Burnout or Compassion Fatigue: A Comparison of Concepts

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Burnout and compassion fatigue (CF) are prevalent across healthcare professions, but particularly within nursing. Both are detrimental to nurses’ professional quality of life (PQoL) (Magtibay et al., 2017). They contribute to nearly 20% of nurses leaving a position in the first year and many leaving the nursing profession (Kelly & Todd, 2017). Because definitions of burnout and CF are inconsistent, the relationship between the two is unclear (Elkonin & Van der Vyver, 2011; Sabo, 2011). Healthcare organizations and the professional nursing workforce are weakened when nurses experience CF or burnout (Kelly & Todd, 2017). Clear understanding of these concepts is needed to prevent their development and address interventions. The aim of this article is to compare CF and burnout using the Walker and Avant (2019) method of analysis.

Background

Burnout first was used by American psychologist Herbert Freudenberger (1974) to describe what occurs following exposure to constant occupational stress over time. The term compassion fatigue was used initially to describe nurses who had disconnected from or had become desensitized to patients and families (Joinson, 1992). While relationships between the two are unclear, burnout has been identified as related to CF (Jenkins & Warren, 2012), as an antecedent (Klein et al., 2018), or a consequence (Kelly & Todd, 2017).

Nurses can draw great satisfaction from patient care and experience positive PQoL. However, negative aspects of providing care exist and are detrimental to the PQoL (De La Rosa et al., 2018). Compassion fatigue was found to be associated with a nurse’s intent to leave, job satisfaction (Kelly et al., 2015), poor patient outcomes, and poor quality of life for nurses (Adriaenssens et al., 2015; Bao & Taliaferro, 2015). Nurses experiencing CF and burnout cannot provide the level of care needed to satisfy patients (Maslach et al., 2012).

CF and burnout lack clear definitions or boundaries and are viewed differently throughout the literature. Are they the same, does one exist without the other, or are they two different but connected concepts? This concept analysis will compare burnout and CF to determine how they are similar and different, and whether the terms can be used interchangeably.

Concept Analysis

Concepts encompass unique attributes that allow them to be the foundation of theory construction. Conducting a concept analysis assists in identification of defining characteristics. Comparative concept analysis of burnout and CF was selected (step 1) to clarify the differences between the two concepts (step 2) (Walker & Avant, 2019). Completing a comparative concept analysis for CF and burnout allows distinction between these related concepts as well as identification of concept uniqueness. Walker and Avant’s concept analysis procedure uses eight steps (see Table 1). While these steps appear to be sequential, the process to analyze concepts is fluid and frequently requires modifying previous steps.
Identification of Uses

For concept analysis, the definition or structure along with the uses or functions must be identified clearly (Walker & Avant, 2019). According to Walker and Avant, clear identification of the structure and function of the concept provides a clear understanding of the concept when it is used. Differentiating uses offers valuable information that assists the selection of defining attributes and provides evidence to support analysis.

Joinson (1992) used CF to portray the cost of caring, while Figley (1995) adopted the term to describe clients’ experiences of secondary traumatic stress (STS). Figley determined the clients experienced more complex issues than solely secondary exposure to traumatic events, and a more complex concept thus was needed (Coetzee & Klopper, 2010). Figley (2015) specified CF as “a state of exhaustion and dysfunction...as a result of prolonged exposure to compassion stress” (p. 253). According to Coetzee and Klopper (2010), CF is the depletion of compassionate energy to the point there are no remaining restorative processes. For nurses, CF is emotional, physical, social, and spiritual exhaustion leading to desensitization toward patients and loss of the ability to nurture or care for self or patients adequately (Hinderer, 2014).

In comparison, burnout is described as the loss of control of how a job is done, working toward goals that do not make sense, and the lack of social support (Psychology Today, n.d.). Building on Freudenberger’s definition, social psychologists Maslach and Jackson (1981) conceptualized burnout by three dimensions: emotional exhaustion, depersonalization, and a sense of low personal accomplishment. Later, Platt and Olsen (1990) affirmed burnout to be a “syndrome of emotional exhaustion and cynicism that frequently occurs among individuals who spend considerable time in close encounters with others under conditions of chronic tension and stress” (p. 192). Confusion of terms began early, however. Aycock and Boyle (2009) suggested CF has replaced the term burnout. Elkonin and Van der Vyver (2011) defined burnout as an extreme case of CF, while Sabo (2011) proposed burnout is an antecedent of CF.

Function

While the concept of CF is commonly used in healthcare settings, it affects the PQoL in various helping professions (e.g., counselors, first responders, social workers, ministers, teachers) (Jenkins & Warren, 2012). Nurses, in particular, are known for being caring and compassionate. They protect, promote, and optimize health whenever there is a need for nursing knowledge, compassion, and expertise (American Nurses Association, 2015). When nurses are unable to provide this compassionate care, CF occurs.

Burnout functions similarly to CF in interfering with nurses’ quality of care as well as quality of life. The term is used frequently to describe the same issues in nurses as CF. Nurses are accountable for the integration of all aspects of patient care, communicating and collaborating with other care providers, educating the patient and family, driving healthcare policy, directing quality improvement, and providing a safe environment for patients while maintaining a compassionate relationship with them and their families. Burnout occurs with the divergence that exists between nurses’ expectations of what should be accomplished and what can be accomplished when requirements and responsibilities are greater than the resources (Paterson et al., 2013). As in CF, decreased PQoL (Dugani et al., 2018) and decreased quality of patient care occur (Lewis et al., 2015).

Defining Attributes

Defining attributes or characteristics of a concept distinguish one concept from another to diminish ambiguity (Walker & Avant, 2019). Those attributes are “frequently associated with the concept” and “immediately bring the concept to mind” (p. 173). Defining attributes of CF and burnout are identified in Table 2. Studies have shown a significant positive correlation between CF and burnout, suggesting an overlap of components of these concepts (van Mol et al., 2015; Whitebird et al., 2013). Nurses experiencing CF or burnout can be angry, frustrated, depressed, and anxious. The key differences in the concepts are noted in the defining attributes.

Defining Attributes of CF

These include sudden onset, emotional exhaustion, perceived failure, desensitization to patients, apathy, and helplessness (Clifford, 2014). CF can occur in an instant with little warning, resulting in immediate behavior changes (Figley, 2015). Caregivers may feel the need to hide their emotions from clients, which can lead to emotional exhaustion (Berg et al., 2016; Ledoux, 2015). Nurses with CF have reported symptoms of stress manifested through anxiety at work, errors in judgment, difficulty sleep-
ing, and even nightmares, which can result in physical and emotional exhaustion (Berg et al., 2016). When nurses no longer can feel compassion for patients, contentment is replaced with apathy and patient connection is lost (Todaro-Franceschi, 2013). Helplessness results when no coping strategies for stress exist or those strategies have been exhausted (Clifford, 2014). Nurses with CF perceive no one or nothing can help. Providing patient care becomes emotionally, physically, socially, and spiritually exhausting, which causes desensitization, apathy, or depersonalization for others. Although nurses continue to function, there is a sense of unreality during trauma or suffering. In addition, they no longer can feel empathy for patients (Figley, 2015).

Defining Attributes of Burnout

These are uniquely different from CF; they include progressive development, feelings of exhaustion, cynicism, and hopelessness (Maslach & Leiter, 2008). Unlike the sudden onset of CF, burnout can appear as subtle changes in personality, perspective, values, and behavior. Over time, the imbalance of workplace demands and available resources increase along with the feeling reality does not match the ideal. Frequently burnout is characterized as running on empty; nurses have given all with the feeling nothing is being accomplished, which results in emotional exhaustion (Todaro-Franceschi, 2013). According to Maslach and Leiter (2008), emotional exhaustion results when the workplace does not recognize nurses’ continued efforts in the workplace. Moderate-to-high levels of emotional exhaustion and cynicism due to moral distress have been reported in healthcare providers with burnout (Dugani et al., 2018). Moral distress is the result of nurses recognizing the responsibility they have to patients and being unable to fulfill that responsibility due to ineffective communication, lack of teamwork, value conflicts, policies, and tasks that go against nurses’ moral compass (Rushton et al., 2015).

CF and Burnout Cases

CF Model Case

According to Walker and Avant (2019), a model case is an example that demonstrates all defining attributes of the concept. This model case for CF involves an experienced nurse who worked on a progressive care unit for 12 years. The unexpected death of a 28-year-old mother of two little girls resulted in abrupt changes in the nurse’s behavior. The nurse was apathetic, desensitized to her patients, and emotionally as well as physically exhausted. She called her patients by room number instead of name, nodded off continually, and began to make errors. This nurse exhibited all defining attributes and was determined to be experiencing CF.

Burnout Model Case

Another nurse had 4 years of experience on the medical-surgical unit. He was engaged with his team and spent as much time teaching and interacting with patients as possible. Due to changes in the work environment, this nurse began to believe there were more tasks being assigned to nurses with fewer nurses to do the work. He struggled to provide his customary high level of care and began to feel his work did not make a difference. He became emotionally exhausted and hopeless, and was developing burnout. This nurse demonstrated cynical behavior when he told teammates he was not going to be available to help with anything extra, stating, “Why bother? Nothing ever changes.”

CF Borderline Case

A borderline case contains most but not all the defining attributes of the concept and is used to help clarify thinking regarding the concept characteristics (Walker & Avant, 2019). The nurse in this case was a 36-year-old father of four and had worked in the Emergency Department for 3 years. He was assigned a 36-year-old male patient who had three children. This patient’s van was crushed by an 18-wheel truck on the interstate highway; the accident resulted in multiple broken bones for the patient, a severe head injury for one of his children, and the death of another child. The next shifts following this event, the nurse frequently forgot to administer medication or treatment as assigned, often was found dozing in the breakroom, ignored call lights, and avoided families and coworkers. He still viewed his patients as individuals and knew he could make a difference, but he just couldn’t focus and realized he needed to get help. This nurse had a secondary exposure to trauma that resulted in a sudden change in behavior. He demonstrated emotional and physical exhaustion and apathy. However, he did not experience depersonalization of patients or feel helpless.
Burnout Borderline Case

In a borderline burnout case, one nurse experienced work stress that gradually increased and resulted in emotional exhaustion. The acuity of her patients increased while the staffing matrix did not cover the patients’ needs. She did not believe she was making a difference because she never had time to provide the type of care desired. This nurse is on the verge of burnout due to emotional exhaustion, but she had not yet become cynical or hopeless.

Related Cases: CF and Burnout

Related cases help to define how the concept fits with other ideas that are similar (Walker & Avant, 2019). Related cases do not contain all defining attributes, but they are connected to the central concept in some way. Burnout and CF are related concepts with some of the same antecedents and consequences, but they differ in defining attributes. STS is also a concept related to CF. In this related case, the nurse worked in the ED where she cared for victims of violence and trauma. For the third time in a week, she was assigned to care for a rape victim. She did not speak to the patient while she collected specimens and treated the wounds. Once she left the room, she began to sob and told the charge nurse she couldn’t do this anymore. While this was a sudden onset of behaviors, it also was preceded by increasing stress. This nurse experienced hopelessness as in burnout but also depersonalized the patient as in CF. This could represent burnout that became CF, or it could be STS.

CF Contrary Case

Contrary cases are helpful “because it is often easier to say what something is not than what it is” (Walker & Avant, 2019, p. 177). Contrary cases are examples that are nothing like the concept and do not demonstrate any of the defining attributes. In a CF contrary case, the nurse provided compassionate care to patients and left her shift knowing her work had an impact on her patients. Even though she worked in the ED and experienced traumatic events, she was resilient and found an outlet for the frustration, anger, or anxiety she experienced. This nurse knew there was always help for any situation and was satisfied with her career.

Burnout Contrary Case

In the burnout contrary case, the nurse had multiple coping strategies to relieve stress, so it does not accumulate. He believed administrators were open to hearing from the staff, and he would share his ideas for process improvement when needed. Even though the unit had a hiring freeze, he and his coworkers created innovative solutions and met the staffing needs. This nurse did not burn out because he continued to demonstrate hope, was emotionally healthy, and had a positive outlook for the future of nursing.

Antecedents and Consequences

Walker and Avant (2019) discussed the importance of antecedents and consequences in further identification of the defining attributes. “Antecedents are those events that must occur or be in place prior to the occurrence of the concept” (p. 178). Consequences are the outcomes that occur as a result of the concept.

Antecedents: CF and Burnout

Several triggers exist for CF, but just a few true antecedents. The antecedents include secondary exposure to traumatic events or STS, perceived relationship between a person and the perceived victim, and perceived futility. Experiencing trauma firsthand (e.g., first responders) or experiencing trauma vicariously (e.g., nurses, social workers, family caregivers) is an antecedent of CF (Berg et al., 2016). Exposure to traumatic events, such as death, fatal diagnoses, or abuse, also can trigger CF. Trauma can take many shapes and is unique to each person. To experience CF, the person first must perceive a relationship with the patient or client. The person experiencing CF must have the ability to recognize and comprehend what the patient or client is feeling. Finally, there must be a perception of futility, that no action will change the outcome. This perception of futility is almost debilitating, especially to nurses (Clifford, 2014).

Job-related stressors lead to burnout (Aronsson et al., 2017). The following job stressors are the current antecedents of burnout: goal-oriented mindset, excessive workload, and negative work environment or occupational factors. Persons experiencing burnout tend to be focused on achievement, take pride in their work, and frequently have some level of perfectionism (van Mol et al., 2015). The personal factors included in the goal-oriented mindset can lead to self-pressure for perfectionism, frustration with professional growth, and decreasing teamwork as withdrawal begins. Excessive workload plays a sizable role in the development of burnout (Baier et al., 2018). Workload can include high numbers of patients/clients, tight deadlines or time limitations, high turnover of patients/clients, or high caseloads. As the final antecedent to burnout, work environment includes changes in team dynamics or leadership that sway the work environment in a negative direction (van Mol et al., 2015). Work environment also includes loss of autonomy, an imbalance in resources or recognition, and a compiled amount of work during the shift (Baier et al., 2018).

Consequences: CF and Burnout

Several consequences of CF occur in nursing. Psychological effects of CF result in isolation, depersonalization, apathy, and emotional, physical, and spiritual exhaustion. Physical implications of CF include decline in the immune system, forgetfulness, headaches, hypertension, weight gain, and stomachaches (Fetter, 2012). CF also results in decreased quality of patient care,
increased risks to patient safety, and reduced professional and personal quality of life for the nurse (Adriaenssens et al., 2015; Bao & Taliaferro, 2015). Burnout also has severe potential consequences. Nurses with burnout experience absenteeism, job dissatisfaction, and lack of confidence in performance (van Mol et al., 2015). Burnout negatively impacts nurses’ physical and emotional health, decreases patient/client satisfaction, and influences patient outcomes and mortality (Clifford, 2014). Employees who experience burnout are more likely to move away or isolate themselves from coworkers (Baier et al., 2018).

Empirical Referents
Delineating the empirical referents is the final step of the Walker and Avant (2019) method of concept analysis. “Empirical referents relate directly to the defining attributes and not the entire concept itself” (p. 180). CF is measured by observing behaviors of desensitization, depersonalization, and apathy (Todaro-Franceschi, 2013). Patient complaints, clinical errors, and absenteeism also are measures of how much of self nurses are giving. Continual exposure to suffering or trauma can be measured by nurses’ assignments and the patient census. Observations of behaviors, such as frustration, anger, and cynicism, provide a measure of burnout (Aronsson et al., 2017). According to Maslach and Jackson (1981), other behaviors include emotional exhaustion, depersonalization, and a sense of low personal accomplishment. Self-awareness is important for nurses to recognize CF and burnout as well as to identify resources and support systems (Lachman, 2016). Recognition of CF and burnout as two different concepts is vital for prevention and intervention. Attention to the antecedents and defining attributes of these separate concepts can assist nurses in developing interventions and strengthening coping skills to help prevent burnout and CF and possibly to ensure a healthy nursing workforce.

Nursing Implications
Nurses experiencing CF or burnout can place themselves and their patients at risk (Magtibay et al., 2017). While the concepts of CF and burnout have been used interchangeably, this analysis supports their existence as different concepts. While burnout is an accumulation of stress related to work environment, CF is depletion of compassion resulting from exposure to suffering and trauma. Discussed consequences demonstrate the potential harm to nurses.

Further research identifying effective interventions for burnout and loss of compassion would benefit not only nurses, but all caregivers. Development of coping strategies that address work and lifestyle to promote rest, relaxation, social support, and exercise can prevent both conditions (Clifford, 2014; Hinderer et al., 2014; Whitebird et al., 2013).

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