Adv Nurs Midwifery | Original Article
Autumn 2018, Volume 27, Issue 3

Compassion Fatigue in Clinical Nurses: An Evolutionary Concept Analysis

Mahdieh Sabery [1], Mansoureh Zagheri tafreshi [2], Meimanat Hosseini [3,*], Jamileh Mohtashami [4], Abbas Ebadi [5]

[1] Student Research Committee, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran
[2] Nursing Management Department, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran
[3] Community Health Nursing, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences,Tehran , Iran
[4] Pyshiatric Nursing, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran
[5] Behavioral Sciences Research Center, Nursing Faculty, Baqiyatallah University of Medical Sciences, Teheran, IR Iran

*** Corresponding author:** *Meimanat Hosseini, Community Health Nursing, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences,Tehran , Iran. Email: m_hosseini@sbmu.ac.ir*

DOI: 10.9252/ANM-027032

Submitted: 13/04/2017
Accepted: 19/08/2017

Keywords:
Compassion Fatigue
Nurse
Analysis

How to Cite this Article:
Sabery M, Zagheri tafreshi M, Hosseini M, Jamileh M, Ebadi A. Compassion Fatigue in Clinical Nurses: An Evolutionary Concept Analysis. *Adv Nurs Midwifery*. 2017;**27**(2):7-14. DOI: 10.21859/ANM-027022

© 2017. Advances in Nursing and Midwifery

Abstract

Introduction: Despite the agreement regarding the significance of the concept of compassion fatigue (CF) in nursing, it has been unrecognized and there is no clear definition of CF in the context of nursing. The aim of this study was to inductively develop or formulate a clear and uniformed definition of compassion fatigue in the context of nursing.
Methods: This study was conducted using the Rodger's concept analysis, literature-based method and thematic analysis. Steps of the Rodger's concept analysis encompass identifying the concept and associated definition, attributes, antecedents, consequences, surrogate terms, related concepts, and a model case exemplar. A literature search was performed from 1992 to 2016. Finally, 45 references were selected. A thematic analysis was conducted for data analysis.
Results: In this analysis, after defining attributes such as cumulative and progressive process, individualized, self-absorption, and comprehensive, CF can be defined in this way: "CF is a cumulative, progressive, and individualized process that is caused by prolonged exposure to patients in pain, suffering and distress and threatens integrity of nurses' life. Nurses with CF lose their caring or nurturing ability and then they will not able to care own selves and others (patients, organization and members of the family)".
Conclusions: This analysis demonstrated that the concept of CF consists of excessive empathy, symptomatology of secondary traumatic stress, problematic work environment of burnout and coping mechanism deficit.

INTRODUCTION

Nurses must present caring behaviors such as empathy, respect and warmth for patients to express feeling cared for. The impact of caring for patients who are in pain, suffering, and traumatization on a daily basis can take a toll on nurses and put them at risk of a compassion fatigue (CF). Nurses suffering from CF may experience a noticeable change in work performance, a change in personality, a decrease in physical and emotional health [1] and are not able to provide quality patient care, consequently put patients at risk [2]. Helper professionals such as policeman, fire fighters, paramedics, law enforcement personnel, lawyers, psychiatric, social workers, and health care professionals, who help individual in distress, also have been recognized to be at risk for developing CF [3-5]. Compassion fatigue was found to be present in various nursing contexts [2] such as oncology [6], emergency [7], pediatric nurses [8] intensive care unit [9], and hospice nurses [10]. Therefore, attention to this phenomenon is essential. The effects of CF can encompass tiredness, fear, anxiety, insomnia, loss of strength, weariness, reduced output, diminished performance, loss of endurance, lessened enthusiasm, desensitization, irritability,

lack of spiritual awareness, impaired ability to concentrate, disordered thinking, loss of hope, exhaustion, loss of empathy and depersonalization [4, 11-14]. In fact, despite the agreement regarding the significance of the phenomenon of CF and despite widespread evidence about the concept of CF in nursing, this concept has been unrecognized, and has not been differentiated adequately from related terms [15], which has created confusion regarding its definition [16, 17]. Therefore, conceptual clarification of CF is the absolute necessity. The development of a clear and integral definition may apply as one point of movement in comprehending more about CF and help to the development of a theory of CF within nursing practice [18]. If the concept continued to be confounded and defined weakly, prevention and management of compassion fatigue would be more difficult and impossible [19, 20].

Objectives

The aim of this study was to inductively develop or formulate a clear and uniformed definition of CF in the context of nursing.

METHODS

An evolutionary concept analysis was selected to identify detailed process of clarifying the current use of a concept. This approach is systematic with rigorous procedures and provides a solid base for further research and nursing practice [21]. The evolutionary method of concept development specifically focuses concepts as being dynamic and changing over time and context. Also, this method confirms the existence of vast interrelationships among phenomena and associated concepts. Steps of the Rodger's concept analysis encompass identifying the concept and associated definition, attributes, antecedents, consequences, surrogate terms, related concepts, and a model case exemplar [21].

Searches for Data and Selection Process

A literature search was performed to determine suitable references for developing the concept analysis [21]. The samples were selected from English and Persian language literature published in nursing during 1992-2016. Nursing constitutes the focus of the study because of our primary interest in conceptualization of CF in healthcare professionals, especially nursing. The MeSH database was used to find keywords such as CF, secondary traumatic stress (STS) and nurses. The large volume of literature was known under the major headings of CF and secondary traumatic stress. Therefore, there was no need to develop the search using other keywords. All references were organized with EndNote X7.5. initial search uncovered 2782(408 references in PubMed, 1077 references in Science Direct, 1296 references in Wiley online library and 1 reference in Iranmedex). After removal of duplicate articles, 1180 articles remained. Subsequently, the references only published as an abstract (n = 40) or non-English (n = 35) were removed. At the first round, the references were screened by the title and abstract for relevancy. Any literature about CF in other disciplines was excluded. Finally, 180 articles remained. Based on the Rodger's approach for the evolutionary concept analysis, 30 items or 20% of available literature was the minimum needed to facilitate a valid analysis [21]. Then, 36 references were randomly selected and for further validity, 45 references were selected. Lastly, two of the authors independently reviewed all abstracts.

Data Collection

Each reference was read to identify the general theme. This stage focused on immersion in the literatures regarding the uses of the CF. Expression, and themes were written on coding sheets created for data organization. A coding sheet with heading "definitions" was developed to document relevant data about this question "what are the attributes of the CF?" The common characteristics in definitions were identified. Similarly such coding forms were used for other aspects such as antecedents, consequences, relevant concepts, and surrogate terms. Analysis was delayed until all sources were retrieved and organized. However, minimal analysis was conducted for better organization and formal analysis.

Data Analysis

Analysis focused on the nursing literature during 1992-2016 to reveal an operational definition of the CF. An inductive, and thematic manner similar to content analysis were conducted related to each major category of data [21]. It means that all data were analyzed under the heading "Definition" to identify common attribute and contextual data (e.g., antecedent and consequential occurrences, surrogate term, and related terms) to identify other aspects of CF.Data were organized and reorganized until a consistent series of categories emerged for each aspect of CF and then word labels were selected for each aspect of the concept to provide clear definition[17](. Due to the fact that the focus of this analysis was to explore the CF in clinical nursing, the sample was purposively selected from a nursing-specific data base, and thus interdisciplinary comparisons were not conducted.

Data Trustworthiness

The trustworthiness of this concept analysis was enhanced by the use of the techniques of qualitative studies [22]. To guarantee the credibility of the finding, large sample size was selected and a reflective journal was kept to record methodological decisions, thoughts, and perceptions, which emerged during data collection and analysis. Also, trustworthiness or rigor of the study was supported by involvement of two researchers to decrease bias in the organization of the data

RESULTS

Historically, the concept of CF has evolved. During evolution of concept, it has been identified as a multidimensional concept with multifaceted definitions [23]. Compassion fatigue has been studied primarily in other professions than nursing [11, 24]. In recent years, it has received increased attention related to the realm of stress in caregivers, especially nurses [11]. However, a lot of literatures were commonly discussed regarding incidences, symptoms and interventions for prevention and management of CF, but the operational definition of CF has not been proved by authors and a consistent definition of CF has not presented in the literature [2, 16]. The term CF first is appeared in literature in the early 1990s by Joinson and American literature [25], while she was examining the burnout in nurses in an emergency department and noticed that nurses seemed to have lost their "ability to nurture" in result of repeated exposure to suffering patients during work. Joinson described CF as a "unique form of burnout" [5, 19, 26, 27]. The

compassion fatigue never formally has been defined by Joinson, and then developed by Figley. Figley is a prominent researcher and has the most researches on the conceptualization of CF. he has expanded the concept of CF by creating a model of the CF. Many researchers have been used some terms such as secondary traumatic stress (STS), secondary traumatic stress disorder (STSD), vicarious traumatization, and burnout interchangeably in research and clinical assessments, because they believed that the these terms are similar or identical [20, 28-32].
Figley adopted CF as a more "user-friendly term" for STS [30, 33]. Although CF has interchangeably been referred to STS by figley and many researchers, the synonymous use of CF and STS seems somewhat antithetical to original impression of Joinson's "about CF [34] because Figley's research is based on the experiences of psychotherapist but does not include nurse participants. Coetzee and Clopper stated that STS is not even synonymous with CF [19]. Jenkins and Baird in their analysis stated that the content validity of STS and CF is really different [4] and may be phenomenologically different. White identified a distinction between STS and CF. This difference may be due to the role of empathy and desire to help someone who is suffering and traumatized in CF [32], but Figley believed that empathy had a very important role in the conceptualization of CF and STS [32]. What becomes more clear and evident is that the terms CF, STS, and BO have similar physical and emotional outcomes and there are the mutual relationships between CF and various concepts, for example, there is a positive relationship between CF and STS and between CF and BO in some studies, suggesting an overlaps in one or more components of these concepts [34]. Different opinions exist regarding the relationships among related terms. Some researchers stated, CF may be a precursor to STS and some believed burnout may be a precursor to CF [34-36]. Also, Meadors suggested that STS and BO are as independent variables that can contribute to developing CF, and STS is a stronger predictor of CF than burnout [32].
Figley defined CF as comprised of two main elements: burnout and STS [15, 30]. The burnout entails issues such as exhaustion, depression, and frustration. The STS is the negative feeling accompanying with avoidance and arousal symptoms, intrusion, and hyper-vigilance [26, 30, 32].

Terminology of Compassion Fatigue

"Compassion fatigue" is divided into its root words: "compassion" and "fatigue". The word of "compassion" is a feeling of empathy that arises resulting of witnessing the suffering of others and gives rise to an active tendency to help and decrease another's suffering [19]. Fatigue is an overwhelming sense of exhaustion and reduced capacity for physical and psychological work at the normal level [4]. Based on online Cambridge Dictionary, compassion fatigue was defined as follows: the situation in which people stop thinking or worrying about a problem that is affecting a lot of people and stop giving money to them because the problem has continued for too long (http://dictionary.cambridge.org/dictionary/english/compassion-fatigue).

A model Case of compassion fatigue

Most of the time, NICU was very busy and there was a shortage of nurses and resources on the one hand and organizational multiple tasks on the other hand that nurses should do, and babies who are hospitalized often ill and high workload.
Nurses are often in contact with this stressful environment for a long time because many of shifts are long time (12 hours). Nurse A was a woman, 32 years old with 5 years' experience working in the ICU. She is married and has a two-year-old girl. According to their own saying, she is affected by physical, social and emotional problems. She said one of the recent events has caused a lot of stress for her." I was in night shift. I admitted one newborn. He had a good appearance and nobody could understand that this newborn is sick and only after breast feeding, the milk came out from nose and he vomited. Consequently, the baby was referred to our center after doctor visit.
I admitted this baby, Chest x-ray was taken. After complete assessment, her diagnosis was advanced Choanal Atresia.
I was very upset and I told to myself: "why this baby who is still 24 hours old has to undergo surgery three times? I did not like this baby to be manipulated as it was emphasized for him.The next day, emergency surgery was performed. In operation room, the baby was intubated and ventilated and two chest tubes were inserted for him. After operation, when I received the baby, it was incredible. It was not the baby's whom I admitted. He was a plump, white, and beautiful baby, but now he was ragged and very ill. His lungs were bleeding, and drainage of bile secretion was ample.
Every day I was to shift, I was responsible for caring of this baby. I was depressed and anxious. As soon as changes occurred in the overall health status, I was stressed and started crying and restlessness.
When performing painful procedures for this baby, I was upset. I would have liked to do something for healing. At home, my mind was very involved so that all family members noticed my discomfort and depression.
Even, I requested from the family members to pray for the baby and his recovery. I was very attached and dependent to the baby. I had anorexia and headache. Errors in my work had increased, I was irritable and aggressive. I had no incentive to work. I was detached from my wife and my daughter. I was secluded. My physical and psychological conditions had deteriorated so much that we had not power for caring of patients. I felt very tired. I wanted to be alone. I did not like to think of my own problems and others' problems".

Figure 1: A model Case of Compassion Fatigue in Nurses

ATTRIBUTES

Attributes, are the essential characteristics that help to distinguish the concept from other related concepts and clarify its meaning [18]. In spite of various definitions for CF, main categories, which were introduced in literatures as attributes included:

EMPATHY

Cumulative and progressive process

THERAPEUTIC RELATIONSHIP

Emotional burden

EMPATHY

Empathy is one of the important attributes of CF and is human inherent [19, 30, 37]. Figley showed that nurses are at risk for CF because of their compassion and empathy [29, 33]. This attribute is double-edged sword because not only is a core value for nurses in their work but also it can be caused vulnerability among nurses at the same time [38]. It means that empathic nurses indirectly experience and absorb the trauma of their patients, and their efforts to empathize often lead to increased self-sacrifice and inadequate self-care [26, 33].

THERAPEUTIC RELATIONSHIP

Literatures have suggested that CF is dependent on a therapeutic relationship between the nurses and patients who are suffering or traumatized, and consequently nurses experienced patients' distress unconsciously and CF occurred [16, 39-41]. The therapeutic relationship is a main component of CF in the model of professional quality of life [34].

CUMULATIVE AND PROGRESSIVE PROCESS

Compassion fatigue is defined as a cumulative and progressive process and develops over time (25, 32). It is a natural consequence and final result of continuous and prolonged exposure of caring for patients who are in pain and suffering such as patients with cancer, patients at the end of life, patient with incurable dieses, infant or young age of patients [12, 23, 30, 40, 42, 43], because prolonged exposure to suffering patients creates a cumulative effect on nurses. When nurse directed his/her energy towards patients in daily basis and do not see positive outcomes of patients, CF developed [32].

EMOTIONAL BURDEN

Because of a caring nature in nursing, the nurses constantly share their compassion with suffering and in pain patients on a daily basis. Eventually, this may result in emotional burden that its handling is difficult [3, 30, 39, 44, 45].

ANTECEDENTS

Antecedents have been entailed as events that must occur prior to the occurrence of the concept [18].
The following are the main categories that in literatures were introduced as antecedents:

INDIVIDUAL CHARACTERISTICS

Stress
Ineffective coping strategies

Individual Characteristics

Theorists have stated that the nurses who have sacrifice behaviors, capacity for empathy, resiliency, and a higher level of personal stress are more vulnerable to CF [10, 13, 30, 39, 41].

Stress

There are multiple professional and personal stressors in nursing. Professional stressors such as patient-related stress (the stress resulting from helping a traumatized or suffering patients, stressful situations for patients, death of patients) [45], work related stress (inadequate Financial and human resources, equipment unavailability, staff shortages, increased patient assignments, workload, working extra shifts, paperwork, lack of appropriate nursing skills and knowledge, inadequate preparation, lack of management support, conflict with doctors and other nurses, closed environment, witnessing patients' distress and being unable to help them, exposure to multiple patients' needs, confused policy and procedures, faulty organizational culture) [3, 26, 44, 46] and personal stress (self-conflict and feeling a sense of uncertainty [45, 46], commitment to helping others, and meeting the overwhelming needs of patients) [26] have been associated with decreased personal productivity, diminished work engagement, high turnover, absenteeism, medical errors, decreased morale, and nurses' decreased physical and emotional health; all of these factors can decrease the quality of care [47] and nurses who cannot manage their stress are at risk to develop CF [41].

Ineffective Coping Strategies

Coping strategies enable nurses for resolution and management of multiple stressors and afford protection for them, thus coping strategies deficit puts nurses at risk of CF [3, 39, 48].

Consequences

Consequences have been entailed as events that occur after the presence of the concept [18]. Based on the literatures, nurses with CF are at risk for development of various symptoms [23]. Two main categories of consequences of CF were depicted as:

Integrity threat of the nurse

nurse' inability in self-care and another care

Integrity Threat of the Nurses

Some authors have defined CF as "a state of exhaustion and dysfunction, physiologically, behaviorally, emotionally, spiritually and socially" [5, 49].
Some of the symptoms of CF include physical symptoms (e.g., reduced general health, poor immunity, chronic fatigue, headaches, insomnia, various pain, muscle tension, digestive complaints, lack of energy, and loss of power), cognitive

symptoms (e.g., poor concentration, impaired memory, increased errors, incomplete concentration, poor attention, and irregularities), emotional symptoms (e.g., discouragement, loss of ability to empathize with the patient, sadness, apathy, and cynicism), spiritual symptoms (lack of spiritual awareness), and social symptoms (drug abuse, relational problem, disruption in life and divorce, loss of enjoyment of life, isolation, loneliness, inability to participate or reduce the suffering of others, loss of interest in activities that one has already enjoyed them, lack of accountability, and separation from friends and family) [23, 31, 33, 39, 41, 45, 50].

Nurse' Inability in Self-care and another Care

One of the most important adverse consequences of CF was nurse's inability for self-care and another care. It means that when nurses are not able to help to rescue or save patients with malignant cancer, patients at the end of life, and those with incurable disease they may feel helpless, powerless, uncertainty and hopelessness in the caregiving situation. Hopelessness was also associated with higher levels of anxiety, depression and results in guilt and distress in nurses, which had induced inability for self-care and other care especially their family members and other patients [3, 23, 24, 42, 51]. Figley noted that the family of nurses will become secondary victims of CF.

Surrogate Terms

Surrogate terms are words that state a concept's ideas with other words that the researcher has used in his/her study. Surrogate terms of CF are "provider fatigue" [45], "emotional contagion" [13, 29, 30], "helper syndrome" [34], "helper stress" [30].

Related Terms

Related terms are words that have something in common with the concept but do not have the same characteristics or features [18]. These terms have been described as the harmful psychological effects on care providers [15, 30, 52]. Some authors pointed out that the term of CF is problematic and is often interchanged with variety of related terms such as STS, burnout, vicarious traumatization, counter-transference [15, 20, 24, 30, 33]. Van Mol mentioned the related terms as emotional distress, because of the same causes, intervention, and outcomes [34].

Secondary Traumatic Stress

A term that is often used interchangeably with CF is STS [34, 52]. Based on literature, STS has commonalities with CF and has been defined as the distress and emotional disruption associate with an exposure to traumatized individuals. Meadors et al. speculate that STS does not compose empathy and desire to help as parts of its criteria and not built on a cumulative effect [46]. The secondary traumatic stress may be nearly identical to posttraumatic stress disorder (PTSD) [43], with this differenc that STS is indirect traumatization and PTSD is direct traumatization. Also, STS is defined as the outcome of knowing about a traumatizing event or incidents experienced by others and the subsequent stress resulting from helping or wanting to help. The symptoms associated with STS may also be manifested in an individual with CF [29, 33].

Burnout

Burnout is associated with feelings of hopelessness, frustration and apathy. It makes an inability to perform one's job responsibilities effectively [53]. Burnout is associated with a problematic culture in work place such as work overload, long hours, intense work environments, paperwork, inadequate management support, etc. [46]. Compassion fatigue and burnout are closely related and symptoms of them are similar [30, 39] but some researcher considered CF and burnout are related but separate concepts. However, some studies showed that CF is different from burnout, because underlying mechanisms are very different [34, 41]. The CF creates from a rescue-caregiving response with empathy but burnout from assertiveness-goal attainment response and not typically related to empathy [11, 41, 53]. Burnout is a gradual process and progressively worsens and results from an imbalance between their expected and outcomes in the workplace [30]. It caused by repeated exposure to chronic stressors and led to low levels of motivation and job satisfaction. Aycock and Boyle propose that burnout is the outdated term and CF has replaced with it, because burnout does not really draw the results of the longitudinal workplace consequences of sorrow and desperation on nurses [17].

Vicarious Traumatization

Vicarious traumatization (VT) is permanent and unconscious transformation cognitive frame [30, 54]. Care providers exhibit physiological symptoms such as disturbances in self-identity, world view, spirituality and cognitive frame (belief systems about oneself, others, and the world around him/her) about one's self and others regarding five major psychological needs: safety, trust, esteem, control, and intimacy [32, 43]. Researchers suggested that empathetic engagement with trauma survivors is risk factor for VT. Most researchers pointed out that VT occurs most often among mental health providers and no research has been conducted with other healthcare providers. A case model of CF is presented in Table 1 for more clarification and differentiating the concept from related terms.

Definition of Compassion Fatigue after Thematic Analysis of Literature

In this analysis, after defining attributes such as cumulative and progressive process, individualized, self-absorption, and comprehensive, CF can be defined in this way: "CF is a cumulative, progressive, and individualized process that is caused by prolong exposure to patients in pain, suffering and distress and threatens integrity of nurses' life. Nurses with CF lose their caring or nurturing ability and then they will not able to care own selves and others (patients, organization and members of the family)".

DISCUSSION

In spite of various understandings about the nature of CF and interchangeable use of related terms, systematic approach of the Rodger's concept analysis can help us in understanding the meaning, recognition, and clarification of relevant as-

pects, antecedents, and consequences of CF. Current findings showed that the synonymous use of CF and STS seems somewhat far removed, even antithetical to original impression of Joinson about CF [34]. Joinson (1992) was a nurse and when she was studying burnout in emergency department, she detected that nurses seemed to have lost their "ability to nurture" as a result of prolonged exposure to patients pain and suffering during work. Then, Figley selected the term 'CF' as a 'more user-friendly term for secondary trauma' and vicarious traumatization, but the findings showed that these concepts have distinctions in terms of theoretical basis and symptoms, interchangeable use of them seems illogical and a wrong perception. Also, Sheppard (2015) claimed that the term "CF" was apparent as stigmatizing and negative and the nurses were concerned about losing their job by accepting this label. Thus, consistent with Sheppard (2015), renaming CF is necessary to better represent this phenomenon in nurses and he suggested that "provider saturation" or "care distress" may be alternative terms of CF among nurses.
The majority of authors stated that CF arises due to caring (they used the terms caring and compassion synonymously) and CF is often defined as cost of caring. This hypothesis expressed that "engagement in caring creates risk for the nurses and they are at risk for emotional exhaustion from their work [55].
In this analysis, after defining attributes such as cumulative and progressive process, individualized, self-absorption, and comprehensive, CF was defined. This definition is consistent with original impression of Joinson's "loss of the nurturing" about CF and also affirms Ledoux (2015) beliefs about CF as "CF is not "cost of caring" but multiple factors such as patient-related stress, work-related stress, and personal stress put nurses at risk of CF. Based on this concept analysis, number of questions is identified for future research. The results showed the additional development of the concept is needed. These findings not only offer further clarity but also facilitate productive inquiry. Derived definition in this concept analysis may help policy makers, managers and nurses to identify CF and prevent from complicated and negative consequences of it. The results of CF are devastating and adversely affecting the nurse, patient, organization and society, thus changes in governmental, organizational and individual level is are needed to deal with significant challenges to nursing practice. Nurses' awareness of contributing factors (antecedents) may help prevent negative effects of CF on the nurse's personal and professional life and decrease the personal and professional costs of CF.
The consequences of CF identified through this analysis provide direction for additional research. These consequences offer a basis for reconceptualization and evaluation of CF outcomes. Also, nurses' awareness of harmful outcomes (consequences) of CF may cause nurses develop and apply appropriate and timely interventions. Considering high stressors in nursing professions, developing interventions to build individual resilience within the workforce, providing supportive and friendly work environments and offering preventive and proactive support services for nurses is essential. These interventions enable nurses to resolute multiple stressors and work in the challenging environments of the recent century. According to the interchangeable usage of CF and related terms, conceptual clarification of related terms would be a major step in enhancing knowledge and promotion differentiation of these concepts. Also, development of an appropriate instrument for CF and each of these terms should be conducted for future research. Thus, a next step in my research is to identify and explore CF among nurses in Iranian religious and cultural context using an interview-based research. In fact, the current study could be the first step of the concept development procedure presented by Schwartz-Barcott and Kim (hybrid concept analysis). This approach combines a literature-based analysis and interview-based research (field work).
Current findings show that synonymous and interchangeable use of CF and STS seems illogical and wrong and renaming CF is necessary to better representation of this phenomenon in nurses. This analysis shows that the concept of CF consists of excessive empathy, symptomatology of STS, problematic work environment of burnout and coping mechanism deficit.

ACKNOWLEGDEMENTS

The authors would like to thank the managers of the Shahid Beheshti University of Medical Sciences for providing the opportunity to conduct this study. We are also grateful to all of the participating nurses from the hospitals affiliated with the Kashan and Shahid Beheshti Universities of Medical Sciences.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

FUNDING

This study was exclusively funded by the Shahid Beheshti University of Medical Sciences

ETHICAL CONSIDERATIONS

This study was conducted as a part of thesis with the ethical code: SBMU2.REC.1394.46, approved by Shahid Beheshti University of Medical Sciences. All of the participants signed written informed consent before participation, and allowed the researcher to record the interviews.

AUTHOR CONTRIBUTIONS

Study concept, design and data acquisitio: Mahdieh Sabery; data analysis and interpretation, Manuscript drafting and critical revision of the manuscript for important intellectual content: Mahdieh Sabery, Mansoureh Zagheri tafreshi, Meimanat Hosseini, Jamileh Mohtashami, Abbas Ebadi.

REFERENCES

1. Hooper C, Craig J, Janvrin DR, Wetsel MA, Reimels E. Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. J Emerg Nurs. 2010;36(5):420-7. DOI: 10.1016/j.jen.2009.11.027 PMID: 20837210
2. Ledoux K. Understanding compassion fatigue: understanding compassion. J Adv Nurs. 2015;71(9):2041-50. DOI: 10.1111/jan.12686 PMID: 25981240
3. Schwam K. The phenomenon of compassion fatigue in perioperative nursing. AORN J. 1998;68(4):642-5, 7-8. PMID: 9795719
4. Jenkins B, Warren NA. Concept analysis: compassion fatigue and effects upon critical care nurses. Crit Care Nurs Q. 2012;35(4):388-

95. DOI: 10.1097/CNQ.0b013e318268fe09 PMID: 22948373
5. Frank DI, Adkinson LF. A developmental perspective on risk for compassion fatigue in middle-aged nurses caring for hurricane victims in Florida. Holist Nurs Pract. 2007;21(2):55-62; quiz 3-2. DOI: 10.1097/01.HNP.0000262018.49550.5a PMID: 17327748
6. Quinal L, Harford S, Rutledge DN. Secondary traumatic stress in oncology staff. Cancer Nurs. 2009;32(4):E1-7. DOI: 10.1097/NCC.0b013e31819ca65a PMID: 19444086
7. Dominguez-Gomez E, Rutledge DN. Prevalence of secondary traumatic stress among emergency nurses. J Emerg Nurs. 2009;35(3):199-204; quiz 73-4. DOI: 10.1016/j.jen.2008.05.003 PMID: 19446123
8. Maytum JC, Heiman MB, Garwick AW. Compassion fatigue and burnout in nurses who work with children with chronic conditions and their families. J Pediatr Health Care. 2004;18(4):171-9. DOI: 10.1016/j.pedhc.2003.12.005 PMID: 15224041
9. Maiden J, Georges JM, Connelly CD. Moral distress, compassion fatigue, and perceptions about medication errors in certified critical care nurses. Dimens Crit Care Nurs. 2011;30(6):339-45. DOI: 10.1097/DCC.0b013e31822fab2a PMID: 21983510
10. Abendroth M, Flannery J. Predicting the Risk of Compassion Fatigue. J Hosp Palliat Nurs. 2006;8(6):346-56. DOI: 10.1097/00129191-200611000-00007
11. Boyle DA. Countering compassion fatigue: a requisite nursing agenda. Online J Issues Nurs. 2011;16(1):2. DOI: 10.3912/OJIN.Vol16No01Man02 PMID: 21800933
12. Melvin CS. Professional compassion fatigue: what is the true cost of nurses caring for the dying? Int J Palliat Nurs. 2012;18(12):606-11. DOI: 10.12968/ijpn.2012.18.12.606 PMID: 23560318
13. Adams RE, Boscarino JA, Figley CR. Compassion fatigue and psychological distress among social workers: a validation study. Am J Orthopsychiatry. 2006;76(1):103-8. DOI: 10.1037/0002-9432.76.1.103 PMID: 16569133
14. Newsom R. Compassion fatigue: Nothing left to give. Nurs Manage. 2010;41(4):42-5. DOI: 10.1097/01.NUMA.0000370878.55842.e7 PMID: 20375677
15. Flarity K, Gentry JE, Mesnikoff N. The effectiveness of an educational program on preventing and treating compassion fatigue in emergency nurses. Adv Emerg Nurs J. 2013;35(3):247-58. DOI: 10.1097/TME.0b013e31829b726f PMID: 23899949
16. Day JR, Anderson RA. Compassion fatigue: an application of the concept to informal caregivers of family members with dementia. Nurs Res Pract. 2011;2011:408024. DOI: 10.1155/2011/408024 PMID: 22229086
17. Aycock N, Boyle D. Interventions to manage compassion fatigue in oncology nursing. Clin J Oncol Nurs. 2009;13(2):183-91. DOI: 10.1188/09.CJON.183-191 PMID: 19349265
18. Walker LO, Avant KC. Strategies for theory construction in nursing. 5th ed2005.
19. Coetzee SK, Klopper HC. Compassion fatigue within nursing practice: a concept analysis. Nurs Health Sci. 2010;12(2):235-43. DOI: 10.1111/j.1442-2018.2010.00526.x PMID: 20602697
20. Najjar N, Davis LW, Beck-Coon K, Carney Doebbeling C. Compassion fatigue: a review of the research to date and relevance to cancer-care providers. J Health Psychol. 2009;14(2):267-77. DOI: 10.1177/1359105308100211 PMID: 19237494
21. Rodgers B, Knafl K. Concept development in nursing: Foundations, techniques, and applications. Philadelphia: Saunders; 2000.
22. Lincoln YS, Guba EG, Pilotta JJ. Naturalistic inquiry. Int J Intercult Relat. 1985;9(4):438-9. DOI: 10.1016/0147-1767(85)90062-8
23. Owen RP, Wanzer L. Compassion fatigue in military healthcare teams. Arch Psychiatr Nurs. 2014;28(1):2-9. DOI: 10.1016/j.apnu.2013.09.007 PMID: 24506980
24. Yoder EA. Compassion fatigue in nurses. Appl Nurs Res. 2010;23(4):191-7. DOI: 10.1016/j.apnr.2008.09.003 PMID: 21035028
25. Hegney DG, Craigie M, Hemsworth D, Osseiran-Moisson R, Aoun S, Francis K, et al. Compassion satisfaction, compassion fatigue, anxiety, depression and stress in registered nurses in Australia: study 1 results. J Nurs Manag. 2014;22(4):506-18. DOI: 10.1111/jonm.12160 PMID: 24175955
26. Branch C, Klinkenberg D. Compassion fatigue among pediatric healthcare providers. MCN Am J Matern Child Nurs. 2015;40(3):160-6; quiz E13-4. DOI: 10.1097/NMC.0000000000000133 PMID: 25594692
27. Drury V, Craigie M, Francis K, Aoun S, Hegney DG. Compassion satisfaction, compassion fatigue, anxiety, depression and stress in registered nurses in Australia: phase 2 results. J Nurs Manag. 2014;22(4):519-31. PMID: 24926496
28. Bourassa DB. Compassion fatigue and the adult protective services social worker. J Gerontol Soc Work. 2009;52(3):215-29. DOI: 10.1080/01634370802609296 PMID: 19308828
29. Figley CR. Treating compassion fatigue. Routledge. 2002.
30. Sabo BM. Compassion fatigue and nursing work: can we accurately capture the consequences of caring work? Int J Nurs Pract. 2006;12(3):136-42. DOI: 10.1111/j.1440-172X.2006.00562.x PMID: 16674780
31. Figley CR. Compassion fatigue: psychotherapists' chronic lack of self care. J Clin Psychol. 2002;58(11):1433-41. DOI: 10.1002/jclp.10090 PMID: 12412153
32. Meadors P, Lamson A. Compassion fatigue and secondary traumatization: provider self care on intensive care units for children. J Pediatr Health Care. 2008;22(1):24-34. DOI: 10.1016/j.pedhc.2007.01.006 PMID: 18174086
33. Figley CR. Compassion fatigue: Toward a new understanding of the costs of caring. USA: American Psychological Association; 1995.
34. van Mol MM, Kompanje EJ, Benoit DD, Bakker J, Nijkamp MD. The Prevalence of Compassion Fatigue and Burnout among Healthcare Professionals in Intensive Care Units: A Systematic Review. PLoS One. 2015;10(8):e0136955. DOI: 10.1371/journal.pone.0136955 PMID: 26322644
35. Joinson C. Coping with compassion fatigue. Nursing. 1992;22(4):116, 8-9, 20. PMID: 1570090
36. Lynch SH, Lobo ML. Compassion fatigue in family caregivers: a Wilsonian concept analysis. J Adv Nurs. 2012;68(9):2125-34. DOI: 10.1111/j.1365-2648.2012.05985.x PMID: 22435873
37. Fernando AT, 3rd, Consedine NS. Beyond compassion fatigue: the transactional model of physician compassion. J Pain Symptom Manage. 2014;48(2):289-98. DOI: 10.1016/j.jpainsymman.2013.09.014 PMID: 24417804
38. Perry B, Toffner G, Merrick T, Dalton J. An exploration of the experience of compassion fatigue in clinical oncology nurses. Can Oncol Nurs J. 2011;21(2):91-105. PMID: 21661623
39. Sabo B. Reflecting on the concept of compassion fatigue. Online J Issues Nurs. 2011;16(1):1. DOI: 10.3912/OJIN.Vol16No01Man01 PMID: 21800932
40. Bush NJ. Compassion fatigue: are you at risk? Oncol Nurs Forum. 2009;36(1):24-8. DOI: 10.1188/09.ONF.24-28 PMID: 19136336
41. Benson J, Magraith K. Compassion fatigue and burnout: the role of Balint groups. Aust Fam Physician. 2005;34(6):497-8. PMID: 15931410
42. Potter P, Deshields T, Divanbeigi J, Berger J, Cipriano D, Norris L, et al. Compassion fatigue and burnout: prevalence among oncology nurses. Clin J Oncol Nurs. 2010;14(5):E56-62. DOI: 10.1188/10.CJON.E56-E62 PMID: 20880809
43. Beck CT. Secondary traumatic stress in nurses: a systematic review. Arch Psychiatr Nurs. 2011;25(1):1-10. DOI: 10.1016/j.apnu.2010.05.005 PMID: 21251596
44. Sung K, Seo Y, Kim JH. Relationships between compassion fatigue, burnout, and turnover intention in Korean hospital nurses. J Korean Acad Nurs. 2012;42(7):1087-94. DOI: 10.4040/jkan.2012.42.7.1087 PMID: 23377605
45. Perry B. Why exemplary oncology nurses seem to avoid compassion fatigue. Can Oncol Nurs J. 2008;18(2):87-99. PMID: 18649700
46. Meadors P, Lamson A, Swanson M, White M, Sira N. Secondary traumatization in pediatric healthcare providers: compassion fatigue, burnout, and secondary traumatic stress. Omega (Westport). 2009;60(2):103-28. PMID: 20222232
47. Berg GM, Harshbarger JL, Ahlers-Schmidt CR, Lippoldt D. Exposing Compassion Fatigue and Burnout Syndrome in a Trauma Team: A Qualitative Study. J Trauma Nurs. 2016;23(1):3-10. DOI: 10.1097/JTN.0000000000000172 PMID: 26745533
48. Hinderer KA, VonRueden KT, Friedmann E, McQuillan KA, Gilmore R, Kramer B, et al. Burnout, compassion fatigue, compassion satisfaction, and secondary traumatic stress in trauma nurses. J Trauma Nurs. 2014;21(4):160-9. DOI: 10.1097/JTN.0000000000000055 PMID: 25023839
49. Showalter SE. Compassion fatigue: what is it? Why does it matter? Recognizing the symptoms, acknowledging the impact, developing the tools to prevent compassion fatigue, and strengthen the professional already suffering from the effects. Am J Hosp Palliat Care.

2010;27(4):239-42. DOI: 10.1177/1049909109354096 PMID: 20075423

50. Romano J, Trotta R, Rich VL. Combating compassion fatigue: an exemplar of an approach to nursing renewal. Nurs Adm Q. 2013;37(4):333-6. DOI: 10.1097/NAQ.0b013e3182a2f9ff PMID: 24022287
51. Makic MBF. Taking Care of the Caregiver: Compassion Satisfaction and Compassion Fatigue. J Perianesth Nurs. 2015;30(6):546-7. DOI: 10.1016/j.jopan.2015.09.006 PMID: 26596389
52. Young JL, Derr DM, Cicchillo VJ, Bressler S. Compassion satisfaction, burnout, and secondary traumatic stress in heart and vascular nurses. Crit Care Nurs Q. 2011;34(3):227-34. DOI: 10.1097/CNQ.0b013e31821c67d5 PMID: 21670622
53. Hunsaker S, Chen HC, Maughan D, Heaston S. Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. J Nurs Scholarsh. 2015;47(2):186-94. DOI: 10.1111/jnu.12122 PMID: 25644276
54. Benoit LG, Veach PM, LeRoy BS. When you care enough to do your very best: genetic counselor experiences of compassion fatigue. J Genet Couns. 2007;16(3):299-312. DOI: 10.1007/s10897-006-9072-1 PMID: 17318455
55. Sheppard K. Compassion fatigue among registered nurses: connecting theory and research. Appl Nurs Res. 2015;28(1):57-9. DOI: 10.1016/j.apnr.2014.10.007 PMID: 25434861