EXPLORING COMPASSION FATIGUE IN EMERGENCY NURSES

by

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As members of the DNP Project Committee, we certify that we have read the DNP Project prepared by Lindsay Bouchard entitled "Exploring Compassion Fatigue in Emergency Nurses" and recommend that it be accepted as fulfilling the DNP Project requirement for the Degree of Doctor of Nursing Practice.

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Final approval and acceptance of this DNP Project is contingent upon the candidate's submission of the final copies of the DNP Project to the Graduate College.

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DEDICATION

To Claire:

You make everything better, including me.

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ABSTRACT

The purpose of this study was to describe the experiences, symptoms, and effects of compassion fatigue among emergency nurses, and to identify potentially effective interventions. Compassion fatigue within the profession of nursing is of growing concern due to its negative impact on nurses' mental and physical health, productivity, and patient care. There is a notable paucity of available qualitative research related to compassion fatigue in nursing, but available quantitative data indicates that emergency nurses could be especially at risk for developing compassion fatigue. Compassion fatigue is commonly conceptualized as being composed of burnout and secondary traumatic stress; however, previous exploratory research indicated that this definition might not adequately fit emergency nurses. Focus group interviews were conducted with emergency department nurses from four local hospitals. The participants were asked about their experiences, symptoms, and perceptions of the effects of compassion fatigue, and about potentially effective interventions to address compassion fatigue within their work setting. A content analysis of the interview data was performed to identify categories, common threads and patterns, and related themes. Although the participants' average length of time working in the emergency setting was less than two years, they all reported having intense experiences related to professional burnout, secondary traumatic stress, and the negative effects of compassion fatigue. The development of compassion fatigue was contributed to both organizational (time pressure and lack of resources and leadership support) and patient (clinical uncertainty, reason for seeing care, and witnessing grief) factors. The main symptoms of compassion fatigue were exhaustion, impaired communication, decreased emotional tolerance, coping with dark humor, and detachment/dissociation. These symptoms affected the participants

both at work and home. The suggested potential interventions comprised of self-care activities, debriefing with clinical staff, continuing education, and increasing awareness about compassion fatigue in the work setting. The data from this qualitative descriptive study expands our knowledge of the concept and ramifications of compassion fatigue in nursing, specifically in the emergency setting. It also offers potentially effective interventions to prevent and address the negative effects of compassion fatigue.

INTRODUCTION

Background Knowledge

Compassion fatigue within the profession of nursing is of growing concern due to its negative impact on nurses' mental and physical health, productivity, and patient care. Commonly conceptualized as the combined negative effects of occupational burnout and secondary traumatic stress (Stamm, 2010), compassion fatigue can manifest in ways that negatively impact nurses emotionally, intellectually, socially, spiritually, and professionally (Boyle, 2011). High levels of burnout increases nurses' intentions to leave their jobs, while lowering compassion fatigue levels in nurses can decrease burnout and turnover rates (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Najjar, Davis, Beck-Coon, & Doebbeling, 2009). For emergency nurses, compassion satisfaction, compassion fatigue, and burnout are associated with engagement, the key predictor of nurses' intention to leave their positions (Sawatzky & Enns, 2012). Nursing turnover has a variety of damaging effects, including decreased productivity, poor work environment and culture, compromised quality of patient care, and additional turnover (Jones & Gates, 2007). The problem is cyclical, with nursing shortages causing more nurses to want to leave the profession (Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2005). This is occurring within a context of a national nursing shortage that is expected to grow; there will be a projected 1.05 million registered nursing job openings by the year 2022 (United States Department of Labor, 2013).

In addition to having detrimental effects on staff and retention, compassion fatigue poses a patient safety threat. This phenomenon can decrease nurses' ability to provide quality patient care and has been linked to adverse patient events such as urinary tract and surgical site

infections, as well as patient and family complaints and verbal abuse (Billeter-Koponen & Freden, 2005; Bogaert et al., 2014; Cimiotti, Aiken, Sloane, & Wu, 2012). Rising expectations for healthcare standards has resulted in increased nursing workloads and higher levels of stress and compassion fatigue (Groves, 2014). Compassion fatigue has been studied in a variety of healthcare professions, including physicians, genetics workers, child protective professionals, trauma therapists, and nurses (Sorenson, Bolick, Wright, & Hamilton, 2016). This phenomenon has been identified in nurses working in a variety of settings, including intensive care (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Mason et al., 2014), palliative care (Melvin, 2015; Sabo, 2008), oncology (Hooper et al., 2010; Sabo, 2008), and emergency nursing (Hooper et al., 2010; Hunsaker, Chen, Maughan, & Heaston, 2015).

Nursing is widely acknowledged as a helping profession that can be both rewarding and highly demanding. The tasks and emotions associated with the role influence nurses' professional quality of life, which is defined as "the quality of life one feels in relation to their work as a helper" and includes positive compassion satisfaction and negative compassion fatigue (Stamm, 2010, p. 8). Professional quality of life is affected by three domains related to the work (organizational features and required tasks), client (patient and family), and person (nurses' actions and characteristics) (Stamm, 2010). These domains are aligned with the commonly accepted nursing metaparadigm, which includes the concepts of environment, person, and nursing (Fawcett, 1984). Each of these domains can influence workers' levels of compassion satisfaction and compassion fatigue.

Definition of Terms

Our understanding of compassion fatigue in nurses has evolved since its appearance in the literature in the early 1990s (Joinson, 1992; Sheppard, 2015). This phenomenon is most commonly conceptualized as the combined negative impact of burnout and secondary traumatic stress, and offset by positive compassion satisfaction (Stamm, 2010).

Compassion Satisfaction

Compassion satisfaction refers to "the pleasure you derive from being able to do your work well" (Stamm, 2010, p. 12). It can include positive feelings about coworkers and the ability to contribute to the work environment (Stamm, 2010). Compassion satisfaction is characterized by feeling invigorated, competent, and successful in the work being done. Workers feel that they are making a difference and are motivated to continue working by the positive reinforcement they receive from their colleagues and patients (Stamm, 2010). Higher levels of compassion satisfaction in emergency nurses have been associated with longer duration of being in the profession, higher levels of education, shorter shift length, and perceived adequate managerial support (Hunsaker et al., 2015). Nurses also experience higher levels of professional satisfaction when they perceive that they have control over their situation and the ability to overcome the challenges that are presented (Morrison & Korol, 2014). Compassion satisfaction could be a protective factor against some components of compassion fatigue in nurses working in acute-care environments (Craigie et al., 2015).

Compassion Fatigue

Broadly, compassion fatigue "refers to the stress, strain, and weariness of caring for others who are suffering from a medical illness or psychological problem" (Thomas & Wilson,

2004, p. 82). Risk factors are thought to be related to intense and prolonged contact with patients, use of self, and stress exposure (Coetzee & Klopper, 2010). The development of compassion fatigue can be related to individual factors relating to personality, work responsibilities, and processes of engaging with others, as well as macro-level environmental and cultural factors (Austin, Goble, Leier, & Byrne, 2009). For instance, when nurses feel a lack of control and significant difficulty addressing the demands of their work, this can result in compassion fatigue (Morrison & Korol, 2014). Compassion fatigue can have emotional, intellectual, physical, social, spiritual, and professional ramifications for nurses (Boyle, 2011). Nurses experiencing compassion fatigue report symptoms such as physical exhaustion, difficulty sleeping, feelings of ineffectiveness, purposeful emotional distancing from patients, and negative effects on their personal lives (Austin et al., 2009).

Burnout. Professional burnout has three key dimensions: overwhelming exhaustion, feelings of cynicism or detachment from the job, and a sense of ineffectiveness (Maslach, Schaufeli, & Leiter, 2001). Burnout occurs after a person's demands and responsibilities outweigh nourishing stimulating challenges and can cause people to react inappropriately, worry, and suffer from insomnia (Ekstedt & Fagerberg, 2005). Emotional signs of burnout include frustration, anger, depression, hopelessness, unhappiness, disconnectedness, exhaustion, and feeling overwhelmed (Stamm, 2010). The phenomenon might also be cyclical in nature, as physical and mental exhaustion can also contribute to developing burnout (Ekstedt & Fagerberg, 2005). The occurrence of burnout is influenced by personal characteristics, attitudes, and beliefs (Sabo, 2011), as well as organizational processes, structures, and values (Maslach et al., 2001). Burnout has been associated with high workloads and nurse-to-patient ratios, inadequate nurse

staffing, poor system functioning, and a perceived non-supportive work environment (Aiken et al., 2002; Leiter & Laschinger, 2006; Roder, 2010; Stamm, 2010).

Secondary traumatic stress. Secondary traumatic stress refers to negative emotions driven by exposure to work-related trauma (Stamm, 2010). Empathy and exposure to others' traumatic experiences are central to developing secondary traumatic stress (Beck, 2011), both of which are common within the profession of nursing. With secondary traumatic stress, "the helper develops acute, chronic, or prolonged stress reactions which adversely impact psychological functioning" (Thomas & Wilson, 2004, p. 84). The negative effects of secondary traumatic stress include difficulty sleeping, intrusive images or thoughts, forgetfulness, and "an inability to separate one's private life and his or her life as a helper" (Stamm, 2010, p. 21). Secondary traumatic stress has been reported in nurses working in various settings, including oncology, pediatrics, forensics, hospice, and emergency nursing (Beck, 2011).

Local Problem: Compassion Fatigue in Emergency Nurses

Compassion fatigue is commonly conceptualized as being composed of burnout and secondary traumatic stress (Stamm, 2010); however, this conceptual model might not adequately fit the experiences of compassion fatigue within the profession of nursing or the specific setting of the emergency department (Bouchard & Sheppard, 2016; Sheppard, 2015). Empathic strain is associated with professional work that includes empathic identification with patients or clients (Thomas & Wilson, 2004), but it is still unknown how nurses' empathy and engagement with patients contribute to the protection or development of compassion fatigue (Sabo, 2011). In emergency nurses, a high level of empathy might be correlated with psychological well-being and not distress (Bourgault et al., 2015).

Given their frequent exposure to traumatic events and high levels of work-related stress, emergency nurses could be especially at risk for developing compassion fatigue. Quantitative data from 128 trauma nurses found 35.9% with significant burnout levels, 7% with secondary traumatic stress, and 27.3% with compassion fatigue (Hinderer et al., 2014). Exploratory qualitative data suggest that manifestations of compassion fatigue in emergency nurses include feelings of ineffectiveness, physical and mental exhaustion, emotional detachment from patients, intense negative emotions related to patients and their families, inappropriate emotional responses outside of work, sleeping difficulties, and worry about work tasks, patients, and own family's health (Cais & Sheppard, 2015).

Synthesis of Related Literature

A literature review was conducted in order to explore the currently available research related to the phenomenon of compassion fatigue among emergency nurses. The Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and PsycINFO databases were searched using the terms "compassion fatigue + emergency nurs*." With the limits of full text availability and published within the past five years, there were 9, 14, and 5 results, respectively. When these databases were searched using the terms "burnout + emergency nurs*" and the same limits, there were 32, 42, and 15 results, respectively. Searching with the same limits and the terms "secondary traumatic stress + emergency nurs*" produced 6, 15, and 3 results, respectively.

Burnout in Emergency Nurses

Research with emergency department staff has indicated an association between burnout and chronic work-related stress, sleeping difficulties, exhaustion, and interrupted sleep (Farias,

Teixeira, Moreira, de Oliveira, & Pereira, 2011; Oliveira, Alchieri, Pessoa, de Miranda, & Almeida, 2013). Experiencing exhaustion "prompts actions to distance oneself emotionally and cognitively from one's work, presumably as a way to cope with the work overload" (Maslach et al., 2001, p. 403); therefore, this fatigue could lead to another dimension of job burnout: detachment. This cynicism, or "depersonalization," component of burnout is "a negative, callous, or excessive detached response to various aspects of the job" (Maslach et al., 2001, p. 399). Emergency room staff have been shown to have significant levels of emotional exhaustion and depersonalization related to the nature of their work environment (O'Mahony, 2011; Potter, 2006).

The available research reports different prevalence of burnout in emergency nurses. In one American acute care hospital, 82% of sampled emergency nurses were found to have moderate to high burnout levels and almost 86% had moderate to high compassion fatigue levels (Hooper et al., 2010). Hunsaker et al. (2015) also examined the prevalence and variables associated with the development of compassion fatigue and burnout, and in their study emergency nurses reported low to average burnout and compassion fatigue levels (Hunsaker et al., 2015). The authors hypothesized that the difference in their findings versus Hooper et al. (2010) was due to the fact that they recruited nurses from the Emergency Nurses Association mailing list, and this level of professional involvement might decrease professional burnout and compassion fatigue levels (Hunsaker et al., 2015).

A systematic review that examined the prevalence and determinants of burnout among emergency nurses found 17 studies, all quantitative, conducted between 1989-2014 (Adriaenssens, Gucht, & Maes, 2015). The studies reported an average of 26% of emergency

nurses experienced burnout and the determinants included both individual (demographics, personality characteristics, and coping strategies) and work (exposure to traumatic events, job characteristics, and organizational variables) factors (Adriaenssens et al., 2015). The authors focused on this population of nurses because the emergency specialty and setting is notably hectic, unpredictable, and constantly changing, and includes a wide range of patient disease, injuries, and issues requiring nurses having to address multiple urgent situations without adequate recovery time (Adriaenssens et al., 2015).

When exploring burnout among emergency nurses, Garcia-Izquierdo and Rios-Risquez (2012) analyzed variables that affected the three components of burnout: overwhelming exhaustion, feelings of cynicism or detachment from the job, and a sense of ineffectiveness (Maslach et al., 2001). They found that that the emotional exhaustion, cynicism, and reduced professional efficacy were associated mainly with excessive workload, lack of emotional support, interpersonal conflicts, and the type of shift worked (Garcia-Izquierdo & Rios-Risquez, 2012). Other research with emergency nurses also indicates that working night shifts increases occupational stress, causes mood alterations, and maintains a sleep deficit (Bezerra, da Silva, & Ramos, 2012). Low levels of nurse burnout occur with perceived adequate staffing, positive interprofessional relationships, and administrative support (O'Mahoney, 2005; O'Mahony, 2011; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004), while higher burnout in emergency nurses has been closely linked to interpersonal conflicts and excessive workload (Garcia-Izquierdo & Rios-Risquez, 2012).

Another concept associated with nursing burnout and turnover is moral distress (Corley, 2002). Fernandez-Parsons, Rodriguez, and Goyal (2013) found overall low moral distress in 51

surveyed emergency nurses, but moral distress was reported as the reason for leaving a previous position (6.6%), thoughts of leaving a position but staying (20%), and current considerations of quitting (13.3%). Situations that caused the highest level of moral distress in these emergency nurses were working with other healthcare professions deemed incompetent, poor team communication that resulted in diminished quality of patient care, and futile care of patients (Fernandez-Parsons et al., 2013). Wolf et al. (2015) collected qualitative data to explore the phenomenon of moral distress in emergency nurses. The main themes included challenges of the emergency care environment (e.g., staffing levels, conflicting expectations of the nursing role, and quality and safety of patient care), being overwhelmed (e.g., patients who were frequent users, patient volume and flow, and time pressures), and adaptive/maladaptive coping regarding emotional fallout, physical symptoms, and stress management (Wolf et al., 2015). The nurses reported that they were not able to provide the quality of care that their patients deserved due to their moral distress (Wolf et al., 2015).

Secondary Traumatic Stress in Emergency Nurses

For nurses, secondary traumatic stress might be more significant than burnout to the development of compassion fatigue (Sheppard, 2015). Secondary traumatic stress refers to negative feelings driven by primary or secondary work-related trauma (Stamm, 2010), and emergency nurses have a higher exposure to traumatic events than other types of nurses, including patients' sudden death, serious injury, and mutilation; grief of patients' family members; and potentially dangerous situations (Adriaenssens, de Gucht, & Maes, 2012). The frequency of experiencing traumatic events increases with years of experience as an emergency department nurse (Lavoie, Talbot, & Mathieu, 2011), but levels of secondary traumatic stress

have been negatively correlated with years of trauma nursing experience (Von Rueden et al., 2010). Experienced trauma nurses may have lower levels of secondary traumatic stress due to increased desensitization or use of coping skills and support systems (Von Rueden et al., 2010).

Reported symptoms of secondary traumatic stress in emergency nurses include irritability, difficulty sleeping, diminished activity levels, intrusive thoughts, emotional numbing, and avoidance of patients (Dominguez-Gomez & Rutledge, 2009). Dominguez-Gomez and Rutledge (2009) found that 85% of sampled emergency nurses had experienced at least one symptom of secondary traumatic stress within the past week. Another study found that 87% of emergency nurses surveyed reported at least one traumatic event confrontation within the past 6 months (Adriaenssens et al., 2012). Encountering sudden deaths, especially of children and adolescents, was identified as the most distressing type of event (Adriaenssens et al., 2012). The emergency nurses also reported considerable levels of anxiety, depression, somatic complaints, fatigue, and post-traumatic stress disorder symptoms (Adriaenssens et al., 2012). Duffy, Avalos, and Dowling (2015) found that 82% of emergency department staff nurses met secondary traumatic stress criteria, and these nurses had significant levels of considering changing careers and using alcohol to relieve their work-related stress.

Study Aims

Further exploring the experiences, symptoms, and effects of compassion fatigue among emergency nurses would allow a better understanding of this phenomenon within this setting. This would expand our knowledge of the concept and ramifications of compassion fatigue in nursing. Additionally, this would aid in the identification and development of effective interventions to prevent and address the negative effects of compassion fatigue on nurses,

healthcare organizations, and the quality of patient care. Therefore, the purpose of this study was to describe the phenomenon of compassion fatigue among local emergency nursing staff. The specific aims were to describe the experiences, symptoms, and effects of compassion fatigue, and to identify potentially effective interventions.

Theoretical Framework

The framework of Normalization Process Theory (NPT) can be used to analyze social aspects within healthcare organizations, as it incorporates the influence of organizational structures, group processes, and social norms on healthcare practices (May, 2013; May & Finch, 2009). Compassion fatigue is a social phenomenon that can become a common and seemingly unavoidable part of unit culture, as burnout and secondary traumatic stress result from nurses' interactions with coworkers, patients, and families.

The development of compassion fatigue occurs within social contexts, as it is related to processes of engaging with others within environmental and cultural dynamics (Austin et al., 2009) and "emanates from relational connections nurses have with their patients or the patient's family" (Boyle, 2011, p. 3). Qualitative interview data, including within focus groups, contains individual responses shaped by social processes and occur in relation to a group context (Polit & Beck, 2008). Therefore, utilizing a social organization theory such as NPT could be useful to aid in understanding of the phenomenon of compassion fatigue with the qualitative methods chosen for this study. NPT includes four key generative mechanisms of the work of implementation: coherence, cognitive participation, collective action, and reflective monitoring (May & Finch, 2009). The main components of NPT can be linked to the currently accepted conceptual model of compassion fatigue (Stamm, 2010) and this study's qualitative research design (Figure 1).

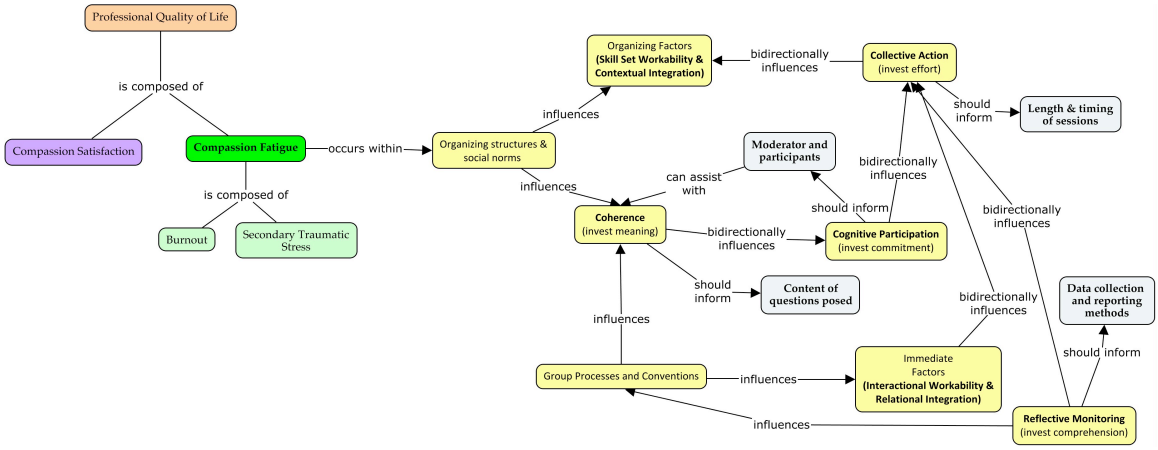

FIGURE 1. Map of Concepts Related to Compassion Fatigue, NPT, and the Current Study's Methods.

The concept of coherence refers to the fact that the incorporation of a practice is related to its usefulness and meaning (May & Finch, 2009). Meaning "is learned, shared, and experienced by actors in specific social contexts, as they work the practice through. This meaning is *internalized* and contributes to embedding by anchoring the practice in the lived experiences of individuals" (May & Finch, 2009, p. 543). Interviewing can be utilized to collect data related to others' lived experiences and associated meanings (Seidman, 2006). Therefore, using a qualitative data collection method was appropriate to gain a better understanding of compassion fatigue in emergency nurses, and the questions posed during the focus groups were designed to elicit this information.

Cognitive participation refers to the processes that occur within interaction chains that compose an implementation process (May & Finch, 2009). Relevant concepts include enrolment, or organizing a community of practice, and legitimation, which includes interpreting and 'buying into' a practice (May & Finch, 2009). Emergency nurses within a department needed to believe in the meaningfulness and importance of the study in order to agree to participate. Within the

context of NPT, it is critical to include ‘champions’ to encourage adoption, meaning, and buy-in, such as a nurse managers and educators (May & Finch, 2009; May, Sibley, & Hunt, 2014). Formal and informal nurse leaders within local emergency departments were notified of the study’s purpose and methods and agreed to aid in the recruitment of participants.

The next key domain, collective action, incorporates a practice’s interactional workability (how it is operationalized), relational integration (how it is understood), skill-set workability (distribution and conduct of work), and contextual integration (incorporation within social context) as main components of the normalization model (May & Finch, 2009). The composition, timing, length, and structure of the focus groups were designed to collect data in an efficient and valid manner. The required amount of work related to a practice is also important to take into account (May & Finch, 2009); thus, the focus groups were offered at convenient times for the participants. Within the related concept of relational integration, a practice will affect a person’s knowledge and “the ways that they understand the actions of people around them” (May & Finch, 2009, p. 544). Conducting focus groups allows for interaction and comparison among participants (Morgan, 1998), potentially creating increased understanding during the action of data collection.

The fourth key concept within NPT is reflexive monitoring. Reflexive monitoring incorporates feedback about the usefulness of a new practice within socially patterned beliefs (May & Finch, 2009). As is recommended, the participants were informed of the plan for data collection, analysis, and dissemination, as well as how the findings could benefit them and the organization (Krueger & Casey, 2009). During the focus group interviews, the participations were asked about the usefulness of potential interventions to counteract the effects of

compassion fatigue on their unit. Additionally, the study participants were notified that they would have access to the findings after the completion of the study through dissemination activities.

METHODS

Design

There is a notable lack of available qualitative research related to compassion fatigue in nursing. Therefore, this research was a descriptive study with qualitative methods, utilizing focus group interviews. Qualitative research methods are appropriate for "understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences" (Merriam, 2009, p. 5). Interviewing can be useful when researchers are interested in understanding others' lived experiences and associated meanings (Seidman, 2006). Focus groups are often used to learn about poorly understood topics and groups of people, and are effective in exploring perceptions and feelings (Krueger & Casey, 2009; Morgan, 1998). Using focus groups can "be an efficient means of determining how people express their ideas relating to the construct" (Polit & Beck, 2008, p. 477). This type of data collection method allows participants to share and compare, providing a thorough view of their experiences and perspectives (Morgan, 1998). It is recommended that focus groups are a size that allows all participants to have the opportunity to share but also offers a diversity of perceptions (Krueger & Casey, 2009; Polit & Beck, 2008). In this study, focus groups were scheduled with four participants from multiple hospitals in order to accommodate the 1-2 hour timeframe in which the participants were available while including perspectives from different practice locations.

Criteria for developing trustworthiness in qualitative research include credibility, dependability, confirmability, transferability, and authenticity (Guba & Lincoln, 1994; Polit & Beck, 2008). Credibility signifies the level of confidence in the truth of the data and its interpretation (Polit & Beck, 2008). This criteria involves both implementing a study with methods that enhance the findings' believability and demonstrating credibility in dissemination efforts (Guba & Lincoln, 1994; Polit & Beck, 2008). Dependability denotes reliability and stability of data over time, and includes the likelihood of similar findings being produced with similar participants in similar contexts (Polit & Beck, 2008). Confirmability refers to being objective and the potential for the data to be accurate, relevant, and meaningful to independent people (Polit & Beck, 2008). This criteria also requires that the data reflects the study participants' point of view and not the researcher's perspectives or biases (Polit & Beck, 2008). Transferability equates to the generalizability of data, which requires providing adequate descriptive data when reporting the findings (Polit & Beck, 2008). Lastly, authenticity is achieved when research "invites readers into a vicarious experience of the lives being described, and enables readers to develop heightened sensitivity to the issues being depicted" (Polit & Beck, 2008, p. 540). I strove to promote all five criteria related to trustworthiness in the way I collected, analyzed, and reported the findings of this study.

Recruitment and Participants

The inclusion criteria for the study participants were registered nurses of any age with emergency department experience within the Tucson community working full- or part-time, any shift, and who were fluent in spoken and written English. Following University of Arizona Institutional Review Board approval, participants were recruited from local emergency

departments using key informants, who included staff nurses and nurse educators in multiple hospitals in Tucson. The key informants distributed fliers asking for nurse volunteers to participate in a study to learn more about compassion fatigue among emergency nurses. The flier included the study purpose, approximate time commitment, focus group method, and my contact information. Interested nurses contacted me, and then I coordinated focus group sessions at a time that was convenient for multiple participants. Demographic information was collected via an anonymous questionnaire at the time of the interview.

Two focus group sessions were conducted with three participants each, due to scheduling conflicts and the limited availability of interested participants. The participants worked in four different local hospitals and included two male and four female nurses. Five participants identified as Caucasian/White and one as African. The average age of the participants was 28.5 years (range: 25-31) and their average length of time working in the emergency setting was 1.8 years (range: 3.5 months to 4 years). Their current positions were all full-time and they worked a combination of shifts; three worked 7 am to 7 pm, two worked 10 am to 10 pm, and one worked both 1 am to 1 pm and 3 am to 3 pm shifts.

Data Collection and Analysis

The focus group interviews were conducted in a private setting at the University of Arizona College of Nursing. During interviews, questions posed to participants and their sequence should be carefully determined, posed in familiar language, and open-ended (Krueger & Casey, 2009; Merriam, 2009). Six recommended types of questions include those that address experience and behavior, opinions and values, feelings, knowledge, sensory, and

background/demographic (Merriam, 2009). The questions that were asked in the focus groups during this study were:

1. How satisfied are you with being a nurse? An emergency nurse?
2. What do you like best about being an emergency nurse?
3. What do you know about the phenomenon of compassion fatigue? How would you define it?
4. What do you think about professional burnout? How does it feel and what causes it?
5. What do you think about secondary traumatic stress? How does it feel and what causes it?
6. What experiences and symptoms have you had related to compassion fatigue? Are there specific patient situations that affect it the most?
7. How do you think compassion fatigue affects you?
8. What do you think can help address or prevent compassion fatigue?

The interviews were recorded using a digital audio recorder and lasted an average of 73.5 minutes (range: 55-92 minutes). Analysis of focus group data should be systematic and verifiable (Krueger, 1998; Krueger & Casey, 2009; Polit & Beck, 2008); therefore, I also took field notes regarding the key points of the discussion and any important nonverbal observations. A professional transcription company performed the transcription of the audio files of the interviews. A content analysis of the data was then performed for this descriptive qualitative study. The transcribed focus group interview data was read and grouped into categories (Seidman, 2006). Transcripts were read multiple times to ensure all data were assigned an

appropriate category. The categories were then compared for common threads and patterns, and subsequently organized into related themes (Seidman, 2006).

Ethical Considerations

Relevant ethical considerations were included regarding the validity and reliability of qualitative research in the way the data were collected, analyzed, and reported (Merriam, 2009). This is necessary when using an interview methodology, as the data and meaning can be influenced by the participants' interactions with the interviewer, as well as the researcher's interpretations of the data (Krueger & Casey, 2009; Seidman, 2006). Study participants have the right to understand the potential risks, know the confidentiality measures, and experience minimum associated stress (Morgan, 1998); therefore, the participants were provided with a disclosure statement and local mental health resources during the present study. Reliability was enhanced through the use of audit trails, in which I kept records of how the data were collected, categories were derived, and decisions were made during the study (Merriam, 2009; Seidman, 2006).

Additional ethical considerations for qualitative research include obtaining maintaining confidentiality and secure storage of data (Merriam, 2009; Polit & Beck, 2008). Interview data should be managed by keeping participant information forms and properly labeled audio files in a safe and secured location (Seidman, 2006). Immediately after the interviews, the audio files and demographic information were transferred to a password-protected computer. The professional transcription services used secure data transmission methods for the audio files and completed transcripts. Within focus group interviews, participants learn about each other and there is a risk of over-disclosure; this can also pose a privacy issue, especially when discussing

emotional topics (Morgan, 1998). The participants were asked to set ground rules for protecting privacy and setting discussion limits at the beginning of the session, and they were provided with professional resources in the event that they became distressed during or after the interview due to discussing emotional topics (Hegney & Chan, 2010; Morgan, 1998). Another strategy to enhance confidentiality is to include the following topics within the introduction for each the focus group: description of the study, who will have access to the audio recording and findings, how the findings could benefit the participants, promise of researcher confidentiality, and a request that the group also maintains confidentiality (Krueger & Casey, 2009); this information was provided in the study's disclosure statement and in my statements at the beginning of each focus group session.

FINDINGS

The purpose of this study was to describe the phenomenon of compassion fatigue among local emergency nursing staff, specifically their experiences, symptoms, and effects of compassion fatigue, and to identify potentially effective interventions. Content analysis of the interview data revealed information related to three main categories: contributing factors to compassion fatigue, symptoms of compassion fatigue, and potential interventions to prevent or address compassion fatigue.

Contributing Factors to Compassion Fatigue

The contributing factors to compassion fatigue that the study participants identified were related to both organizational and patient factors. The organizational factors were time pressure and lack of resources and leadership support. The patient factors were clinical uncertainty, reasons for seeking care, and witnessing grief.

Organizational Factors

The participants reported that experiencing compassion fatigue in the emergency setting was highly associated with consistent time pressure and a perceived lack of necessary resources and leadership support.

Time Pressure

A main contributing factor to compassion fatigue was viewed as the difficulty of providing high quality patient care within the limited timeframe expected in emergency departments (ED) or emergency rooms (ER). One participant explained, "In the ER, they come in unstable, so it is a lot of pressure to be able to play your role, do it quickly, think fast." The participants described experiencing distressing tension between wanting to provide patient-centered care and needing to maintain the speed required in the emergency setting. One participant stated, "There are some pretty heartless, spectacular ER nurses…I don't want to be that, by any means…I don't want to be like ruthlessly efficient." Another participant associated compassion fatigue with the desire "to have a meaningful experience with every patient. When you couple that with the fast pace of the ER." He expressed feeling guilty about not allowing patients to have the opportunity to fully tell their stories because "with the time limit, it's so difficult to do that."

The time pressure was related needing to meet specific goals in the emergency department, such as having a 7-minute triage time or ending a patient encounter within two hours. One participant explained, "We want to be present, but then there are certain structures that limit you. At the end of your 12-hour shift, you're constantly struggling with that. How are you present versus how do you meet the goals?" Another participant explained how he viewed himself as being a "clinically bad" emergency nurse when he occasionally spent five to fifteen

minutes more when discharging a patient in order to deliver person-centered care. One participant perceived that the time pressure continually grew, saying, "You're trying to get your tasks done and it's always one more task to get done within a certain amount of timeframe. That timeframe keeps getting smaller and the tasks keep getting greater."

Prioritizing time goals over providing compassionate care led the participants to question their actions and ethics. One participant reported feeling "inhumane" when she worked "just with the goal of time," as opposed to outside of work, where she was "compassionate, kind, and present." Multiple participants reported feeling conflicted and unhappy when they prioritized being efficient or when they were juggling multiple patient needs at once. One participant stated,

> "Your patients have these demands where they just want you to sit and talk with them. They just wanna spend time with you. You just can't because you have something else to do with another patient or somewhere else in the ED. It breaks your heart….it leaves me questioning like, 'Am I a horrible person for doing that?' I don't think I'm a horrible person, but I did make that decision, and I stand by that decision."

Thus, the participants described how compassion fatigue stemmed from working with two different metrics by which they were evaluating themselves: the time goals of the department and their own ethical standards of providing patient-centered care.

Another consequence of the time pressure was their limited self-care during the shift. In order to make more time to perform their work duties, the participants reported that they frequently skipped self-care activities, which also contributed to compassion fatigue. They would commonly forgo eating and using the bathroom, sometimes for the entirety of their shift. One participant explained that she would not take a lunch break because "I felt the more I can do, the more I can help, the more I push, the better nurse I am, the better the patients would be." Two of the participants reported that they made sure to take their allotted breaks when they had students

working with them, but otherwise they would not make time for self-care during their shifts to be more efficient. One participant explained that this was "to present an atmosphere, try to protect the student from the pain that I'm experiencing." They reported feeling the need to shelter students from experiencing all the demands of their professional role. Another participant reported that he would have more job satisfaction and less burnout when he had more help from students or peers:

> "I have a buddy and not much work to do, and I take lunch, and go to pee multiple times a day… I drink coffee, I drink water, I eat food…Still, these little things just—their inclusion in the work day or their exclusion can lead to a really nasty burnout. For me, at least, or enjoy going in to work."

In addition to influencing how the participants felt about their job, their difficulty in engaging in self-care also affected their relationships outside of work. One participant explained how her husband worked from home as an editor, which often made her feel resentful because he had more freedom in his workday. She explained:

> "I tell him, 'You're so lucky. You get to be home,' and editing I'm sure can be stressful, but honestly, you can get up and go get some coffee; you can go to the bathroom…Me, if I have to pee, I don't get to pee when I want. I have to wait."

Thus, the time pressure in the emergency department led the participants to feel that they did not have time to adequately take care of their patients or themselves, and this was viewed as a significant contributing element to developing compassion fatigue.

Lack of Resources and Leadership Support

When asked about professional burnout, the participants related this concept to compassion fatigue and reported that it was mostly due to a perceived lack of necessary resources and leadership support. The participants expressed that healthcare organizational

leadership and coworker expectations to do more in less time increased their sense of professional burnout and compassion fatigue. One participant explained:

> "…professional burnout happens more from the administrative side…Your resources keep dwindling as far as your team and who can help you and what you have to work with… I think it all has to do with bureaucracy and people trying to cut costs."

The participants reported that they felt the most burned out when they had low perceived leadership support and a lack of required resources, as mentioned above, especially when providing high acuity care. One participant explained that she experienced compassion fatigue as a result of decisions made by her nursing leadership:

> "You don't have 20 hall patients when you've only got 14 rooms open. You don't develop staffing matrixes that predict nobody's going to get a lunch… Sometimes it's just by design that you are going to be experiencing what you experience, I think, from an administrative level."

Another participant relayed a story of having to provide extensive care after a patient experienced cardiac arrest while the "charge nurse literally just stood at the desk and watched," which made her feel unsupported and frustrated. She subsequently experienced feeling burned out and less motivated to provide high quality patient care. Another participant explained, "If all those things that make my professional role and environment one that doesn't have burnout as an issue, I imagine I'm able to maintain my compassionate capacity." In addition to aspects related to their work environments' time and task expectations, resources, and leadership support, the study participants also identified patient factors related to experiencing compassion fatigue.

Patient Factors

The participants reported that they most enjoyed working in the emergency setting due to the frequent opportunities to learn and think critically, as well as the patient variety and high acuity. However, many of these features were also related to factors that they perceived as causal

to developing compassion fatigue. The main patient factors contributing to compassion fatigue within the emergency setting were clinical uncertainty, reasons for seeking care, and witnessing grief.

Clinical Uncertainty

Although the participants stated that the variety, unpredictability, and fluctuating acuity were aspects that they liked most about working in the emergency department, they also reported that the clinical uncertainty of their patients contributed to developing compassion fatigue. Patients presented with a wide variety of chief complaints; as one participant stated, "In the ER, you never know what you're going to get." The participants reported working with patients for only a short period and often did not know the outcome of their efforts. One participant stated, "You don't even know what happens in the end. Does he rehabilitate and go home and they have their 20 years or does he die once he goes to ICU?" Similarly, another participant expressed that "you don't necessarily know what the rest of the story was" due to having less "continuity of care" in the emergency setting, which made it more difficult than on other types of units. A participant shared that fast, critical thinking was required in the moment of providing patient care, and she often wondered afterwards about the patient's well-being. She reported that she would "go home wondering" if her patients ended up living or dying, "because you are a nurse because you care, so you do think about them."

Even when the participants knew a patient's outcome, uncertainty about the series of events during their care was also a contributing factor to compassion fatigue. One participant explained that she experienced compassion fatigue when "something bad happens and instead of getting it off your chest or exploring what the possibilities were or what you did right and what

you did wrong…That's just going to keep going at you, keep eating at you." Thus, the inability to review and process fast and high acuity care often raised many unanswered questions, which they believed led to the development of symptoms of compassion fatigue.

Reasons for Seeking Care

Another aspect of compassion fatigue that was seen to be relevant in the emergency setting was the patient's reason for seeking care, whether for a serious health condition or not. At work the participants would often have multiple patients each experiencing extreme distress. A participant reported, "It's hard, though, because I feel like every room you go into, you're dealing with that person on their absolutely worst day." Another participant explained the related emotional difficulty, saying, "You're taking on that person's worst day with them and then you're trying to balance three other people's worst days." The emergency department's protocols were seen to increase patients' vulnerability and loss of control; one participant explained:

> "Most of the time it's their worst times, and they're most vulnerable. They get naked in front of us, like you said. Again, all of their belongings are stripped from them and put off to the side. They're reduced to an arm band and a number, and vitals on a machine. That is what they are. We've taken away everything from them and we have their lives in our hands, literally. We control everything that's happening to them in that time."

Thus, caring for multiple high acuity patients throughout a shift was viewed as contributing to compassion fatigue within this practice setting.

Frequently having patients who were in life-threatening danger also made it challenging to care for less acute patients seeking care in the emergency department. Interestingly, the participants all reported that they felt symptoms of compassion fatigue when caring for patients during "not their worst times." One participant explained that she did not have a problem with the job's requirement to "deal with people on their worst day. The part that gives me the

compassion fatigue is when they come in— And they're fine." When this sentiment was expressed during each focus group interview, the other participants all groaned in recognition and agreement. Caring for low acuity patients in an emergency department resulted in feelings of annoyance and resentment. One participant described it by saying, "Unless that next patient is another code, you're like, 'Yeah, your problem isn't that big of a deal. Go away.'" Another participant said, "Or you're in that room, you're coming out to get something and their family members are like, 'How long is it gonna be?' I'm like 'Someone's dying. Stay there. You're not dying. You have a cold.'" Similarly, one of the participants expressed:

> "'I need ice chips.' You're like, 'Ice chips are the least of my worries…I'm sorry. Somebody's having an anaphylactic shock next door. Your ice chips don't matter, sorry.' You find that you just don't have the—what do you say? You don't have patience for stuff that's not so intense and that's probably not so great."

The participants thought that this aspect to caring for patients was more prevalent in the emergency setting versus on other types of units. One participant stated, "When I was med-surg like I knew all my patients needed to be there…In the ER, not everybody has a reason to be there." The participants expressed a frequent sense of judgment about the necessity of patients seeking care in the emergency department. Therefore, caring for both high and lower acuity patients could contribute to their development of compassion fatigue.

Witnessing Grief

The participants were not aware of the concept of secondary traumatic stress, but after it was defined they immediately related it to experiences of witnessing others' grief while working in an emergency department. During the interviews, the study participants expressed the most emotion when discussing this topic. Although they reported that they could usually provide care for patients without an acute emotional response, they had a difficult time seeing patients' family

members or their coworkers reacting to a poor patient outcome. One participant reported, "I don't remember the patients; I remember the family. I remember the family screaming over the body." Another participant said, "…my perspective watching a parent watch their child dying? That kills you. That's like the worst thing." In addition, one participant explained that she had experienced secondary traumatic stress when she witnessed her coworkers' grief:

> "Them being affected by it affects me. That's kind of how I'm interpreting this secondary trauma. Where my coworker breaks down because they're personally affected by it, or my coworker doesn't have the coping to deal with this patient dying or with the family members crying in front of 'em. That's when I start to be affected by their pain and their trauma and their hurt…When someone that I work with is breaking down next to me, it's very hard not to be affected by their pain."

Many of the participants reported that this aspect of working in the emergency department was the biggest contributing factor to developing compassion fatigue, as these experiences stayed with them beyond their shift. One participant stated, "That wife screaming for her husband… I just hear it in my mind all the time." Another participant reported, "It gives me goosebumps. I think that's the worst thing leading to compassion fatigue…Those family members are burned in your head." One participant explained that she had a strong emotional response to seeing loss in the pediatric emergency setting:

> "…the screaming, it sticks in there or the words: 'you're my whole world.' That's the one that sticks in my head. This guy said it to his kid. It was like, 'You are my whole world,' and I'm just like, 'Oh, I'm out. I gotta go before I start crying with him.' It's rough."

Being affected by these types of experiences was viewed as unavoidable and long lasting. Another participant expressed difficulty witnessing others' grief in this way:

> "You get the family members who are screaming in the hallway. Originally, you weren't very upset by this patient who died, but now this family member is literally in the hall screaming at the top of their lungs. Of course, that's going to be very traumatic to anyone who can hear that, see this mother screaming for her child or a son screaming for his father. It is very traumatic to anyone. That's what stays with you. It's not the fact—

> necessarily the fact that your patient died, but then what the family did afterwards that you were a part of, that you witnessed, that you were right there next to, that you had to deal with for the rest of your shift that day. That's what you take home with you, and that is very traumatic. That stays with you."

The participants explained that these experiences affected them both while they were at work and at home, in a variety of symptoms of compassion fatigue.

Symptoms of Compassion Fatigue

The study participants identified multiple symptoms related to compassion fatigue that stemmed from the contributing organizational and patient factors. The symptoms included exhaustion, impaired communication, decreased emotional tolerance, coping with dark humor, and detachment/dissociation.

Exhaustion

A major symptom of compassion fatigue for the study participants was mental, physical, and emotional exhaustion. The mental exhaustion was related to the fast pace and high levels of critical thinking required in the emergency setting. The participants expressed this by saying, "Your mind is just going so fast and so you do get exhausted" and "You go home and you're just exhausted from running, running, running, running all day long and trying to constantly have your critical thinking skills on. Your brain is just constantly going." They reported high levels of physical exhaustion. One participant explained, "Especially in the emergency department it is exhausting. I've never been so tired in my life. You're on your feet running for that entire time." Another participant reported that providing care in the emergency setting was "a huge responsibility…That adds also I think to the fatigue and stress and you're just stressed so much of the time, you are exhausted, physically exhausted a lot." The mental and physical exhaustion affected their activities at home; one participant explained, "You go home. What's my priority?

Now my priority is now I need to go to bed because I have to get up at 6:00 a.m. so I can get to work."

In addition to experiencing mental and physical exhaustion, all of the participants reported frequent emotional exhaustion and an associated feeling of emptiness by the end of their shifts in the emergency department. One participant explained, "By the time you get home, you're like, 'I'm done; I just can't anymore.'" Another participant agreed, stating, "…by the end of the day, like you said, 'Okay, I'm done with people's problems; I'm done.' I do see that." A participant described her emotional exhaustion in this way:

> "A lot of times I feel like I've given all that I can give and there's nothing left to give. I don't dig down deeper within myself to find something more to give. It's, at a certain point in the day, in the week, in the month, there's no time for it. It can happen at any time where I'm just like, 'I would love to care right now, but I just can't.'"

Another participant described her experience and subsequent guilt related to emotional exhaustion from work:

> "…you try to be compassionate to everyone that you take care of, but then at a certain point, you don't have any compassion left to give…At some point it's all gone…That's what I've always interpreted compassion fatigue as. It's where, at the end of the day, you just have nothing left to give. You shouldn't be going home like that. You shouldn't be going home emotionless."

The participants reported that their mental, physical, and emotional exhaustion also contributed to the development of other symptoms of compassion fatigue, including impaired communication and decreased emotional tolerance.

Impaired Communication

The study participants identified impaired communication as a principal symptom of compassion fatigue, occurring at both at work and home. One participant shared a story in which he was frustrated with the work of a coworker, but instead of talking directly to him about it, he

approached management. In this way, he perceived that "poor communication is my symptom of compassion fatigue." He also expressed impaired personal communication, stating, "It could translate even to my household with my wife, 'I need to go to sleep because I need to wake up in the next morning. Are you okay? Good. Okay, good night.'" Another participant also explained that she had difficulty communicating with people after work due to her physical and emotional exhaustion:

> "I go home and people wanna talk to me and I find that I'm just zoned out. Like I just don't care; I don't or I'm so exhausted and they're like—I say, 'Tomorrow; tomorrow we can talk.' 'I wanna tell you right now.' 'What? Okay,' and I finally just sit there and they do talk, but I hear nothing."

Similarly, another of the participants reported experiencing ineffective personal and professional communication; when people spoke to her after work, she explained, "You'll hear it and you're like, 'Okay. I'll deal with that later,' and then it'll just be like, 'Mm-hmm. Mm-hmm. Hmm.' Just like you are with some patients when you're doing assessment and they're like talking at you." The potential reasons for the impaired communication at home were viewed as exhaustion, time pressure at work, and feelings of resentment towards loved ones who worked in different professions. One of the participants expressed that after a challenging shift caring for multiple high acuity patients, he would come home and when his wife would complain about her day at the office and then ask, "'How was your day?' 'Fine.' 'Tell me more.' 'It's fine.' 'Want to talk?' I'm asleep." In addition to feeling a reduced desire or ability to communicate with others at home, the participants also reported experiencing decreased emotional tolerance for people outside of work.

Decreased Emotional Tolerance

Due to caring for patients in the emergency setting, the participants reported that they had less emotional tolerance outside of work. One participant explained the consequences of her physical and emotional exhaustion from work in this way:

> "I don't know how often I ever sit down in the ER, but by the time I get home, I find that I'm easier agitated with my own family, which is terrible because they don't deserve that, but it's like you've put so much of your good behavior and caring and you just get so worn out…it just seems like you run out by the time you get home. It shouldn't be that way, but it is. I felt terrible, like this horrible person, but after talking to other nurses it sounds like it's more common than I had realized."

Two of the study participants shared stories about witnessing car accidents outside of work in which they hesitated before offering to help the victims due to their exhaustion and minimal emotional response. One participant explained that she wanted to stop and help, "but I also really wanted to go home and get out of my scrubs. That's horrible." Another participant described that her work in the emergency department caused emotional distance in her personal relationships:

> "You see stuff at work and you just feel absolutely no sympathy for anything and you start pushing people away or if you kinda say those kind of things, like, 'Look, I just don't care right now. I'm done. Seen enough at work; I'm done.' If you get in an argument about it, like, 'Well, you should care. This is your family,' but then again, you're like, 'Well, I don't,' and so you do; you start pushing away. That's hard, I think."

Multiple of the participants expressed that they had a low emotional response to their loved ones' health concerns because of the high acuity of patient care they frequently provided at work. One participant explained that since starting work in the emergency department, his perspective had changed:

> "…things don't carry the same weight as I am exposed to it…I think it becomes harder to be empathic when you—when you're sort of placing this on a spectrum that has now really widened, like bad is here now. Whereas like, this that you're dealing with used to be, 'Whoa, that's horrible! Let me sit with you and this pain.' Now it's like, 'Oh, that's not that bad.'"

Another participant described finding that he was often "transferring the emergency atmosphere" to his friends' and family's health concerns, which seemed minor in compared to the physical and emotional trauma he witnessed at work. Similarly, another participant described:

> "Not caring as much about everything else because everything else is just kinda blunted in comparison to what we've seen and what we do every day. It's just not as extreme. We get extreme situations and so when we encounter something mediocre in the world where everyone thinks is extreme, but we just think it's mediocre…"

A participant reported that her lack of emotional response to a family member's health condition was because she had cared so much about patients at work and felt emotionally exhausted; she said, "By the time you go home, you're like, 'I can't deal with you right now. I'm just done. I don't care about your problems; I don't care if something bad happened in your day.'" This attitude bothered her family members, who would say "'Well, you're a nurse. You should care,' and I'm like… Yeah, I do care at work. I care at work, where I'm paid to care." Thus, her ability to care about others was prioritized in her professional role versus her personal life. Another participant reported that she did not share her family's concern about her brother's serious complications of diabetes because she was confident he would survive, and because she thought that his own actions led to his health condition. Therefore, this symptom was also related to patients' reasons for seeking care, with the common judgment the participants reported experiencing at work. A participant summarized this symptom by stating: "What used to be sympathy is now judgment."

Although the study participants reported having less concern for others with nonlife-threatening health issues outside of work, they reported a heightened sense of fear about loved ones' safety due to their frequent exposure to traumatic injuries at work. One participant stated, "As a nurse, we know people die; we know people get hurt. Especially as an ER nurse, we know

life's unpredictable." Similarly, another participant stated: "I mean you see how quickly in a instant people can die, so then I prepare myself, like, 'Oh, my gosh. These people can just die at any moment.'" A participant reported an increased fear of driving "because of all the trauma that comes in and all these accidents and how badly people are injured. I realize way more than probably other people how much damage can be done just from random accidents." Therefore, the participants expressed that their experiences working in the emergency department decreased their emotional tolerance for people's relatively minor health concerns outside of work, while increasing their fear for their loved one's safety related to potential life-threatening traumas.

Coping with Dark Humor

The participants viewed responding with humor instead of an emotional response when seeing trauma at work was another symptom of compassion fatigue. One participant stated, "We don't talk about the guy that just died. We just start crackin' jokes…We just go on." A participant explained, "The dark humor that everybody uses to cover up and there's so much—they use humor to cover up all of their hurt." Another participant agreed, stating that after patients die in the emergency department, "we all walk out. The body's still there, the family's going in and we walk back to a nurses' station and just start BS-ing because that's how we cope. We don't talk about what just happened." The participants viewed this practice as problematic, as one reported: "it's funny to us, but it's not funny." It was reported as the common practice within their units' culture. Although they did not think that patients' injuries and deaths were humorous, they acknowledged that emergency nursing staff prefer to joke instead of discussing or processing emotional experiences at work.

Detachment/Dissociation

Another coping mechanism that the participants used but also considered a symptom of compassion fatigue was detachment, or dissociation. One participant stated that he had an "ER mode where I shut down." Another participant explained that at work, he would "shut my brain down…go to my happy place. Then 13 hours later, I can turn it back on and come back to the real world because I've survived the beat-down, so to speak." A participant also described this phenomenon in this way: "I think I have a decent sense of circumstance in the moment, but it's like—it's more mechanical and less of a spiritual, emotional process." Another participant explained that this process was easy to do when the patients all looked similar after being put in a gown per department protocol:

> "I feel insulated from the realities of what got them there that I think are pretty traumatic. I might be aware of them, but they just—they all look the same. All the same color gown. They're in the bed or hooked to the monitor. I'm getting their vitals…I'm just going through the day."

A participant explained that the detachment/dissociation was a deliberate choice due to the high levels of emotional demands of her work:

> "…how can I be expected to deal with that…in every, single patient that I see? I can't be expected to do that. At some point, I had to make a decision, like a conscious decision, to just accept that…and just grin and bear it and kind of move on with my life. It sucks that we can't give these people our hearts in that situation, but it just isn't possible."

Another participant described how after having a particularly difficult shift, she delayed coming back to work because she viewed her detachment as frightening and detrimental to patient care:

> "I called out…the next shift…because my patients could've been lit on fire; I would've been like, 'Where are the damn marshmallows?' I was so detached from them, it was like not even funny. I've never been that detached from my patients. It scared me how detached I was from them."

Additionally, one of the participants described how she started experiencing dissociation not only at work, but also at home; she reported: "I do find that I get dissociated from my—everybody in my life. You start not caring…I'd find that I've kind of pushed myself away from everybody around me." The participants all agreed that the symptoms of compassion fatigue that they experienced had detrimental effects on both the quality of patient care they provided and their personal lives. They expressed a strong desire to have interventions to combat these negative effects.

Potential Interventions

The study participants readily suggested interventions to prevent and address compassion fatigue within the emergency department setting. Specifically, they thought that acknowledgement of compassion fatigue, self-care activities, debriefing with clinical staff, and continuing education would be beneficial.

Acknowledgement of Compassion Fatigue

Many of the study participants expressed relief when they learned about this research project, as they had never been offered the opportunity to discuss or hear about compassion fatigue. One participant reported, "I thought it was interesting…when I saw the sheet that was being passed around. I was like, 'Wait a second. I wanna talk about this.' Nobody's ever really asked about it." Another participant thought that her workplace was "not preventing the issue…I'm not surprised that no one's ever come up to me saying like, 'We want to help you…you're at risk for compassion fatigue. We want to help you with that.'" Although the participants all agreed that symptoms of compassion fatigue were common and problematic in

their work settings, they did not see any acknowledgement or interventions from their employers. One participant explained:

> "The actual hospital, itself, and the people I work for never said, 'Hey, we understand (a) that this happens to everyone in your profession, and (b) here's what we're trying to do to help you deal with that, (c) what are your suggestions to try?'…They never acknowledge compassion fatigue and that it exists everywhere. They never try to do anything about it to help us deal with it. They just let us be. They just let us suffer through it with—and pretend like it's not even there, when it's like you're running the hospital, you have to know about compassion fatigue. If you don't know about compassion fatigue and you're the CNO, then you shouldn't be in your job. They still don't address it. It's rampant."

Other participants agreed, she thought it was a duty of healthcare organizations to address compassion fatigue in their nursing staff. The lack of acknowledgement and intervention by healthcare organizations was viewed as prioritizing "everyone else's wellbeing." One participant stated:

> "It would be amazing if someone would even acknowledge it, to begin with, and then give us something to help deal with it. Support groups, talking, education, something. If anything, at least show that they care about our wellbeing, not the patients' wellbeing and the HCAHPS and patient satisfaction, but our wellbeing is just as important…"

The participants reported believing that investing in measures to prevent or address compassion fatigue could decrease nursing turnover rates and improve the quality of patient care provided in their departments. Therefore, the study participants viewed efforts to acknowledge, prevent, and address compassion fatigue in the emergency department as beneficial for the both emergency department staff and patients.

Self-Care Activities

As described above, the participants identified difficulty engaging in self-care due to time pressure during their shift as a main contributor to compassion fatigue. One participant noted important benefits from prioritizing self-care, stating, "I feel like I was a better—not only nurse,

but a better spouse or better teacher when I started taking care of myself." Another participant reported that she thought it was helpful that her department required and facilitated lunch breaks for every nurse, "That definitely makes a difference…At least out of all the other BS that we have to deal with, we know at least we're going to be able to eat our food and sit down for 30 minutes." She described how the charge nurses would offer to cover her so that she could have a break because the nursing leadership enforced the mandatory lunch break for every nurse. The participants working in different hospitals agreed that they would prefer their workplaces to have similar policies. One participant thought that it was ironic that nurses have such difficulty engaging in self care because the "goal of the profession is to strive for health and wellness, to find avenues so that that could be achieved or to be honored." The participants perceived that nurses were able to do this for their patients, but for themselves. The study participants reported that they desired an approach that was more "preventative versus treating the issue" of compassion fatigue. In addition to self-care activities, they also recommended having the opportunity to debrief related to their work in the emergency setting.

Debriefing with Clinical Staff

As described above, the participants reported that clinical uncertainty was a main component of compassion fatigue. One suggested intervention was to address this through debriefing sessions. At some hospitals, the emergency staff engage in after-action reviews, which the participants viewed as helpful. During these sessions, they would review the clinical interventions and "if it is something that we did wrong, then we know next time to do it right or we didn't do it for this reason and then it makes it at ease in my mind." Another participant

agreed that having time to formally or informally process events during the shift would be helpful, especially after potentially traumatizing experiences, like her first cardiac code:

> "Like a counseling or something or debriefing after the fact…When it doesn't happen I think that that is a big deal because this did happen to me. It was my first code, horrific. There was blood just spewing out of the guy's mouth with every compression that they did and I'm just in the corner. The wife's on the other corner screaming, 'You promised me 20 years. You promised, you promised,' and I'm just like, 'Oh, my gosh. This is horrific,' and then after…I have to clean up the body, pack it and take it downstairs. I come back up and there's a patient waiting for me, a new one and in the same room. They could've reassigned a room or maybe said, 'Hey, are you feelin' all right? Do you need a few minutes for yourself?'"

The participants reported that without the opportunity to debrief after sentinel events, they were also more likely to experience detrimental effects of compassion fatigue outside of work. One participant stated, "If we could word vomit at the end of our shift and walk away… then it's like, 'Okay, now I can go home.'" Another participant explained:

> "It doesn't matter how long you've been a nurse…you deal with such intense moments there and you go home and your family a lot of times doesn't understand what you're going through and if there's not debriefings, you do; you just hold onto that."

Thus, having the opportunity to debrief and process events during work hours could decrease compassion fatigue symptoms at home.

Multiple participants stressed the importance of debriefing with clinical staff, as opposed to professional counselors who did not work in the emergency setting. Having clinical staff involved in the debriefing process could address the clinical uncertainty that the nurses identified as contributing to compassion fatigue. One participant explained, "I don't want to talk through it with a counselor. I want to talk to another nurse that experienced it with me that can tell me what happened…I need my questions answered to feel better about it." Similarly, another participant said that professional counselors would not be helpful because they would not understand the

demands specific to the emergency setting, or could be suffering from compassion fatigue themselves. The participants desired debriefing and/or counseling from someone who could relate to their experiences and potentially aid in addressing their questions due to clinical uncertainty. This type of support could help in processing emotional experiences at work and decrease the amount of emotional exhaustion they experienced at work and at home.

Continuing Education

Another potential intervention suggested to decrease compassion fatigue was to provide more time and opportunities for continuing education. One participant explained, "I've found that, as education has wiggled its way into my professional role… I really invest myself in learning…It's helped alleviate the burnout… It's not merely surviving the day." Multiple of the study participants reported a desire to return to school for advanced degrees that was at least partially due to the detrimental effects that they experienced related to burnout, secondary traumatic stress, and compassion fatigue. One participant reported, "Going into advanced practice, that's something I'm really hoping to look forward to. Choosing where and how I practice as getting back to kind of a person and not just seeing throughput as my objective." Pursing an advanced nursing role was viewed as a way to focus more on providing compassionate, person-centered care versus the need to always prioritize efficiency.

DISCUSSION

The purpose of this study was to describe the phenomenon of compassion fatigue among local emergency nursing staff. The specific aims were to describe the experiences, symptoms, and effects of compassion fatigue, and to identify potentially effective interventions. Content analysis of focus group interview data revealed that the study participants identified both

organizational and patient factors that contributed to compassion fatigue. The participants reported multiple symptoms of compassion fatigue, which affected them both professionally and personally. They also identified potential interventions to prevent and address compassion fatigue in emergency nurses. Existing literature was reviewed to aid in interpreting these findings.

Interpretation

The findings of this study both align with existing research data and provide new insights into the experiences, symptoms, and effects of compassion fatigue in emergency nurses. The participants suggested multiple interventions in order to prevent and address the detrimental symptoms of compassion fatigue that they experienced at work and home. The participants also described organizational and patient factors that contributed to the development of compassion fatigue.

Contributing Factors

Compassion fatigue is commonly understood to be the combined negative impact of burnout and secondary traumatic stress, and offset by positive compassion satisfaction (Stamm, 2010). The participants identified that their professional satisfaction was primarily related to the emergency setting's high acuity, intellectual demands, and variability. Intriguingly, these aspects also were perceived contributors to compassion fatigue. Existing literature has described the emergency setting to have frequent unpredictability, change, patient variety, and demands of addressing multiple urgent situations without adequate recovery time (Adriaenssens et al., 2015). Working in this setting has also been associated with a higher exposure to traumatic events in patient care and witnessing the grief of their family members (Adriaenssens et al., 2012).

Qualitative research with emergency nurses related to the challenges of patient deaths reported competing demands, not having enough time, witnessing grief, and needing to both support the patient's family while addressing the needs of other patients (Hogan, Fothergill-Bourbonnais, Brajtman, Phillips, & Wilson, 2016). The participants in the current study reported these factors as all contributing to the development of compassion fatigue.

Broader professional quality of life is understood to be affected by three domains: the work (e.g., organizational features and required tasks), the client (e.g., patient and their family), and the person, which in this case would be the nurse (Stamm, 2010). Other research with emergency nurses identified burnout determinants related to both work (e.g., job characteristics, traumatic events, and organizational variables) and individual (e.g., personality characteristics and coping strategies) factors (Adriaenssens et al., 2015). Interestingly, the participants in the present study identified factors related to the work/organization and client domains/determinants, but did not describe any of their own actions or characteristics that impacted their professional quality of life. Further research about potential effects of personal characteristics and coping skills may be beneficial in understanding compassion fatigue, as more data is needed regarding why some nurses develop symptoms and others do not (Hinderer et al., 2014).

The participants reported organizational factors that included having increasing numbers of tasks to complete within a limited timeframe, a lack of resources, and low perceived leadership support. These aspects were viewed as decreasing the participants' quality of patient care and job satisfaction. The strong influence of perceived leadership support has been reported in emergency nurses in other research related to contributors of compassion fatigue (Hunsaker et al., 2015). Burnout in nursing has been associated with multiple organizational aspects and

leadership decisions, including high workloads, inadequate staffing, poor system functioning, and a perceived unsupportive work environment (Aiken et al., 2002; Garcia-Izquierdo & Rios-Risquez, 2012; Leiter & Laschinger, 2006; Roder, 2010; Stamm, 2010). The lack of resources required for their work as a contributing factor to compassion fatigue has also been suggested in previous studies; Morrison and Korol (2014) reported higher levels of professional satisfaction when nurses perceived an ability to overcome challenges and high levels of compassion fatigue when nurses felt a lack of control and difficulty addressing the demands of their work.

The study participants reported that the significant patient factors in the emergency setting were the clinical uncertainty, both related to their patients' outcomes and the quality of their patient care, and the reasons for seeing care. The participants expressed a sense of judgment about the appropriateness of the patients coming to the emergency department; when it was warranted, it was stressful to provide such high acuity care, and when it was deemed unnecessary, it led to feelings of burnout. This occurrence could also be related to the symptom of emotional exhaustion. These could potentially be novel findings and should be further explored, as the study participants reported that they believed this was unique to the emergency setting.

The most emotionally charged contributing factor was witnessing others' grief in the emergency department, which included patients' family members and the participants' coworkers. They associated these experiences with secondary traumatic stress, mostly related to witnessing the emotional trauma of others. These experiences stayed with them long after the shift was over, as they could all recall specific sounds and images that were "burned" and "stuck" in their minds. Prior research has suggested that experienced trauma nurses may have

lower levels of secondary traumatic stress due to increased use of coping skills and support systems (Von Rueden et al., 2010); thus, the participants in the present study may have been more at risk for secondary traumatic stress due to their relatively short length of experience working in the emergency setting.

Symptoms of Compassion Fatigue

Although the participants' average length of time working in the emergency setting was less than two years, they all reported having intense experiences and symptoms related to professional burnout, secondary traumatic stress, and compassion fatigue. These symptoms were exhaustion (mental, physical, and emotional), impaired communication, decreased emotional tolerance, coping with dark humor, and detachment/dissociation. Previous research has suggested that acute care nurses who are in the Millennial Generation (aged 21-33) are more likely to experience professional burnout (Kelly, Runge, & Spenser, 2015), and the participants of the present study were part of this age group (25-31 years old). Some of the participants expressed that their experiences related to compassion fatigue caused them to consider going back to school for advanced degrees. This is consistent with research by Sheppard (2015) with graduate nursing students, in which 81% of the sample had moderate-high levels of burnout, 74% had moderate-high levels of secondary traumatic stress, and 71% had moderate-high levels of compassion fatigue. However, other research has associated higher levels of compassion satisfaction in emergency nurses with higher levels of education (Hunsaker et al., 2015). Additional research efforts are needed to explore the occurrence and effect of compassion fatigue in graduate students and advanced practice nurses (Sorenson et al., 2016).

Previously reported symptoms of compassion fatigue in nursing included physical exhaustion, purposeful emotional distancing from patients, and negative personal consequences (Austin et al., 2009), which the participants in the current study also reported. Previous qualitative data from four emergency nurses suggested that manifestations of compassion fatigue in emergency nurses involve physical and mental exhaustion, emotional detachment from patients, and intense negative emotions related to patients and their families (Cais & Sheppard, 2015); these symptoms were also reported in the current study. A secondary analysis of the exploratory qualitative data revealed multiple symptoms and detrimental effects that were not included within the currently accepted compassion fatigue model (Bouchard & Sheppard, 2016; Stamm, 2010). Some of these symptoms were also reported by the participants in the current study, including negative emotions outside of work, difficulty talking about work at home, and worry about work tasks, patients, and their own family's health (Bouchard & Sheppard, 2016). These findings suggest that compassion fatigue may affect emergency department nurses differently than professionals working in other settings, and that the symptoms may profoundly impact their personal lives.

The study participants reported experiencing multiple key dimensions of professional burnout, including exhaustion and feelings of detachment (Maslach et al., 2001). Available research suggests that emergency department staff have significant emotional exhaustion and depersonalization due to the nature of their work environment (O'Mahony, 2011; Potter, 2006). Notably, the detachment was reported to be a consciously used coping mechanism at work, both in the current study and the previous exploratory qualitative research with emergency nurses (Bouchard & Sheppard, 2016; Cais & Sheppard, 2015). This phenomenon may be related to their

symptoms of mental, physical, and emotional exhaustion, which can lead to cognitive and emotional distancing as a way to cope with high work demands (Maslach et al., 2001). The participants' choice to emotionally distance themselves from their patients may not be a healthy coping skill, as high levels of empathy in emergency nurses has been correlated with psychological well-being (Bourgault et al., 2015). The participants in the current study reported feeling frightened and appalled when they were detached from their patients, but viewed it as a consequence of the emotional and time demands of their work environment.

In the present study, the participants perceived impaired communication to be a main symptom of compassion fatigue, which affected both their professional and personal interactions. Previous research has associated poor team communication in emergency nurses with moral distress, resulting in diminished quality of patient care (Fernandez-Parsons et al., 2013). Wolf et al. (2015) reported causes of moral distress that were also found in the present study, including having overwhelming time pressure and patient volume, conflicting expectations of the nursing role, and concerns about the quality and safety of patient care. The nurses reported that they were not able to provide the quality of care that their patients deserved due to their moral distress (Wolf et al., 2015). In the findings from the present study, multiple of the participants expressed feeling "horrible" about themselves when they prioritized efficiency over providing patient-centered care due to time pressure, and when their decreased emotional tolerance caused them to became agitated with their families. They expressed impaired communication both at work and home, which led to morally distressing concerns about their self worth, decisions, and the quality of patient care that they provided.

The study participants reported multiple symptoms of secondary traumatic stress that were also identified in previous research, including irritability, diminished activity levels, and emotional numbing (Dominguez-Gomez & Rutledge, 2009). Notably, the participants in the current study reported that they experienced these symptoms while they were at home. Negative emotions outside of work and difficulty talking about work while at home may be symptoms of compassion fatigue not included in the current conceptual model (Bouchard & Sheppard, 2016). More research is needed in order to better understand the concept of compassion fatigue for healthcare professionals, including nurses (Sorenson et al., 2016). This understanding would allow for better data collection and analysis, and as well as more effective interventions to address and prevent the detrimental effects of this phenomenon (Sorenson et al., 2016).

Currently, the most common way to measure compassion fatigue is the ProQOL, a quantitative self-report measure with 30 items and associated subscales for compassion satisfaction, burnout, and secondary traumatic stress (Stamm, 2010). The survey includes some of the symptoms reported in the current study, including physical exhaustion, intrusive thoughts, and difficulty separating one's personal life and life as a helper (Stamm, 2010). However, a notable number of the symptoms reported by emergency nurses in previous exploratory research and the current study are not included within the ProQOL (Bouchard & Sheppard, 2016). For example, the ProQOL does not include items regarding communication impairment, diminished emotional tolerance, difficulty talking about work at home, purposeful detachment/dissociation, dark humor, or worry about work tasks, patients, and own family's health. The implications of this are that the ProQOL potentially does not completely capture the experience of compassion fatigue among emergency nurses. Thus, a better understanding of the symptoms of compassion

fatigue in emergency nurses could aid in developing a more effective tool to further study this phenomenon, identify nurses at risk, and measure change related to interventional efforts.

Interventions

The participants suggested multiple interventions to prevent or address compassion fatigue; specifically, acknowledgement of compassion fatigue, self-care activities, debriefing with clinical staff, and continuing education. Incorporating these interventions could be helpful in decreasing the detrimental effects of compassion fatigue, both at work and home. The literature indicates that self-care and educational efforts to prevent compassion fatigue in healthcare workers are the most effective interventions known (Sorenson et al., 2016), and the participants in the current study identified these types of activities as potentially useful for their work setting. It has been proposed that compassion fatigue can be understood as "the high cost of an imbalance between caring for others and self-care" (Sawatzky & Enns, 2012, p. 699). Therefore, efforts to facilitate regular self-care activities could offset the effects of the demands of patient care in the emergency department. The study participants also stressed the importance of increasing acknowledgment of compassion fatigue in their work settings. Even without any formal education efforts from healthcare leadership regarding compassion fatigue, the participants could identify contributing factors and detrimental effects that they experienced both at work and home. Educational modules have been successful in increasing awareness of the symptoms and risks for compassion fatigue in critical care nurses, and healthcare providers need more opportunities to receive this type of education (Meadors, Lamson, & Sira, 2010). Pursuing more formal nursing education could also help alleviate compassion fatigue, as higher levels of education have been associated with greater compassion satisfaction (Hunsaker et al., 2015).

This fact also supports the need for interventions for floor nursing staff with lower levels of formal education, who may be more at risk for developing compassion fatigue. The participants in the current study reported that because their symptoms of compassion fatigue stemmed from their work experiences, they believed that it was a duty of the healthcare organization to provide interventions to prevent and address the detrimental effects of this phenomenon.

The study findings also indicated that nurses working in the emergency setting might require interventions to address compassion fatigue that are tailored to their unique experiences and symptoms. Debriefing after high patient acuity events or at the end of every shift may be especially advantageous in the emergency setting. The development of compassion fatigue is thought to depend on the meaning given to a situation, as opposed to a simple reaction to external events (Geoffrion, Morselli, & Guay, 2016). Therefore, having a structured process to interpret and influence the meaning of situations encountered in the emergency setting could have a strong impact on compassion fatigue. Available literature has described the importance of holding after action reviews following significant events in reducing the risk for burnout in emergency nurses (Cook & Kautz, 2016; Meadors et al., 2010). Debriefing helps provide nurses with closure after patient deaths, increased role satisfaction, and diminished thoughts about work after the shift (Hogan et al., 2016). Others view prevention of compassion fatigue in the emergency setting as needing "a disciplined and reflective daily response, not merely an afterthought following a difficult event" (Crowe, 2016, p. 107). Research by Meadors et al. (2010) regarding compassion fatigue in critical care nurses supports the beneficial effect of regularly scheduled debriefing sessions. Based on this research and the perspectives offered by

the participants in the current study, giving nurses regular opportunities to review and process patient care events could help improve both the quality of patient care and nurses' mental health.

Leadership, Policy, and Clinical Implications

The nursing implications of this study's findings include that compassion fatigue has a variety of contributing factors and detrimental effects for nurses working in emergency settings. Without interventions to address the professional and personal ramifications of the symptoms, compassion fatigue can inhibit nurses' effectiveness and professional satisfaction, as well as negatively impact their communication, mental health, and emotional response to loved ones. Compassion fatigue can be viewed as a social phenomenon with contributing factors and symptoms related to interactions between nurses and their coworkers, supervisors, patients, and families. By providing interventions to address and prevent compassion fatigue symptoms, emergency nurses could experience greater effectiveness, professional satisfaction, and personal quality of life.

Doctoral essentials of advanced nursing practice include organizational and systems leadership, health care policy advocacy, and clinical scholarship (American Association of Colleges of Nursing [AACN], 2006), and the findings of this study have leadership, policy, and clinical implications for advance practice nurses. The study participants identified multiple organizational factors that contributed to the development of compassion fatigue, including system resource availability, leadership support, and time expectations that diminished self-care activities and the ability to provide patient-centered care. The lack of opportunities to debrief after high acuity and emotionally charged events also was reported as contributing to compassion fatigue. These findings suggest the importance of promoting supportive nursing leadership,

organizational policies that protect regular self-care activities and debriefing opportunities, and time expectations that allow emergency nurses to balance the efficiency and quality of patient care. Advanced practice nurses could influence all of these issues, as DNP prepared nurses can utilize practice management principles and both conceptual and practical strategies to balance productivity and quality of patient care within organizational policy (AACN, 2006). The study findings also indicate that there is more data to be collected regarding how emergency nurses develop and experience compassion fatigue, offering additional opportunities for clinical scholarship regarding this phenomenon and its effect on patient care. Advanced practice nurses could also be involved in providing the suggested interventions, such as leading debriefing sessions and providing education to increase awareness of compassion fatigue in this practice setting. As the study participants reported benefiting from the focus group interview experience, allowing opportunities for emergency nurses to discuss compassion fatigue in small groups may also be advantageous. Nursing leaders could use the findings of this study to help create a healthcare organizational culture in which compassion fatigue is recognized, addressed, and further studied in order to enhance the quality of nurses' professional and personal life, as well as patient care.

Focus Groups as an Intervention

The strengths of this study include its qualitative design, which helps address the current paucity of available qualitative research related to compassion fatigue in nursing. The study's methods were grounded in a theoretical framework that viewed compassion fatigue as a social construct, as it occurs within unit culture and from nurses' interactions with colleagues, patients, and families. The findings indicated that the contributing factors, symptoms, and interventions

relevant to compassion fatigue included social aspects involving coworkers, organizational leadership, patients and their families, and their own loved ones. The study's design allowed for exploration of the experiences, symptoms, and effects of compassion fatigue in emergency nursing, many of which may not be present in other practice settings, thus increasing our understanding of this phenomenon. Including participants from four Tucson hospitals provided perspectives from multiple local emergency departments. The focus group design was an effective, efficient means to collect data and provided the participants with an opportunity to interact and learn about other local emergency nurses' perspectives, experiences, and opinions. Additionally, it demonstrated to the study participants that they were not alone in their experiences and symptoms related to compassion fatigue. The participants expressed that this experience was beneficial because it allowed them to interact with emergency nurses from other local hospitals and receive validation of their common experiences, emotional responses, and concerns.

Trustworthiness

The criteria for developing trustworthiness in qualitative research include credibility, dependability, confirmability, transferability, and authenticity (Guba & Lincoln, 1994; Polit & Beck, 2008). Demonstrating trustworthiness in qualitative research enhances the degree of confidence in the findings (Polit & Beck, 2008); therefore, trustworthiness criteria were promoted in the study's data collection, analysis, and reporting. Interview audio recording, verbatim transcription, and field notes were used to promote credibility and authenticity. My field notes and audit trails enhanced the confirmability and transferability of the study findings by recording my thoughts and actions when collecting and analyzing the data (Polit & Beck,

2008). The credibility and dependability of the research were also promoted during the interview process by following scripted questions and probing for clarification of the participants' meaning when needed (Polit & Beck, 2008). Providing direct quotations in this paper to directly reflect the participants' statements made during the interviews enhances credibility and authenticity. Thus, multiple aspects of this qualitative study's methods of data collection, analysis, and reporting promote the trustworthiness of the findings.

Limitations

An effort was made to have study participants working in emergency departments from multiple local hospitals; however, a limitation of this study was the relatively few number of participants. In qualitative research, participants should be included until data saturation is achieved (Polit & Beck, 2008). The data in the current study included some redundancy, but not data saturation because it is likely that there is additional new information to still be acquired (Polit & Beck, 2008). Although more nurses expressed interest in the study, time constraints and their limited availability inhibited their participation. Participant selection was determined by the recruitment efforts of the key informants and nurses' voluntary participation, which could have biased the findings by including participants with higher levels of compassion fatigue. Additional studies including more participants with a greater range of ages and length of emergency setting experience would aid in understanding this phenomenon. Thus, the findings of the current study may not be generalizable to all emergency department nurses.

Dissemination and Directions for Future Research

Dissemination efforts will be made locally, regionally, and internationally. Local nurse leaders have expressed interest in presentation of the study findings at Tucson hospitals. The

study participants also expressed a desire to hear about the findings, as they reported benefiting from learning about other's experiences during the focus group interviews. The study and its findings will also be presented to entry-level nursing students in November 2016 in an effort to increase awareness of compassion fatigue at the beginning of their nursing careers and provide encouragement to develop regular self care practices. An abstract describing this research was submitted to the Western Institute of Nursing annual conference, which will be held in April 2017. I gave podium and poster presentations related to this topic the past two years, and received high levels of interest from conference attendees. I have also been invited to give a lecture on compassion fatigue at the local chapter of the Arizona Nurses Association in April 2017. Additionally, a manuscript will be submitted to an appropriate nursing journal in order to publish the study findings internationally. This will hopefully encourage other researchers to aid in conducting further research to better understand this phenomenon and how to best address it.

Suggested directions for future research include conducting additional studies regarding compassion fatigue in emergency nurses with additional participants and in various locations to validate the current findings. This would help provide a better understanding of compassion fatigue in nursing and assist in developing a much needed updated conceptual analysis. In addition to further exploration of the symptoms and effects of compassion fatigue in emergency nursing, future research efforts should address interventions. Feasibility studies related to the effectiveness and practicality of actions to decrease compassion fatigue in various settings would be an important component of preventing the detrimental effects of this phenomenon.

Conclusions

The findings of this study increase our understanding of the experiences, symptoms, and effects of compassion fatigue in local emergency nurses. Additionally, they suggest potentially effective interventions to prevent and address the associated detrimental professional and personal effects. The findings indicate that both organizational and patient factors can contribute to compassion fatigue in the emergency setting. Additionally, emergency nurses experience a wide variety of symptoms that negatively impact the quality of their patient care and ability to communicate and be empathetic with their family members. The participants suggested multiple ways healthcare organizational leadership and advance practice nurses could decrease compassion fatigue and the associated negative effects on patient care and emergency nurses' physical, emotional, and mental health. These efforts could also lessen nursing turnover and burnout from the profession, which contributes to the national nursing shortage, and increase nurses' professional satisfaction.

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