Review article

Nurses’ emotional reactions and compassion fatigue: A systematic review

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Abstract

Aim: While working as a nurse a number of situations arise that cause nurses to be constantly exposed to a variety of factors promoting compassion fatigue which has negative effects on nurses’ well-being and patient care. The paper aims at summarizing the current state of knowledge of the topic of interest.

Methods: The PRISMA checklist was followed to conduct a systematic review using PICo worksheet and searching into PubMed database. Reference lists and citations of eligible articles were also screened and reviewed for additional papers. Additional records identified through other sources without however providing an element of selection bias.

Results: A wide range of stressful factors and negative emotions promote compassion fatigue. Psychological distress may lead to compassion fatigue through reducing self-esteem and creating negative emotions. Secondary traumatic stress may have a mediating role between empathy and compassion fatigue in the nurses. In case of death, nurses’ experience of physical loss and grief considered inconsistent with their role may promote compassion fatigue, especially when the patient had not a ‘good death’ being surrounded by and communicating with family members. Thoughtful reflection (conceived in an inclusive way) may promote compassion satisfaction and prevent compassion fatigue. Trait-negative affect is considered very important factor promoting compassion fatigue. Survivor guilt and omnipotent guilt are types of pathogenic empathy-based guilt and have a mediating role between empathy and compassion fatigue in the nurses. Furthermore, it is argued that touch providing emotional containment and emotion role dissonance are predictors of emotional exhaustion. Moral disengagement has a mediating role between negative emotions and nurses counterproductive work behaviour.

Conclusion: A wide variety of factors are most likely to contribute to the presence of compassion fatigue in nurses. Further research is required to make clear the importance and role of each factor and probably identify new factors. Supportive policies must be a priority to give nurses coping and communication skills and inner resources, and enhance their resilience.

Keywords: Compassion fatigue; Compassion satisfaction; nurses / nursing; emotions; posttraumatic stress.

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Introduction
By profession, nurses engage in helping and providing direct care to patients and compassionate patients who may be severely or critically ill, or in the final stage of life and especially near death. Nursing may be encased within a high-stress settings (i.e. critical care, oncology, elderly care settings or hospice nurses) where they are often faced with situations, such as death, illness, and violence. For instance, nurses working in critical care units steadily encounter every day the consequences of life-threatening situations. Moreover, the fact that nurses may work in in a high-technology environment may be stressful. (Mukherjee et al., 2009). Nursing profession involves providing healing, support, encouragement or even self-giving behaviors, thus posing risk for developing compassion fatigue (Harris and Griffin, 2015). That is, nurses become emotionally over involved. Since nurses are responsible for others' lives and well-being, emotional reactions can be particularly acute when things go wrong. Constant and repeated exposure to extreme stressors causing a state of stress and giving rise to traumatic experiences inherent in nursing profession, as well as the inability to adjust to this challenging, significantly contribute to developing compassion fatigue and imbalance between compassion satisfaction and compassion fatigue, namely, low Professional Quality of Life (Sacco et al., 2015; Craigie et al., 2016). A variety of stressful factors and negative affect promote compassion fatigue and burnout (Zhang et al., 2018). Compassion fatigue may negatively impact not only nurses’ professional quality of life, but also caring and managing patients. Irrespective of preexisting personal factors, exposure to traumatized individuals is considered the major factor associated with compassion fatigue (Adams, Boscarino and Figley, 2006; Adams, Figley and Boscarino, 2008). However, other factors have been associated to compassion fatigue 'such as age, gender, personal trauma history, support, leadership, staffing, policy, self-efficacy, and personality…’ (Craigie et al., 2016; Adams, Figley and Boscarino, 2008; Craig and Sprang, 2010).

A growing number of nurses are engaged in emotional labour (Karimi, Leggat, Donohue, & Couper, 2014) and are experiencing (non-physical) workplace violence (Choi & Lee, 2017; Fute, Mengesha, Wakgari, & Tessema, 2015). Emotional labour ‘requires workers to suppress their private feelings to show desirable work-related emotion’ (Mastracci, Guy, &Newman, 2012). To appear professional, nurses may use mechanisms such as down-regulation of emotions (Allie et al., 2018). Copeland and Henry (2017) stated: ‘Greater attention should be paid to the effect of non-physical workplace violence’ (Copeland and Henry, 2017). Nurses with frequent experience of emotional labour and non-physical workplace violence have low compassion satisfaction, high burnout and secondary stress, which in turn, negatively affect their professional quality of life (Choi & Lee, 2017; Copeland & Henry, 2017; Shin & Kim, 2014). Kwak et al. (2019) related
experience of emotional labour and workplace violence to secondary traumatic stress which, in turn, affects negatively nurses’ professional quality of life.

The levels of compassion satisfaction that nurses gain from providing compassionate care to patients and patients' families may vary significantly depending on the unit worked and time as a nurse (Yoder, 2010). In various studies it has been shown that older nurses who are in senior positions and with more experience have higher levels of compassion satisfaction (Sacco et al., 2015; Yoder, 2010; Kwak et al., 2019). However, ‘experience does not solely relate to the number of working years or the degree of professionalism; it is also associated with job stability’ (Kwak et al., 2019). Kwak et al. (2019) found that compassion satisfaction is lower in younger nurses and in nurses with lower education level. In contrary, a lot of studies have shown that comfort with touch (that is an essential part of caregiving) can effectively relieve fatigue and pain in the workplace among nurses (Pedrazza, 2015). Pedrazza et al. (2015) state that according to the results of their study ‘touch providing emotional containment was the main predictor of emotional exhaustion’ (Pedrazza et al., 2015). Not surprisingly, over the last decade there was a sharp rise in the number of academic publications related to the topic of compassion fatigue among nurses. This paper aims at summarizing the current state of knowledge of the topic of interest and creating an understanding of the topic for the reader. The paper attempts a systematically review the currently available literature reporting correlative associations between nurses’ emotions, compassion fatigue and factors that can affect these conditions.

**Methods**

The PRISMA checklist was followed to conduct a systematic review on the topic of interest. To develop an effective search strategy, the PICo worksheet was used. Relevant articles were selected through a systematic search of the PubMed electronic database. A total of 18 papers found eligible. Reference lists and citations of eligible articles were also screened and reviewed for additional papers.

Search of PubMed using the combination (“Compassion Fatigue” [Mesh]) AND (“Emotions” [Mesh] OR “Affective Symptoms” [Mesh] OR “Emotional Regulation” [Mesh] OR “Expressed Emotion” [Mesh]) AND (“Nurses” [Mesh] OR “Nursing Staff” [Mesh] OR “Nursing” [Mesh] OR “Standard of Care” [Mesh] OR “Evidence-Based Nursing” [Mesh]) resulted in 21 items. Given that three papers were not in English eighteen papers were found eligible for review analysis. Reference lists and citations of eligible articles were also screened and reviewed for additional papers. Moreover, additional records identified through other sources without however providing an element of selection bias.

**The concept ‘compassion fatigue’**

The concept ‘compassion fatigue’ was first introduced (though never formally defined) by Joinson in 1992. Three years later, Figley suggested a
The synonymous use of compassion fatigue with secondary traumatic stress disorder (STSD) (Figley, 1995). However, this approach is ‘far removed from Joinson's original impression of compassion fatigue’ (Coetzee and Klopper, 2010). It is important to note that in literature, the terms compassion fatigue (CF) and secondary traumatic stress (STS) are used interchangeably. However, Meadors et al. (2009–2010) arguably state that researchers should ‘examine and conceptualize the difference in etiology, prevalence, symptoms, and treatment efficacy for CF and STS as separate but related entities’ (Meadors et al., 2009–2010).

Coetzee and Klopper (2010) attempted to provide a concept analysis of compassion fatigue within nursing practice. In that regard, they wrote that compassion fatigue is a ‘cumulative and progressive process’ ‘moving from discomfort to stress and, finally, to fatigue’, giving rise to physical, social, emotional, spiritual, and intellectual effects. The term “spiritual” refers to the ‘nurse's ability to seek meaningfulness through intra-, inter-, and transpersonal connection’ (Coetzee and Klopper, 2010). More recently, Nolte et al. (2017) write that compassion fatigue is a temporal process (component???) characterized by a ‘basic inability to nurture others’ with consequences including intrusive thoughts at work about the home situation, sleep disturbance, and depression (Nolte et al., 2017). Besides, Zhang et al. (2018) state: ‘Compassion is one's empathetic attitude toward another's suffering with a desire to alleviate it’ and ‘Compassion fatigue is the progressive and cumulative outcome of prolonged, continuous, and intense contact with patients, self-utilization, and exposure to multidimensional stress leading to a compassion discomfort that exceeds nurse's endurance levels’. ‘Compassion fatigue has been defined as losing one’s ability to care or nurture because of a combination of physical, emotional and spiritual depletion associated with caring for patients in significant emotional pain and physical distress’ (Allie et al., 2018).

Compassion fatigue may negatively impact nurses’ professional quality of life most significantly. It is clearly stated in the literature that professional quality of life is the balance between compassion satisfaction and compassion fatigue (Sacco et al., 2015; Craigie et al., 2016). Besides, nurses professional quality of life significantly influences not only their personal realm, but also caring and managing patients. (Kelly, Runge, & Spencer, 2015; Yoshizawa et al., 2016). Indeed, high levels of compassion fatigue may have negative implications on nurses’ satisfaction and quality of care. (Zhang et al., 2018; Arimon-Pages et al., 2019).

Nurses with compassion fatigue may express a desire for leaving their profession or at least changing healthcare units. It is clearly stated that compassion fatigue is strongly positively associated with burnout (Zhang et al., 2018). As burnout in health care context has become such a critical issue, mitigating compassion fatigue is of great importance. In that connection, it worthy to note that managing grief associated with death of patients at work, appear related to burnout (Harrad and, 2018). Note
however, that death-related grief is a major emotional reaction that may lead to compassion fatigue among nurses.

**The role of stress and distress**

Emotional exposure, experience of workplace violence and empathy may be associated with compassion fatigue through traumatic stress. Compassion fatigue may mediate ‘associations between nurse stress exposure and job satisfaction, compassion satisfaction, and burnout, controlling for pre-existing stress’ (Meyer et al., 2015). Psychological distress may increase the risk of compassion fatigue through reducing self-esteem and giving rise to negative emotions (Barnett and, 2018). Furthermore, compassion fatigue is often compounded by moral distress (Mason et al., 2014). **Andersen and Papazoglou (2015)** state that the ongoing experience of moral distress may lead to compassion fatigue among police officers. It may also be the case that the ongoing experience of moral distress may lead to compassion fatigue among nurses (Andersen and Papazoglou, 2015; Papazoglou and Chopko, 2017).

Secondary traumatic stress may mediate associations between empathy and compassion fatigue in the nurses. (Mottaghi et al., 2020). Traumatic stress is likely to have mediating role between emotional exposure and experience of workplace violence, and compassion fatigue (Kwak et al., 2020).

‘Posttraumatic stress disorder (PTSD) is a complex, often debilitating, disorder that has far-reaching effects, including anxiety, depression, burnout, and compassion fatigue’. (Salmon and. 2019). In literature, vicarious trauma (VT) and secondary traumatic stress (STS) are used interchangeably to refer to symptoms caused by indirect (second hand) exposure to traumatic material. While vicarious traumatization may be caused to nurses by virtue of witnessing the consequences of another’s adverse event (McCann &Pearlman,1990, p. 137), second victimization may be caused to nurses who perceived themselves to have directly participated in another’s adverse event (Wu, 2000). Trauma and second victimization have overlapping components related to symptoms of emotional distress. Hartley et al. (2019) provided the following factors that increase nurses’ vulnerability to vicarious traumatization and second victimization when their patients die. First, unrecognized distress may result from ‘maintaining a physiological focus influenced by a rigid commitment to biomedical values’ through discounting the ‘human response to loss’. Second, positive and fulfilling end-of-life experiences (‘good death’) resulted from good relationships between patients, families and health professionals (i.e. ability to communicate, not isolating death) (McNamara,2004; Kehl, 2006; Hartley et al., 2019). Third, the phenomenon of ‘disenfranchised grief’: an person’s ‘right to grieve’ and experience of grief is culturally dictated and may be considered ‘inconsistent with their role or appropriate response’ (Doka, 1989; Doka, 2008, p. 224). Gerow et al. (2010) state that ‘the grief process for nurses appears to be very different from the grief process of a family member. When experiencing grief, nurses find themselves in conflicting roles’. The
authors write that nurses’ difficult emotions are ‘often compartmentalized or “curtained off” as a result of particular beliefs about the role of the nurse’ (Gerow et al., 2010).

Loss (of life or hope) and bereavement are two major dimensions in the context of nurses’ emotional reaction. Wenzel et al. (2011) conducted a qualitative descriptive study exploring the experiences of oncology nurses. Two themes were identified: work-related loss of life and hope and working through bereavement (Wenzel et al., 2011)

**Negative Emotions**

Compassion fatigue was found to be common among nurses attempting to deal with bereavement overload or patient deaths. (Lombardo and Eyre, 2011). Grief represents psychobiological response to bereavement. Acute grief is the ‘initial response’. Complicated grief is ‘a form of prolonged acute grief’. Integrated grief is the ‘permanent response after adaptation to the loss’. (Shear, Ghesquiere and Glickman, 2013). Is grief an illness? “The power of grief to derange the mind has…been exhaustively noted…. The mourner is in fact ill, but because this state of mind is common and seems so natural… we do not call [it] an illness” (Didion, 2005, p.34, quoting Melanie Klein). At any rate, to grieve is to be vulnerable, to be emotionally exposed and uncertain. (Phillips and Welcer, 2017).

Empathetic caring and interpersonal skills are at the core of the nursing profession (Lombardo and Eyre, 2011). Empathic people are more likely to experience guilt than less empathic people (Leith& Baumeister, 1998).

Empathy-based guilt may be a healthy state (Zahn-Waxler & Kochanska, 1990). For instance, adaptive guilt is a guilt that arises out of real wrongful behaviors. However, empathy-based guilt may be associated with psychopathology (Locke, Shilkret, Everett, & Petry, 2015). Guilt may lead to cognitive errors in analysis of a situation (pathogenic empathy-based guilt) linked to an exaggerated sense of responsibility for others. Nurses may incorrectly believe they cause or are able to relieve others' problems, probably resulting in excessive altruistic behaviors (O’Connor, Berry, Lewis, & Stiver,2012). Duarte and Pinto-Gouveia (2017) particularly focused on two types of pathogenic empathy-based guilt of major importance for health personnel providing care: survivor guilt and omnipotence guilt. The results showed the mediating role of omnipotent guilt, survivor guilt between empathy and compassion fatigue in the nurses. (Duarte and Pinto-Gouveia, 2017).

Survivor guilt can people feel guilty over positive inequities, (Baumeister, Stillwell, & Heatherton, 1994). To make it more clear, it ‘broadly defines the feeling people may experience for “surviving ”harm while others do not, with erroneous beliefs that in some way one is responsible or contributed to that harm’ (Duarte, Pinto-Gouveia, 2017).

Omnipotent responsibility guilt ‘involves an exaggerated sense of responsibility and concern for the happiness and well-being of others…’ (Duarte, Pinto-Gouveia, 2017; O’Connor, Berry, Weiss, Bush, & Sampson, 1997).
Craigie et al. (2016) found that ‘trait-negative affect was clearly the more important factor in terms of its contribution to overall compassion fatigue and secondary traumatic stress’ (Craigie et al., 2016). Trait-negative affect is ‘a pervasive and stable disposition to experience a variety of negative emotions and moods across a range of situations’ (Craigie et al., 2016). However, despite the fact that a clear association emerges between negative affect and compassion fatigue, trait-negative affect as a risk factor for compassion fatigue had not been extensively explored in nurses at least up until a few years ago (Craigie et al., 2016).

**Emotional dissonance**

Emotional dissonance is ‘a gap between felt and expressed emotion, together with reduced emotional regulation’ (Tei et al., 2014). Harrad and Sulla (2018) write that emotion role dissonance refers to a state whereby health professionals are required to inhibit or suppress the emotions normally experience in reaction to a particular situation and display a self within the workplace that is ‘disconnected from their true feelings. The authors state that staff may be ‘required to express a wide variety of emotions during their interactions with patients. They have to switch between keeping a certain emotional distance toward their patients to secure a professional attitude on the one hand, and showing a caring, compassionate attitude on the other.’ (Harrad and Sulla, 2018).

Emotional dissonance may be related to alexithymia: ‘inability to experience or at least describe emotions’ (Darrow and Follette, 2014) or to match experienced and expressed emotions (Tei et al., 2014). While having cognitive empathic abilities within the normal range, high-alexithymia individuals may show reduced emotional reactions due to reduced emotional regulation. Tei et al. (2014) showed that 'reduced' empathy-related brain activity of healthcare professionals is correlated with burnout severity, emotional dissonance and levels of alexithymia. (Tei et al., 2014). However, this correlation has not yet been fully explored. Further, the relationship between empathy-related brain activity and balance between compassion satisfaction and compassion fatigue remains to be explored. In other words, it remains to be explored whether neuronal processes might be associated with compassion fatigue occurrence and severity. Harrad and Sulla (2018) found that high level of emotion role dissonance was associated with both emotional exhaustion and depersonalization.

**Moral disengagement**

Negative emotions may activate moral disengagement. When taking full responsibility for the consequences of one’s actions would imply an injury to their self-esteem and arise unpleasant or even unbearable negative emotions (i.e. a sense of guilt and self-accusation, one may be disengaged from their moral accountability. Being able to acknowledge what is right does not always carry with it the will and capacity to behave accordingly (Caprara et al., 2014). The dissonance between one’s actions and their values may result in a state of cognitive
dissonance (a series of cognitive strategies, resulting in cognitive reconstruction of the behavior itself and making unethical behavior morally acceptable (Bandura, 1990; Bandura, 2016). Zhao and Xia (2019) state that moral disengagement is ‘a secondary cognitive process whereby an individual’s moral code can be momentarily weakened or obscured (Fida et al., 2015)’. This may happen before committing the transgression (Bandura, 2016).

Moral disengagement can operate at four points: ‘redefining the behavior itself, altering the perception of its consequences, obscuring the agentic role of the perpetrator, and depicting the victim as responsible. (displacement, diffusion of responsibility)’ (Bandura, 2016; Frida et al, 2018).

Fida et al. (2015) showed that moral disengagement has a mediating role between negative emotions and counterproductive work behavior (CWB). In that regard, it is important to note that morally disengaging can promote nurses’ knowledge-hiding behaviours and affect negatively their moral reasoning.

Moral disengagement among nurses deserves further research. Redingbaugh et al. found that ‘doctors who spend a longer time caring for their patients get to know them better but this also makes them more vulnerable to feelings of loss when these patients die.’ (Redinbaugh et al., 2003). Given the nature of their work, nurses are very closely involved in providing care and cannot detach themselves from patients. However, Gerow et al. (2010) state that ‘nurses create a curtain of protection to mitigate the grieving process’ (Gerow et al., 2010). It might be formulated the hypothesis that nurses may use (wittingly or unwittingly) emotional detachment or even moral disengagement as a mechanism to protect themselves from the impact that life-threatening situations or patients’ death may have on them. This might be a starting point for further research.

Zhao and Xia (2019) found that nurses’ negative emotions can both directly and indirectly (through moral disengagement) increase nurses’ knowledge-hiding behaviours. The authors also found that ‘ethical leadership not only attenuated the direct effect of nurses’ negative affective states on moral disengagement but also mitigated the indirect relationship between nurses’ negative affective states and knowledge hiding via moral disengagement.’ Furthermore, Kuilman et al. (2019) state that ‘The personality meta-trait 'Stability' is an indicator of moral reasoning and is explained by a lower propensity to morally disengage among highly stable people.’

**Developing strategies and implications for nursing managers to mitigate compassion fatigue**

Meyer et al. (2015) demonstrate a need for hospitals to prevent compassion fatigue in healthcare providers. (Meyer et al., 2015). Sullivan et al. (2019) concluded that evidence-based compassion fatigue programmes and ongoing organizational support and intervention might reduce compassion fatigue. (Sullivan et al., 2019). In planning supportive polices for nurses priority should be given to providing them with knowledge (i.e. to learn to recognize when assistance is needed)
and skills (i.e. communication skills or abilities to maintain work-life balance). Nurses need to develop inner resources necessary to practice effective self-care, thus maintaining their emotional and physical health. (Houck, 2014). Salmon and Morehead (2019) found that building resilience in critical care nurses is of great importance for preventing posttraumatic stress disorder and hence mitigating compassion fatigue (Salmon and Morehead, 2019). Nursing managers should work on building interventions that reduce a nurses’ risk profile (Hegney et al., 2014). The reflective assessment risk profile model constitutes an ‘excellent framework’ for examining whether have a very distressed profile. (Hegney et al., 2014). Drury et al. (2014) suggested that a ‘nurse’s capacity to cope is enhanced through strong social and collegial support, infrastructure that supports the provision of quality nursing care and positive affirmation’ (Drury et al., 2014). Organizational prevention and supportive policies must be a priority to give nurses the skills to cope compassion fatigue. Lack of capable and qualified nurses must be addressed. Addressing emotional labour and preventing workplace violence are of crucial importance for mitigating nurses’ professional quality of life. In that regard, counselling programmes and ‘organizational culture of respect and cooperation in hospitals’ are needed (Kwak et al., 2019). In particular, as regards grief associated with death, providing a safe space for nurses to grieve, and use of techniques such as expressive writing, storytelling, and music are suggested to be used for helping nurses prevent the untoward effects of accumulated grief and suffering they experience in their work (Phillips and Welcer, 2017).

The protective role of reflection

Thoughtful reflection is a practice related to clinician resilience (College of Nurses of Ontario, 2015; Royal College of Physicians and Surgeons of Canada, 2017; Wald, 2015), which can nurture ‘practical wisdom’ (Wald, 2015, p. 702) and help nurses navigate morally complex situations (Hartley et al., 2019). Reflection ‘is recognized as an empowering process that encourages clinicians to engage with their work, reducing vulnerability and moral distress’ (Hartley et al., 2019; Wald, 2015). ‘Reflection is core to professional competency and supports the active, constructive process of professional identity formation’ (Wald, 2015). Wald (2015) offered a more inclusionary definition of reflection considered as continuum (Wald, 2015).

The author ‘proposed refining of Sandars’ reflection definition and expansion of Nguyen et al.’s reflection model’.

Hartley et al. (2019) state that ‘deeper awareness of the social discourses that shape clinicians’ moral and emotional experiences of loss can inform such reflection According to the College of Nurses of Ontario (2015). ‘Practice reflection is more than just thinking about practice’, ‘an intentional process of thinking’, ‘analyzing and learning’, ‘identify learning need’ and ‘a commitment to action’. In that connection it is notable that Kelly, Runge and Spencer, (2015) stated:
‘Based on our research, meaningful recognition may increase compassion satisfaction, positively impact retention, and elevate job satisfaction’ (Kelly, Runge and Spencer, 2015).

Conclusion
A wide range of stressful factors and negative emotions promote compassion fatigue. Psychological distress may lead to compassion fatigue through reducing self-esteem and creating negative emotions. Secondary traumatic stress may have a mediating role between empathy and compassion fatigue in the nurses. Secondary traumatic stress and compassion fatigue are separate albeit related concepts. Balance between compassion satisfaction and compassion fatigue entails nurses’ professional quality of life, which significantly influences not only their personal realm, but also caring and managing patients. In case of death, nurses’ experience of physical loss and grief considered inconsistent with their role may promote compassion fatigue, especially when the patient had not a ‘good death’ being surrounded by and communicating with family members. Thoughtful reflection (conceived in an inclusive way) may promote compassion satisfaction and prevent compassion fatigue.

Trait-negative affect is considered very important factor promoting compassion fatigue. Survivor guilt and omnipotent guilt are types of pathogenic empathy-based guilt and have a mediating role between empathy and compassion fatigue in the nurses. The role of empathy in promoting compassion fatigue is highlighted. Furthermore, it is argued that touch providing emotional containment is main predictor of emotional exhaustion whereas comfort with touch can effectively relieve fatigue and pain in the workplace among nurses. Moreover, emotion role dissonance, namely, expressing a wide range of emotions during nurses’ interactions with patients is suggested to be associated with emotional exhaustion. Moral disengagement is a secondary cognitive process activated by negative emotions and having a mediating role between negative emotions and nurses counterproductive work behaviour (i.e. knowledge-hiding behaviour).

Further research is required to make clear the importance and role of each factor and probably identify new factors promoting compassion fatigue in nurses.

There is a need for health care system to prevent compassion fatigue in nursing personnel. Ongoing institutions and strong organizational support strategies should be developed to reduce compassion fatigue. In this regard, counselling programmes as well as evidence-based compassion fatigue program might be helpful. Supportive policies must be a priority to give nurses coping and communication skills and inner resources, thus enhancing nurses’ resilience. Nurse managers should try to build intervention that reduces nurses’ risk profile and negative affective states, while improving recognition and awareness of compassion satisfaction among nurses. It is furthermore suggested that providing a safe space (and time) for nurses to grieve and the use of techniques such as expressive writing, storytelling, and music help nurses to effectively address the
negative effects of cumulative grief. Further development of risk-profile frameworks might be helpful in preventing nurses’ compassion fatigue.

References


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