Abstract

For Mental Health nurses, a core component of the Nurse-Patient relationship is compassion. Bearing witness however to patient suffering may lead to the manifestation of Compassion Fatigue; a decrease in compassionate and empathic responses due to prolonged contact with patient suffering and distress. Mental Health Nurses, particularly those who work in those areas where they are exposed to frequent crisis presentations, such as inpatients settings and crisis teams, are at risk of developing Compassion Fatigue and yet there remains a paucity of research into the impact upon those delivering mental health care in the UK. This paper highlights the importance of identifying Compassion Fatigue, advocates for open honest and supportive discussions without fear of reprimand, and argues that possible work-place causes should be effectively addressed by Nurse Leaders and organisations, not just for sake of the Mental Health Nurse and their employers but also to ensure positive patient outcomes.

Background

For Mental Health Nursing, the value of the Nurse-Patient relationship and the therapeutic use of 'self' to deliver care (Hurley, 2009) has been widely acknowledged as central to care-delivery since Peplau's theory of interpersonal relations (Peplau 1952). Fundamental to Mental Health Nursing practice, the therapeutic relationship alone is considered to have a curative effect (Wright, 2010) and at its heart is compassion; the ability of the Nurse to connect emotionally with the patient, identifying with patient suffering and distress and having the desire to alleviate this (Mathias & Wentzel, 2017). By understanding the patient's personal feelings or experience without criticising or being judgemental of their distress (Turgoose & Maddox, 2017), compassionate care is said to result in better patient experience and improved clinical outcomes (Upton, 2018).

Bearing witness however to patient suffering may lead to the manifestation of Compassion Fatigue; a decrease in compassionate and empathic responses following prolonged contact with suffering and distress (Rauvola, Vega, & Lavigne, 2019; Mathias & Wentzel, 2017; Turgoose & Maddox, 2017). Defined by Figley (1995) as the "cost of caring", Compassion Fatigue is often experienced by those Nurses who are frequently exposed to the suffering or traumatic experience of patients; triggering a negative emotional response (Sabo, 2011) and impacting upon the Nurse's ability to be empathic (Yang & Kim, 2021).

The risk of developing Compassion Fatigue, is a particular issue for Mental Health Nurses especially those who work with Individuals in crisis, as they are witnesses to severe human distress and suffering on a daily basis (Zimering & Gulliver, 2003; Turgoose & Maddox, 2017). Recurrent reciting of traumatic accounts and frequent and multiple exposures to distressing information, emotional dysregulation and intrusive suicidal thoughts can have a negative impact on the Mental Health Nurse, leaving them vulnerable to developing Compassion Fatigue (Singh, *et al*. 2020; Bell, Hopkin & Forrester, 2019; Ireland & Huxley, 2018).

Furthermore, within Mental Health Crisis services, frustrations regarding being unable to lessen the patients suffering or not seeing progress in patients can be frustrating. Tensions may therefore exist between ideal and the realities of nursing practice, resulting in professional, interpersonal and intrapsychic conflicts and leading to job dissatisfaction and Burnout, both also linked to Compassion Fatigue (Pérez-García, *et al*. 2020; Jack, 2017). These conflicts may, in turn, impact upon professionalism and performance and reduce the Nurse's ability to empathise with patient suffering.

Whilst the impact of Compassion Fatigue has been explored in other settings such as oncology, emergency care, paediatric and hospice Nursing, research in relation to Mental Health Nurses working

with Individuals in crisis in the UK appears to be limited (Singh, *et al*. 2020), despite many possibly already having experienced this phenomenon (Upton, 2018). Poor recognition and insight may explain why this issue is not discussed openly, although also quite likely, Compassion Fatigue is seen as a taboo subject within Mental Health Nursing (Sheppard, 2014). With compassion being viewed as an essential component of the therapeutic relationship, the idea that a Mental Health Nurse could 'lose' compassion is perceived as abhorrent and difficult to admit to oneself; let alone to others.

Conceptualising Compassion Fatigue

Conceptualising Compassion Fatigue is difficult; a lack of a clear definition, presenting a hurdle to researchers, especially when a clear conceptual definition is required to develop accurate instruments to measure Compassion Fatigue (Yang & Kim, 2012). Initially coined by Joinson (1992), who noted that healthcare professionals may lose their ability to care and nurture when experiencing Burnout (Yang & Kim, 2012; Henson, 2017; Aycock & Boyle, 2009), the term was later adopted by Figley (1995) to refer to a state of dysfunctional, emotional, biological and physiological exhaustion in therapists, due to prolonged exposures of compassion stress. Sheppard (2014) criticised this definition, arguing that it does not accurately represent true nature of this phenomenon as experienced by registered nurses. For Mental Health Nurses, however, Figley's definition remains relevant, even within Crisis Care, where frequent and repeated exposure to traumatic accounts and distress arguably replicates the experience of long-term intervention.

Further difficulties identifying a clear definition for Compassion Fatigue lie in the attempts to differentiate it from related concepts such as Vicarious Trauma, Secondary Traumatic Stress and Burnout; terms often used interchangeably within the literature due to an overlap in symptomology (Rauvola, Vega & Lavigne, 2019; Christodoulou-Fella, *et al*. 2017; Figley, 1995) and therefore leading to further conceptual confusion (Ruiz-Fernandez, Prerez-Garcia & Ortega-Galan, 2020). Although they are thought to be related, Compassion Fatigue and Burnout are independent concepts (Bell, Hopkin, & Forrester, 2019). It has been argued that Compassion Fatigue is a cumulative form of Burnout (Pérez-García, 2021); the state of physical, emotional, and mental exhaustion, triggered by long term involvement in emotionally demanding situations (Cetrano, *et al*. 2017), whereas others have argued that they are independent of each other, Burnout, considered to stem from environmental and organisational stressors, as opposed to the psychological and emotional processes associated with Compassion Fatigue (Turgoose & Maddox, 2017).

The impact of Compassion Fatigue

As compassion is expected of Mental Health Nurses, it may be feared that the identification and disclosure of Compassion Fatigue could potentially compromise their employment status (Sheppard, 2014) and lead to stigmatisation. If unresolved, however, Compassion Fatigue may have detrimental consequences, both for the Mental Health Nurse themselves, and the impact upon the quality of care delivered (Sheppard, 2014; Cetrano, *et al*. 2017; Mangoulia, *et al*. 2015). For the Mental Health Nurse, there is an increased risk of enduring physical or mental health issues which may impact upon professionalism, impair job performance and lead to moral, physical, and emotional exhaustion (Cetrano, *et al*, 2017; Mangoulia, *et al*. 2015. Sinclair & Hamil, 2007). All of these issues potentially have financial implications for employers too, Compassion Fatigue being a contributor to absenteeism and high rates of turnover within healthcare. (Upton, 2018; Cetrano, *et al*. 2017; Mangoulia, *et al*. 2015; Sheppard, 2014).

For the patient, however, it may be that the consequences are more severe, going beyond decreased patient satisfaction. Mental Health Nurses experiencing Compassion Fatigue may disengage to protect

themselves from other's suffering (Buchanan & Keats, 2011), leading to individuals experiencing poor; and possibly even harmful care, as evidenced by the Francis inquiry (Mid Staffordshire NHS Foundation Trust, 2013). Medical and clinical errors, poor care planning, negative attitudes towards patients, and a lack of communication (Cetrano, *et al*. 2017; Mangoulia, *et al*. 2015; Sinclair & Hamil, 2007) may all result from Mental Health Nurses experiencing Compassion Fatigue. For the individual who is in crisis and experiencing distress, stigmatising attitudes or disengagement of the Mental Health Nurse may be invalidating and even retraumatising, possibly replicating earlier pathological relationships. The outcome of this is an exacerbation of the crisis or keeping the individual 'stuck' in treatment (Huxley & Ireland, 2018).

Factors that increase the risk

Individual factors can increase the risk of Compassion Fatigue development, with personality (Yu, Jiang & Shen, 2016) age and experience (Xie *et al*, 2020; Mangoulia, *et al*. 2015; Prerez-Garcia & Ortega-Galan, 2020; Sacco, *et al*. 2015) all said to be both predictors and protectors. It may be that these factors impact upon an individual's coping mechanisms (Mangoulia, *et al*. 2015; Yu, Jiang, & Shen, 2016) or lead to differences in exposure to traumatised clients (Xie, *et al*. 2020; Cetrano *et al*, 2017). Educational status is also considered to be a possible predictor (Yang & Kim, 2012); a higher level of Education being associated with lower levels of Compassion Fatigue (Ruiz- Fernandez, Pérez-García & Ortega-Galan, 2020). Health Care Assistants, particularly, are at risk compared to registered nurses, possibly due to the differences between the two groups in respect of exposure to traumatised patients (Yu, Jiang & Shen, 2016; Mangoulia, *et al*. 2015).

Work-related factors that increase the risk of developing Compassion Fatigue include the working environment and job satisfaction, as well as workplace violence and stress (Cetrano, *et al*. 2017). Low job satisfaction is said to increase chances of developing Burnout and therefore also Compassion Fatigue in Mental Health Nurses (Xie, *et al*. 2020). Contributory factors that increase stress levels among nurses (Zerach & Shalov, 2015) include a lower income, poor work environment, a lack of support from organisations and managers or colleagues, increased workload, and staff shortages (Yu, Jiang & Shen, 2016; Mongoulia, *et al*. 2015). Those Nurses meanwhile, with higher salaries, better job satisfaction, more senior job roles and whom belong to teams that function well, experience less compassion stress and so are better protected against Compassion Fatigue and Burnout (Xie, *et al*. 2020; Singh, *et al*. 2020).

The longer that the Mental Health Nurse is exposed to patient suffering; the more they are likely to develop Compassion Fatigue (Pérez-García, 2021; Bell, Hopkin, & Forrester, 2019; Yu, Jiang, & Shen, 2016; Yang & Kim, 2012). Conversely however, a frequent exposure to traumatic incidents in the workplace such as workplace violence and the threat of violence, has also been linked to the development of Compassion Fatigue and Burnout (Xie, *et al*. 2020; Bell, *et al*. 2019; Itzhaki, *et al*. 2018), despite being a primary, rather than secondary, exposure to traumatic events, thus highlighting the complexity of this phenomenon.

Implications for practice: Prevention and management

As many Mental Health Nurses have possibly already experienced this phenomenon (Upton, 2018, further research would be beneficial to establish the prevalence of Compassion Fatigue amongst those who work within mental health Crisis Services in the UK and to explore the potential factors that increase this risk. In the meantime, Nursing Managers and organisations should consider ways to prevent or minimize the risk of Compassion Fatigue among Nursing Staff, particularly as work-related variables are often major predictor and therefore should not ignored (Yu, Jiang & Shen, 2016; Cetrano,

et al. 2017). This has become even more necessary as Staff continue to provide care during the Covid-19 pandemic, against the trend of restrictive measures and increasing referrals.

Providing Mental Health Nurses with a positive and supportive environment acts as a protective barrier to work-related stress (Yu Jiang & Shen, 2016; Bell, Hopkin, & Forrester, 2019; Aycock & Boyle, 2009; Sinclair & Hamil, 2007). Adequate ergonomic conditions that promote trust, autonomy, participation and an adequate balance between work and private life are also essential to mitigating against future risk of Compassion Fatigue (Cetrano, *et al*. 2017).

Insert Fig.1 here

Where there are symptoms of Compassion Fatigue, however, (fig 1.) the initial identification may have a positive impact, minimizing its effects (Cetrano, *et al*. 2017; Xie, *et al*. 2020) and so organisations should support managers to encourage honest and supportive discussions, without judgement and fear of being reprimanded (Sheppard, 2014). Conversations should promote reflexive practice and the development of emotional resilience, which is key to preventing Burnout (Shaw, *et al.* 2011). Managers should employ validating, trauma-informed approaches themselves (Bell, Hopkin, & Forrester, 2019); being mindful not to be dismissive of employee experiences. Training and didactic programs promote an environment for mentoring and supervision, whist also supporting the development of positive coping strategies (Sullivan, *et al*. 2018).

Conclusion

Whilst Compassion Fatigue is a Universal issue that may be experienced by any healthcare worker, Mental Health Nurses are particularly at risk, as they provide care to traumatised individuals and are witnesses to severe human distress and suffering on a daily basis. There remains, however, a paucity of literature, examining this phenomenon amongst Mental Health Nurses working in with Individuals in crisis in the UK. Poor recognition and insight may explain why this issue is not discussed openly, although it is possible that Compassion Fatigue remains a taboo subject within Mental Health Nursing; the Nurse possibly feeling shame and perceiving that their job might be at risk upon identification or disclosure. The associated risks of Compassion Fatigue, however, not just to the worker, but also to the individual receiving care and even employer, means that it is paramount that both Mental Health Nurses themselves and their employers recognise Compassion Fatigue and take appropriate steps to minimize the consequences.

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