185	.051	.283	3.640	.000
Fortitude	-.309	.112	-.240	-2.763	.007

7.2.2 Subscale scores

The regression analysis for compassion fatigue using the subscale scores derived a model with four significant predictors. Specifically, two predictors (restraint coping and alcohol and drug disengagement) were selected in the first step, two more (external stressors and fortitude) in the second step, and none of the demographic predictors in the last step. The summary of the various models formed after the addition of each variable is shown in Table 10. The final model could account for a full 24.4% of the variance of the criterion. The analysis of variance for the final model is shown in Table 11. The

significant result confirms the usefulness of this model. The coefficients for the various predictors are shown in Table 12. As can be seen, the predictor alcohol and drug disengagement was not significant on the 1% level in the final model, and may be left out. All of the remaining predictors are significant on the 1% level.

Table 10 Model Summary for Compassion Fatigue with Subscale Scores

Model	Predictors	R	R Square	Adjusted R Square	Std. Error of Estimate
1	(Constant), Restraint Coping	.260	.068	.061	13.51690
2	(Constant), Restraint Coping, Alcohol and Drug Disengagement	.339	.115	.102	13.21758
3	(Constant), Restraint Coping, Alcohol and Drug Disengagement, External Stressors	.452	.205	.187	12.57693
4	(Constant), Restraint Coping, Alcohol and Drug Disengagement, External Stressors, Fortitude	.494	.244	.222	12.30675

Table 11 Anova for Final Model: Compassion Fatigue with Subscale Scores

	Sum of Squares	df	Mean Square	F	Sig.
Regression	6597.554	4	1649.388	10.890	.000
Residual	20446.589	135	151.456		
Total	27044.143	139			

Table 12 Coefficients for Final Model: Compassion Fatigue with Subscale Scores

	Unstandardied Coefficients		Standardized Coefficients		
	B	Std. Error	Beta		
(Constant)	25.587	8.804		2.906	.004
Restraint Coping	1.881	.435	.339	4.325	.000
Alcohol and drug disengagement	2.770	1.453	.146	1.906	.059
External Stressors	.415	.117	.272	3.535	.001
Fortitude	-.282	.106	-.212	-2.653	.009

A last step in understanding the relationship between these predictor variables and the criterion variable lies in examining the correlations between them. Table 13 and Table 14 show the correlations between the various predictors (total scores and subscale scores) and compassion fatigue. These tables also show the intercorrelations between the different predictors. One would hope that the predictors would be highly correlated with the criterion (hence their inclusion as predictors) but not necessarily highly correlated with each other (thus each accounting for a large proportion of unique variance).

Here again it is evident that the use of the subscale scores improves on our understanding of the relationships between the various variables, as the correlations generally improve when the subscale scores are used. Furthermore, although Fortitude does not correlate significantly with compassion fatigue (although it does with burnout), it does correlate significantly with problem-focused coping, and also specifically with restraint coping (although its higher correlation value with problem-focused coping seems to suggest that it does correlate with at least some of the other forms of problem-focused coping as well). Also, although some of the different predictors were in fact correlated, it generally did hold true that the predictors showed significant correlations with the criterion, but not with each other.

Table 13 Predictor/Criterion Correlations – Total Scores with Compassion Fatigue

	Fortitude	**Problem-Focused Coping**	**Compassion Fatigue**
Work and Life Circumstances	-.148 [a]	.000 [b]	.325 ** [c]
Fortitude		.441** [c]	-.143 [c]
Problem-Focused Coping			.209* [c]

* $p<0.05$

** $p<0.01$

a: N=149

b: N=148

c: N=147

Table 14 ***Predictor/Criterion Correlations – Subscale Scores with Compassion Fatigue***

	Fortitude	Restraint Coping	Compassion Fatigue
External Stressors	-.155 [a]	-.065 [b]	.328** [c]
Fortitude		.352** [c]	-.143 [c]
Restraint Coping			.253** [c]

* $p<0.05$

** $p<0.01$

a: N=149

b: N=148

c: N=147

8. DISCUSSION OF RESULTS

It was firstly postulated that coping strategies used by nurses play a role in determining the outcome in their adjustment to the demands of their careers. Secondly it was further hypothesised that active, problem-focussed strategies as well as emotionally-focussed strategies can be used effectively to combat compassion fatigue. Thirdly, it was postulated that nurses using problem-focussed and emotionally-focussed strategies are expected to experience less compassion fatigue than those using other types of coping strategies. Regression analysis was carried out on the data to investigate whether the hypotheses should be retained or rejected. The following results were yielded:

8.1 The relationship between coping strategies and compassion fatigue

From the results it was evident that the criterion compassion fatigue is significantly related to three of the predictor variables, namely, problem-focussed coping, work and life circumstances and fortitude, while none of the demographic predictors show any correlation with compassion fatigue. When the total scale scores were used, these three varables were able to account for 18.5% of the variance of the criterion. When the

subscale scores were used, four significant predictors emerged, namely, restraint coping, alcohol and drug disengagement (this predictor's coefficient was not significant on the 1% level and is therefore left out in further discussions), external stressors and fortitude which account for a full 24.4% of the variance of the criterion.

The results clearly indicate that nurses who experienced the least compassion fatigue were those engaged in problem-focussed coping strategies, which means strategies involving active planning of solution of problems, not engaging in suppressing competing activities, using restraint coping, religious coping and seeking social support.

Findings of studies mentioned earlier (Raphela, 2001; Ngcobo, 1998; De Wet, 1999; Figley, 1995; Valent, 1995) are all congruent with the findings. The results show that the nurses who use problem-focussed and some emotion-focussed strategies experience less compassion fatigue. The details of these studies, most of which were done on nurses about their stress levels and their levels of either burnout or compassion fatigue were discussed earlier in this report.

Results also indicate that external stressors have an impact on the well-being of nurses. Research by Crestman (1995), for example, showed that nurses who are given supportive supervision and given diverse caseloads experienced decreased vicarious trauma. Programs which were used by traumatologists in the aftermath of September 11 (White, 2001) – concur with the idea that support from peers can boost the morale of caregivers. In this instance, the external stressors (work-related) were alleviated. Nurses would benefit by utilising available resources to combat compassion fatigue.

Fortitude was also found to have a significant role in the experience of compassion fatigue. This means that nurses who used support from people who care about them reported less compassion fatigue. McNeely's study (1995) concluded that nurses who reported that their spouses and colleagues gave them support during stressful situations had less compassion fatigue.

Nurses would benefit by being aware of these factors and try to do something about them. The results about work and life circumstances indicate that nurses who have less external stressors in these areas experienced less compassion fatigue. The nurses' appraisal of stumuli and their responses is what constitutes the components of the scale. Results indicate that nurses who have positive cognitive appraisal of situations experienced positive emotions and they experienced less compassion fatigue. Those nurses who had positive self-appraisal, attached importance in family support and belonging, displayed satisfaction with relationships, experienced less compassion fatigue. The results are congruent with conclusions made by Valent (1998).

The findings of this study are also congruent with previous research done by Figley, (1995); Pearlman and Saakvitne (1995) who found that there is an inverse relationship between adaptive coping strategies and compassion fatigue and vice versa. The results also indicate that fortitude (courage in bearing pain or trouble) has a significant role in combating compassion fatigue.

Lastly, the three hypotheses that were stated should be retained:
Hypothesis I can be retained: The coping strategies used by nurses play a definite role in determining the outcome in their adjustment to the demands of their careers.
Hypothesis 2 can also be retained: Active, problem-focussed strategies like planning and implementing lifestyle changes, as well as some emotionally-focussed coping strategies can be used effectively to combat compassion fatigue.
Hypothesis 3 can be retained: Nurses using problem-focussed coping strategies as well as emotionally-focussed strategies are expected to experience less compassion fatigue than those using other types of coping strategies.

8.2 The relationship between compassion fatigue and demographic variables

The results showed no correlation between compassion fatigue and age. This means that age alone has no influence on the experience of compassion fatigue. Age is only relevant as it goes together with the number of years experience at work. The findings differ from

those of previous studies (Figley, 1995) which held the notion that younger nurses are less prone to suffer from compassion fatigue that their elder colleagues. Marital status was also found not to be a predictor of whether they would be more resistant to compassion fatigue or not. Qualifications were found not to be a predictive variable for compassion fatigue.

9. CONCLUSION

The most important finding of this investigation is that coping strategies like problem-focussed strategies, emotion-focussed strategies and religious coping play a significant role in the combating of compassion fatigue. Nurses who use these adaptive coping strategies experience less compassion fatigue than those who use other strategies. Furthermore, the work and life circumstances of nurses and fortitude also play a significant role in their experience of compassion fatigue. Nurses are an important human resource asset. They spend the most time with the patient compared with the other health team members. They are the ones who have to listen and witness patients' trauma throughout the day. They deserve being taken care of by our health system so that their experience of compassion fatigue can be addressed. The results of this study can make a valuable contribution when planning improvements in the trauma units to address compassion fatigue experienced by nurses working in those units. Although compassion fatigue and burnout are significantly correlated with each other (r = 0,836) compassion fatigue can lead to burnout which can result in serious consequences for the health professions. Increased time spent with traumatised patients seems to increase the risk of stress reactions in mental health professionals (Chrestman, 1995). Therapist exposure to traumatic client material has been found to be an important predictor for symptoms of traumatic stress, and in some, of disrupted beliefs about self and others (Schauben & Frazier, 1995).

Finally, fortitude shows an inverse correlation with compassion fatigue. This means that those nurses who have positive attitudes about themselves, the ability to solve new problems, are satisfied with the support they get from those they count on, exhibited the

lowest levels and those who did not, exhibited higher levels of distress.

It causes concern to witness nurses who have worked for long periods in state hospitals having their personal lives negatively affected by compassion fatigue. This does not only compromise their well-being but also the quality of service they render. Gentry (1997) says that the point at which we may notice that our ability to listen becomes compromised, it is the point at which the silencing response has weakened our clinical efficacy. The vision of the health department could include providing the necessary support for nurses working with traumatised patients and this world have a positive impact not only for the caregivers but to the whole health service.

10. SHORTCOMINGS AND RECOMMENDATIONS

Because this was a study of nurses in the Bloemfontein area, it is difficult to draw conclusions about nurses at large.

For future research, it would be valuable to address individuals' personal differences in future engagements of trauma/human service workers to test them beforehand for possible risk of compassion fatigue and to offer support regularly to all the workers involved and especially those at risk.

Concerning workers in the government institutions, managers could research on how to provide structures offering regular debriefing sessions to traumatised workers. Projects could also be implemented which may serve as incentives that leads to the enhancement of clinical skills and personal life enrichment. An example of such a program can be found in the works of Gentry et al. (2002).

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ABSTRACT

The study investigated the influence of different coping strategies used by nurses working with traumatized patients to try and combat the compassion fatigue they might experience. The role of demographic variables such as age, number of years working experience, marital status and highest qualification were also investigated. A sample of 150 female nurses working in the four state hospitals in Bloemfontein participated in the study. Data was gathered by means of self-report questionnaires compiled by the researcher. The battery of questions included a few biographical questions, a test measuring compassion fatigue and another to identify the type of coping strategies the nurses use. Results showed a strong correlation between compassion fatigue and coping strategies. Nurses who experienced the least compassion fatigue are the ones who use problem focussed coping strategies especially restraint coping. The results showed no significant influence of the demographic variables mentioned above.

KEY CONCEPTS: compassion fatigue; coping strategies; burnout.

ABSTRAK

Daar is in hierdie navorsingstudie ondersoek ingestel na die invloed van verskillende hanteringsvaardighede wat deur verpleegsters aangewend word ten einde deernis-uitputting as gevolg van hul werk met getraumatiseerde pasiënte, teen te werk. Die rol van demografiese veranderlikes soos ouderdom, aantal jare werkservaring, huwelikstatus en hoogste kwalifikasie is ook ondersoek. ‘n Steekproef van 150 vroulike verpleegsters wat in die vier staatshospitale in Bloemfontein werk het aan die ondersoek deelgeneem. Die data is deur middel van selfrapporteringsvraelyste wat deur die navorser opgestel is ingesamel. Die toetsbattery het enkele biografiese vrae, en toetse wat onderskeidelik deernis-uitputting en die tipe hanteringsvaardighede wat verpleegsters gebruik, ingesluit. Die resultate dui op ‘n sterk verband tussen deernis-uitputting en hanteringsvaardighede. Die verpleegsters wat die minste deernis-uitputting ervaar het was diegene wat probleem-gefokusde hanteringsvaardighede, veral selfbeheersing, toegepas het. Die resultate toon geen beduidende invloed van die bogenoemde demografiese veranderlikes nie.

SLEUTELKONSEPTE: deernis-uitputting; hanteringsvaardighede; uitbranding.