

Exposing Compassion Fatigue and Burnout Syndrome in a Trauma Team: A Qualitative Study

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ABSTRACT

Compassion fatigue (CF) and burnout syndrome (BOS) are identified in trauma, emergency, and critical care nursing practices. The purpose of this qualitative study was to measure CF and BOS in a trauma team and allow them to share perceptions of related stress triggers and coping strategies. Surveys to measure CF and BOS and a focus group allowed a trauma team (12 practitioners) to share perceptions of related stress triggers and coping strategies. More than half scored at risk for CF and BOS. Stress triggers were described as situation (abuse, age of patient) versus injury-related. Personal coping mechanisms were most often reported. Both CF and BOS can be assessed with a simple survey tool. Strategies for developing a program culturally sensitive to CF and BOS are provided.

Key Words

Burnout syndrome, Compassion fatigue, Focus group, Trauma teams

Few would dispute that caring for traumatized people is stressful, chaotic, and dramatic (Chase, 2005; Figley, 1995). Over the last 30 years, there has been a surge of research dedicated to the effects and prevention of traumatic stress. Most research published in the field of traumatic stress has been focused on those who experience trauma firsthand, such as first responders in disaster-relief situations (Figley, n.d.; Fullerton, Ursano, & Wang, 2004; Roberts, Flannelly, Weaver, & Figley, 2003) or those in helping professions such as therapists and social workers (Figley, 1995). However, the literature does acknowledge that those individuals who experience trauma indirectly are also vulnerable to secondary traumatic stress (STS; Figley, 1995), also known as *compassion* fatigue

(CF; Figley, 1995; Joinson, 1992). Those suffering from CF present as emotionally exhausted (Figley, n.d.), report sadness, depression, sleeplessness, and general anxiety (Figley, 1995), and often feel as if they have failed at their profession (Pfifferling & Gilley, 2000) and as a result no longer have the capacity to nurture (Joinson, 1992). Constant and prolonged exposure to trauma leading to CF may result in personal symptoms including cognitive reexperiencing (e.g., nightmares, intrusive thoughts), avoidance behaviors, increased arousal, depression, suicidal ideation, anxiety, irritability, lack of confidence, decreased functioning in both professional and nonprofessional settings, a diminished sense of purpose or enjoyment in work, and an increase in self-destructive behaviors (American Psychiatric Association, 2005; Collins & Long, 2003; Figley, 1995; Meadors & Lamson, 2008; Pfifferling & Gilley, 2000; Stamm, 1999). Studies regarding CF often also discuss burnout syndrome (BOS; Maslach, Jackson, & Leiter, 1996), defined as long-term exhaustion and diminished interest (Embriaco, Papazian, Kentish-Barnes, Pochard, & Azoulay, 2007), as well as detachment and low levels of personal effectiveness (Epp, 2012). Commonly reported symptoms of BOS include fatigue, headaches, eating disorders, insomnia, emotional instability, and excessive rigidity in interpersonal relations (Quenot et al., 2012).

Both CF and BOS have been described as common in varying nursing practices (Beck, 2011; Coetzee & Klopper, 2010), emergency departments (Adriaenssens, De Gucht, van der Doef, & Maes, 2011; Dominquez-Gomez & Rutledge, 2009; Duffy, Avalos, & Dowling, 2015; Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010), trauma (Hinderer et al., 2014), and critical care nursing professions (Bakker, LeBlanc, & Schaufeli, 2005; Embriaco et al., 2007; Epp, 2012; Mason et al. 2014; Meadors & Lamson, 2008; Poncet et al., 2007; Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2011). Trauma (Hinderer et al., 2014), emergency (Duffy et al., 2015; Hooper et al., 2010), and critical care nurses (Hurst, 2005; Meadors & Lamson, 2008) have been identified as at high risk for development of CF or BOS due to prolonged exposure (volume and acuity) (Chase, 2005; Figley, 1995), caregiver empathy, unresolved trauma in personal lives, and cases involving suffering children (Figley, 1999). Hinderer et al. (2014) report that as many as 27.3% and 35.9% of trauma nurses have scores consistent with CF

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and BOS, respectively. Poncet et al. (2007) found severe BOS symptoms in one third of more than 2,000 critical care nursing survey respondents.

Moreover, the effects of CF or BOS in individual members can be corrosive to trauma teams and affect patient care (Embriaco et al., 2007). Professional stress has been associated with decreased personal productivity (Pffifferling & Gilley, 2000), impaired concentration, inability to pay attention to detail (Slocum-Gori et al., 2011), absenteeism (Wright, 2004), decreased morale, high turnover (Hurst, 2005; Pffifferling & Gilley, 2000), diminished work engagement (Mason et al., 2014), and medical errors (Jenkins & Warren, 2012; Wright, 2004), all of which can compromise the quality of care (Meadors & Lamson, 2008). In a national study examining critical care nurses, one third of participants experiencing CF also experienced high levels of depersonalization. Those experiencing depersonalization have an increased risk of misinterpreting or not appropriately documenting information, which affects how the trauma team responds to the patient (Jenkins & Warren, 2012). Furthermore, BOS has been noted to be contagious in intensive care settings (Bakker et al., 2005) and can cause concern about team members' ability to fulfill responsibility in highly interdependent tasks (Piquette, Reeves, & LeBlanc, 2009). Yet, although CF and BOS are becoming pervasive, professionals are often reluctant to discuss them for fear of judgment by colleagues (Elkonin & van der Vyver, 2011; Gentry, Baranowsky, & Dunning, 2002; Showalter, 2010).

Although the causes and effects of CF and BOS have been extensively described, trauma staff may not be aware of its insidious nature (Schroeter, 2014). Previous studies have focused on specific disciplines regarding the susceptibility to, risk factors for, and effects of CF and/or BOS; however, there has been little focus on coping within trauma teams as a unit. The aim of this study was to gain insight into a trauma team regarding CF and BOS using qualitative methods, thereby allowing them to share perceptions of related stress triggers and coping strategies.

METHODS

This study employed focus group methodology with approvals from appropriate institutional review boards. Focus group participants were older than 18 years and currently employed as a member of the trauma team in a Midwestern Level I trauma center. Participant recruitment was an invitation to participate issued at several trauma operation meetings. Participation was voluntary, and informed consent was obtained at the beginning of the session. Participants completed surveys for demographic information, perceived quality of life, and a life stress inventory. Three assessment tools were used.

- The Holmes–Rahe Life and Stress Inventory (Holmes & Rahe, 1967) is a 43-item scale used to examine how stressful life events can contribute to illness. Scores fall into four categories: 0–149 = no significant stress; 150–199 = mild stress; 200–299 = moderate stress; and 300–600 = major stress.
- The Professional Quality of Life Scales, the ProQOL (Stamm, 2010), is a tool used to measure compassion satisfaction (defined as feeling satisfied by one's job and from the helping itself) and CF (defined as feeling overwhelmed by work). Compassion fatigue is separated into two scales: Burnout (defined as feelings of unhappiness, disconnectedness, and insensitivity to the work environment) and STS (feeling trapped, on edge, exhausted, and overwhelmed by others' trauma). It comprises 30 statements, which are rated on a 5-point Likert scale from "never" to "very often," based on the last 30 days. Compassion satisfaction, burnout, and STS are all scored on the following scale: 0–43 = low; 44–56 = moderate; and 57 and more = high. The desired scores for compassion satisfaction are high, whereas the desired scores for burnout and STS are low.
- The demographic survey included items related to age, sex, ethnicity, religion, and professional expertise.
- Focus group script included questions about (1) compassion satisfaction (positive aspects of job and ability to contribute to work or society); (2) CF (trauma events that are upsetting to self, team, and trigger reactions); (3) STS (experience with and event triggers); and (4) self-care (coping mechanisms, trauma-specific education on STS, and institutional resources).

The focus group was 1.5 hr in length and was led by a trained facilitator. Two trained researchers took notes during the session, which was also audiotaped and transcribed. A chaplain was available for debriefing following the focus group due to the sensitive nature of the content. Notes and transcripts were independently reviewed by two research team members, and themes were identified. Disparities in theme categorization were addressed by mutual consensus. Data were summarized using means (standard deviation) for interval data and frequencies (percentages) for categorical data.

RESULTS

The focus group ($N = 12$) largely comprised White (83.3%), female (66.7%) nurses (50%) who were older than 40 years (83.3%) (Table 1). Just over half (58.3%) reported no significant problems in the Holmes–Rahe Life

TABLE 1 Participant Demographics (N = 12)

	<i>M (SD)</i>
Age	42.6 (7.5)
Years of clinical practice	14.7 (4.1)
Years in current position	9.3 (4.7)
Participate in religious activities (times per week)	2.9 (5.7)
	<i>f (%)</i>
Race	
White	10 (83.3)
Hispanic/Latino	2 (16.7)
Sex	
Female	8 (66.7)
Male	4 (33.3)
Clinical position	
Trauma surgeon	1 (8.3)
Physician assistant	2 (16.7)
Nurse	6 (50.0)
Other ^a	3 (25.0)
Religious affiliation	
Protestant	8 (66.7)
Catholic	2 (16.7)
Other ^b	2 (16.7)

Note. SD = standard deviation.
^aOther position includes physical therapy and social workers.
^bOther religious affiliation includes Jewish, Muslim, or Other.

Stress Inventory (Holmes & Rahe, 1967), whereas the rest (41.7%) reported mild stress. None of the participants reported moderate or major stress (Table 2). Regarding the individual ProQOL (Stamm, 2010; Table 3), one third (33.3%) scored a combination of low compassion satisfaction and high burnout and another 25% scored mod-

erate burnout. Most (75%) scored at risk, either with high (25%) or moderate (50%) STS. Interpreting the ProQOL scales (Stamm, 2010) in combination (Table 3), almost half (42%) were identified as at risk, with 25% being distressed, overwhelmed, or useless in job and (16.7%) scored at high risk due to burnout.

Focus Group Results

Four themes were identified in the transcription analysis and included positive aspects of job, stress triggers, stress symptoms, and coping with stress.

Positive Aspects of Job

Team members expressed positive aspects of being part of the trauma team including “saving lives,” “knowing you made a difference,” and “touching a [patient’s] family member.” In addition, satisfaction was derived from pride in being part of a team. “It’s like an esprit de corps, do you know what I’m saying, and you have a sense of cohesiveness as a team that makes us special.” A benefit of being part of the trauma team identified by all participants was the excitement of the job, one participant stated, “You never know what’s going to happen next. It’s an adrenalin rush.” In addition to pride in their team, participants also expressed pride in their ability to educate both in-house (e.g., medical students and residents) and outside of the institution at conferences and in peer-reviewed publications. “I think that what makes us a neat group; we realize that we are not perfect, but we keep pushing for perfection, knowing that we probably won’t ever get there but we keep getting a little closer.”

Stress Triggers

Team members appeared to be in agreement regarding events of abuse as stress triggers. Specifically, they identified both pediatric abuse and geriatric abuse, although any case involving a child was a trigger. Also identified were trauma scenarios where multiple family members were injured, injuries from avoidable situations and “senseless” deaths. Several participants agreed that

TABLE 2 Holmes–Rahe Life Stress Inventory (N = 12)

Description	Score Range	Instrument Risk ^a	Participant, <i>f (%)</i>
No significant problem	0–149		7 (58.3)
Mild stress	150–199	35%	5 (41.7)
Moderate stress	200–299	50%	0 (0.0)
Major stress	300+	80%	0 (0.0)

Note. From “The social readjustment rating scale” by T. Holmes and R. Rahe, 1967, *Journal of Psychosomatic Research*, 11, pp. 213–218. Copyright 1967 by the American Psychological Association.
^aRisk of illness/health change.

TABLE 3 Professional Quality of Life Scales, the ProQOL (N = 12)

Interpretation of Scales in Combination	f (%)		
Positive, no significant concerns ^a	3 (25.0)		
Positive, but moderate, concerns ^b	4 (33.3)		
At risk, high burnout ^c	2 (16.7)		
Distressed, overwhelmed, and useless ^d	3 (25.0)		
Interpretation of Individual Scales	f (%)		
	Low	Moderate	High
Compassion satisfaction ^e (high score desired)	4 (33.3)	5 (41.7)	3 (25.0)
Burnout ^f (low score desired)	5 (41.7)	3 (25.0)	4 (33.3)
Secondary trauma stress ^g (low score desired)	3 (25.0)	6 (50.0)	3 (25.0)

Note. Bold indicates areas of concern.

From *The concise ProQOL manual (2nd ed.)*, by B. H. Stamm, 2010, Pocatello, ID: ProQOL.org.

^aHigh compassion satisfaction and moderate to low burnout and secondary trauma stress.

^bModerate to low compassion satisfaction, burnout, and secondary stress.

^cHigh burnout, low or moderate compassion satisfaction, and secondary trauma stress.

^dHigh burnout and secondary traumatic stress with low compassion satisfaction.

^eSatisfied with job and helping.

^fUnhappiness, disconnectedness, and insensitivity.

^gFeeling trapped, on edge, exhausted, overwhelmed.

situations that were more personal could have an adverse effect. One stated,

I think that sometimes people will be able to see something that has happened in their life, like if they have had a death of a child, or if they have had an accident and if they see something very identical come in that they have experienced in their own personal life that is really tough.

Interacting with family members of patients was another stressor identified by participants; “whether they are negative conversations or not, families can be overwhelming and stressful.” While another participant stated, “It’s not always in the trauma bay, at least half my stress is in the ICU or the waiting room outside the ICU.”

Failure to act as a cohesive team was identified as a stress trigger. One participant explained, “It might just be somebody yelling or somebody that is upset about something, or maybe someone is just not in the greatest of moods when they walk in the trauma bay.” Perceived inefficiencies in the system or processes also were stressors for participants. As one participant put it, “If our system is broken, then we have no control over it.” While another expanded, saying,

My biggest button, that makes me get the angriest, is when I see bureaucracy take precedence over patient

care.... It could be lack of equipment because it is still on order or lack of a call schedule list [indicates specialist availability], it is so multi-factorial.

Stress Symptoms

Participants reported a variety of symptoms related to stress including nightmares, flashback memories regarding disturbing cases that went really well or really badly, and second-guessing clinical decisions. In addition, participants described an increased perception of risk of serious injury for their own children or family members. One stated, “My daughter calls me the Safety (Seatbelt) Psycho,” whereas another said, “One of the fears that I have is a drive-by shooting, which I never had prior to working in trauma”. Many participants reported restricting their own and their children’s activities for fear of injury. On the contrary, although participants reported hypervigilance regarding major injury, they also reported being desensitized to injury when it occurred. One mother stated,

There was a time when my son, he and his friend were playing with sticks and he cut his elbow open, and the kid wanted to run in and tell me but my son said my mom’s not going to care unless there is a bone sticking out or I’m bleeding to death.

Coping With Stress

Participants did not feel they experienced CF often, and when they did, coping strategies appeared to differ between respondents. No participants reported receiving any training during their education on how to handle STS, yet trauma workers felt they had the ability to deal with stress themselves. Most were aware of institutional options available but felt uncomfortable or unwilling to engage such services. In addition, coping strategies may differ on the basis of the details of a particular case. One participant shared,

I think [in] our normal situations with adults that we are used to, we are sarcastic and we joke to filter it out a little bit. But with children it is different. Particularly with abused patients we don't have the sarcasm, there is no filter there, and you have to cope with that.

However, coping strategies fell within two themes: group or independent.

Some participants preferred to process in small groups.

We talk amongst ourselves. I think because you understand. Somebody ... that you trust, they understand where you are coming from so it is easier to talk to them. They know what you go through. It is hard to talk to someone who has no idea what you go through. If you are talking to someone on the trauma service, they know what you are experiencing. So they can relate to you.

These spontaneous debriefing sessions were described as informal and often occurred outside of the hospital. A few participants reported relying on talking (in generalizations) with significant others outside of the work environment. For other group members, coping strategies were engaged independently and were described as follows:

I go straight for the bathroom [at home], I fill up the tub and I get in the tub and I sit in there and shut the door.

I make sure no one sees me [in the chapel], I don't want them to think I am weird.

I have bubbles in my drawer, and I go out to the courtyard and blow bubbles when I am stressed so if you see bubbles out there in the courtyard that's me out there. That is my alone time and you will either find me there or in the chapel just sitting there by myself.

I would put some serious miles on the treadmill, that's how I burn it off.

Because team members engaged in different coping strategies, and this was recognized by the group, no recommendations or suggestions for how the institution could facilitate or improve current processes were identified by participants.

DISCUSSION

This study sought to uncover the existence of, and coping skills with, CF and/or burnout within a trauma team, using simple measurement tools and focus group methodology. Findings included that one fourth of the trauma team members scored at high levels of STS and one third scored at high levels of burnout. These percentages are similar to other findings in the trauma environment (Hinderer et al., 2014). There was consensus that certain events (situational rather than injury-based) were more stressful than others. Events identified as high stress were consistent with the literature and involved children (Figley, 1995), abuse (Figley, 1995), family members (Mason et al., 2014), avoidable situations, and those similar to personal experiences (Figley, 1999). Administrative conflict, a non-patient-related theme, was also noted to be consistent with literature (Mason et al., 2014).

Despite identifying many stress-inducing events, participants reported CF as an infrequent experience. This initially appeared to be supported by results of the Holmes–Rahe Life Stress Inventory (Holmes & Rahe, 1967), which indicated that no participants fell into the moderate or major stress ranges and less than half fell into the mild stress category. In addition, focus group discussions identified several group and individual strategies for dealing with traumatic events. Following examination of the ProQOL (Stamm, 2010), however, most participants (75%) were scored in the moderate or high range for STS and more than half (58.3%) scored in the moderate or high range for burnout. This suggests that trauma team members may not be as adept at managing work stressors as well as they perceive. In addition, the lack of reference to, or use of, institutional resources for coping may be concerning. Although first responder teams are often required to attend critical incident debriefings after direct exposure to trauma, this may not be the case for those who experience it indirectly. Thus, internal mechanisms to advocate for team coping may be necessary.

PROGRAM RECOMMENDATIONS

Recommendations for acknowledging coping as teams within trauma programs can include several strategies:

1. As a program, acknowledge and accept that CF and BOS not only exist but also are an expected reality

in trauma-related professions (Schroeter, 2014). It may take a champion (similar to performance improvement and outreach) to educate the team to accept the normalcy of experiencing patient care-related stress while setting boundaries for professional behavior.

2. Educate the team on how to recognize symptoms in themselves (Fearon & Nicol, 2011). Consider introducing and adopting the ProQOL (Stamm, 2010), or other work stress inventories, to assess and score CF and BOS. The ProQOL is a 30-item questionnaire evaluating compassion satisfaction and CF (burnout and secondary trauma) that can be self-scored. The ProQOL is free to use (with permission) and is available at www.ProQOL.org. Suggest team members self-evaluate on an annual basis, maybe to coincide with annual performance evaluations. Using a standardized tool is especially important, as self-report underestimates the incidence of CF. If a team member discloses the need for additional help, provide resources. Both CF and BOS should be used discretely and only for self-awareness, although, collectively, this may be an indicator of health of the trauma team (Embriaco et al., 2007) and could be used for screening to determine need for preventive interventions (Adriaenssens et al., 2011).
3. Embody professional stress relief coping skills as a team. Professional social support or positive coworker relationships can alleviate CF (Gutierrez, 2005; Hinderer et al., 2014). Encourage trauma team members to engage in self-soothing activities, yet recognize they are not alone in their distress. Arrange time for team members to access internal social support from colleagues who have experienced similar feelings.
4. Make social support a priority in leadership development. Job satisfaction has been noted to be strongly associated with social support from (Adriaenssens et al., 2011), or positive working relationships (Poncet et al., 2007) with supervisors.
5. Engage in team discussions about coping as part of regularly scheduled meetings, rather than just in response to crisis or unprofessional behavior. Use questions similar to those presented here. Use caution and have a professional (counselor or chaplain) be available in the event normal conversations trigger stress responses. Be cognizant of those who do not contribute to the conversations, as CF is positively correlated with silence (Elkonin & van der Vyver, 2011). Strive to make the discussion nonjudgmental.
6. Be proactive in responding to identified high crisis situations (e.g., abuse, pediatric, or fatality) with

interventions. Organizational interventions can be as informal, as making a counselor or chaplain available for conversation or more structured in terms of time-limited group therapy, critical incident debriefings, or stress-prevention training. If the trauma team resists institutional debriefings, consider immediate technical debriefings that recap what went well in unsuccessful patient encounters, as reflecting can have a positive benefit (Berg et al., 2014; Fearon & Nicol, 2011) for those who may second-guess their clinical decisions.

7. Emphasize the positive aspects of patient care. Encourage mindfulness and celebration of successful patient care encounters.
8. Consider preemployment screening with standardized questionnaires to identify personalities that naturally exhibit strong coping traits (Burgess, Irvine, & Wallymahmed, 2010).

The use of these strategies can contribute to a developing a culture in which both CF and BOS are accepted realities for trauma care workers and allow staff to participate in support without fear of collegial judgment (Elkonin, & van der Vyver, 2011; Gentry et al., 2002).

This study is limited for generalizability by the qualitative nature, but it rather represents the perceptions and ideas of a Level I trauma team. Responses are categorized by discipline of team members for identity protection within small sample. Focus group findings are limited by the phrasing of questions and skill of moderator. Although focus group members were invited with instructions that honest and open participation was necessary, responses could have been biased by social desirability and desire to not appear weak in front of team members (Elkonin, & van der Vyver, 2011; Gentry et al., 2002; Showalter, 2010).

CONCLUSION

Results of this study indicated that both CF and BOS are not just complex concepts described in the literature but can also be identified as real and present in the midst of an unsuspecting trauma team. Using simple tools and qualitative methodology, a trauma program can conduct a modest, but effective, needs assessment for education, intervention, or even surveillance of CF and BOS within the team. Although data from this study were collected from a small focus group, they give voice to the evidence that describes and quantifies professional stress. Furthermore, the team can self-manage stress by creating a culture that acknowledges, accepts, and proactively supports staff to prevent or control CF and burnout.

KEY POINTS

- Positive aspects of being part of the trauma team included saving lives, being part of a team, excitement of job, and teaching new clinicians.
- Stress triggers reported included situational rather than injury-based cases (children, the elderly, abuse), interacting with family members, events similar to personal situations, failure to act as a cohesive team, and conflicts with management.
- Trauma programs can develop a culture sensitive to CF and BOS by educating team on prevalence and recognition, self-evaluation, boundary setting, setting time for internal social support, social support within leadership development, nonjudgmental team discussions, responses to high crisis situations, be proactive in responding to identified high crisis situations, emphasize positive aspects of care, and consider preemployment screening for coping traits.

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