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Compassion fatigue and coping strategies before death

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Abstract

Compassion fatigue threatens healthcare professionals' mental health in face of difficulties in managing empathy. This integrative review sought to verify the correlation between compassion fatigue and health professionals' performance in hospital units that frequently deal with death, considering the self-care strategies adopted. Bibliographic search conducted on the MEDLINE and PubMed databases retrieved 11 articles published between 2011 and 2021. Results show that compassion fatigue occurs frequently in professionals who deal directly and recurrently with death, especially when dysthanasia measures are adopted. Case discussion between teams, leisure time and peer support, spirituality and meditation as well as constructive leadership were the main psychological adaptation strategies identified. Further and in-depth research is needed given the scarcity of study on the topic, especially in Brazil.

Keywords: Compassion fatigue. Death. Self care. Adaptation, psychological.

Resumo

Fadiga por compaixão e estratégias de enfrentamento diante da finitude

A fadiga por compaixão é uma ameaça à saúde mental de profissionais de saúde diante da dificuldade em manejar a empatia. Assim, buscou-se verificar na literatura científica a correlação entre a fadiga por compaixão e a atuação de profissionais em unidades hospitalares que lidam constantemente com a morte, considerando estratégias adotadas para autocuidado. Realizou-se revisão integrativa da literatura, que identificou 11 artigos, nas bases de dados MEDLINE e PubMed, publicados entre 2011 e 2021. Constatou-se que a fadiga por compaixão ocorre com maior frequência em profissionais que lidam direta e recorrentemente com a morte, principalmente quando medidas distanásicas são adotadas. As principais estratégias de adaptação psicológica detectadas foram discussão de casos entre equipes, momentos de lazer e apoio de colegas, espiritualidade e meditação, além de uma liderança construtiva. Ressalta-se a necessidade de maior aprofundamento e novas pesquisas diante da escassez de estudos sobre o tema, principalmente no Brasil.

Palavras-chave: Fadiga por compaixão. Morte. Autocuidado. Adaptação psicológica.

Resumen

Fatiga por compasión y estrategias de afrontamiento ante la finitud

La fatiga por compasión es una amenaza para la salud mental de los profesionales de la salud ante la dificultad para gestionar la empatía. Se buscó en la literatura científica la correlación entre la fatiga por compasión y el trabajo de los profesionales en unidades hospitalarias que lidian constantemente con la muerte considerando las estrategias adoptadas para el autocuidado. La revisión integradora de la literatura realizada identificó 11 artículos en las bases de datos MEDLINE y PubMed, publicados entre 2011 y 2021. La fatiga por compasión se presenta más en los profesionales que lidian directa y recurrentemente con la muerte, especialmente durante la adopción de medidas de distanasia. Como principales estrategias de adaptación psicológica destacan la discusión de casos entre equipos, el tiempo libre y apoyo de los compañeros, la espiritualidad y meditación, y el liderazgo constructivo. Son necesarias más investigaciones a fondo dados los escasos estudios, especialmente en Brasil.

Palabras clave: Desgaste por empatía. Muerte. Autocuidado. Adaptación psicológica.

Research

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Until the late 17th century, the function of so-called hospitals was to house poor people who were transitioning from life to death, thus separating these sick and marginalized individuals from the rest of the population. With the advancement of technology, wars and epidemics, medical practice came to prevail over human worth and gained a new perspective with the advent of capitalism: people were now viewed as investment and the hospital structure became a therapeutic instrument intended for disease treatment and control [1].

This field of activity includes healthcare providers from different areas whose goal is to assist in the physical and mental recovery of patients. However, in certain situations, these professionals face recurring adverse situations, such as worsening health conditions, death and family suffering. This context leads to the emergence of subjective issues which require emotional management skills lest the pain and suffering of others trigger health problems for those involved in caring for the patient, such as symptoms of anxiety, depression and burnout, negatively affecting their health and the provision of care [2].

Bonding and humanization are characteristics of the performance of individuals involved in health care. Such practices provide support for families and hospitalized patients, who experience uncertainty and distress when faced with the breakdown of their conception of an idealized world [3].

The building of bonds, sensitivity, empathy and scientific knowledge promotes a welcoming and assertive experience in the face of disease, improving the quality of care and relationships. This brings potential benefits and helps promote the well-being of the patient and others involved in the process [4].

Before defining the concept of compassion fatigue, it is worth highlighting the meaning of empathy, an important aspect of human relationships that is linked to the emotional resources of recognizing self and others. It can be defined as the ability to perceive and understand the context and experience of another person. Due to the complexity of its meaning, there is still no consensus among authors about its occurrence; however, empathy is multidimensional and includes several factors (cognitive, emotional, social and behavioral), being key to physician-patient bonding and health care [5-7].

Compassion, in turn, is defined as the ability to be aware of the suffering of others, generating concern, distress, the wish to alleviate suffering and willingness to help. More than a feeling, it can be understood as a guide to behavior [8]. Therefore, while empathy relates to the perception and understanding of the emotions and feelings experienced by someone, compassion is the action taken based on that understanding. In other words, it is empathetic behavior which drives the search for resolutions and interventions that help alleviate suffering and result in cooperative and altruistic action directed towards others when their pain is acknowledged [9].

The vulnerability and suffering to which they are exposed, combined with work overload and the difficulty in managing feelings and emotions, may wear down healthcare providers and cause burnout, making it impossible for them to perform effectively and leading to compassion fatigue [2]. It is noteworthy that the conception of compassion fatigue described by Figley [10] is currently the most commonly used in the scientific literature, as this concept is absent from the *Diagnostic and Statistical Manual of Mental Disorders*, better known as DSM [11].

According to the DSM, post-traumatic stress disorder (PTSD) relates to situations in which people are directly affected by stressful events (violence, illness or accidents) [11]. However, compassion fatigue differs from the aforementioned disorder for being a kind of suffering that is caused indirectly.

It is important to mention that, linked to the previous concepts, burnout often appears in texts on compassion fatigue and is defined as a feeling of emotional exhaustion, depersonalization and reduced feeling of reward from work and personal achievements [12]. Therefore, it is emotional and physical exhaustion accompanied by a feeling of professional disqualification.

This means that, due to chronic stress, performance that could previously generate satisfaction and motivation becomes an exhausting and unpleasant event which, in more serious cases, may cause illness. This situation is characterized as part of compassion fatigue, in its physical dimension, affecting the performance of healthcare providers in situations that require empathy[13].

The constant exposure of healthcare providers to loss and death indicates the need to develop psychological adaptation and coping strategies. The concept of coping is defined by four main characteristics: 1) *interaction between the individual and the environment*; 2) *its function is to manage the stressful situation rather than control or dominate it*; 3) *coping processes presuppose the notion of evaluation, that is, how the phenomenon is perceived, interpreted and cognitively represented in the individual's mind*; and 4) *through the coping process, individuals undertake cognitive and behavioral efforts to manage (reduce, minimize or tolerate) the internal or external demands that arise from their interaction with the environment*[14].

According to the reviewed literature, in terms of support and self-care, healthcare providers usually resort to social support, problem solving, emotional management, avoidance of situations considered stressful/unnecessary, and reevaluation of behavior based on context and acceptance. Thus, individuals take responsibility for solving the problem they face, preserving the two main objectives of coping: changing the problem's trigger and controlling their emotional response to the conflict[15].

The constant exposure of healthcare providers to terminal illness makes it necessary to explore and understand their experiences in facing end of life. Considering the context of performance and culture, it is important to reflect on possible self-care strategies in order to develop institutional behaviors and facilitate personal strategies, so as to avoid probable occupational illness and poor quality of care offered to patients.

Considering this context, this study aimed to investigate the occurrence of compassion fatigue in healthcare providers who constantly deal with end of life in adult healthcare centers, as well as possible coping and psychological adaptation strategies, through the analysis of the scientific literature.

Method

A search was carried out in the MEDLINE and PubMed electronic databases with the following descriptors: "*compassion fatigue* and *death* and *coping* or *self-care*." The inclusion criteria were: 1) qualitative and/or quantitative field study with healthcare providers; 2) carried out in the context of adult health care; and 3) time frame between 2011 and 2021. The exclusion criteria were: 1) bibliographic review; 2) carried out in a neonatal and pediatric context; 3) scale validation study; and 4) experience report. Only full articles were selected, in any language, and data were cross-referenced to avoid duplication (Figure 1).

Following this step, the records were broken down by type of study, sample, method, research site and goals (Chart 1).

Figure 1. Article selection flowchart

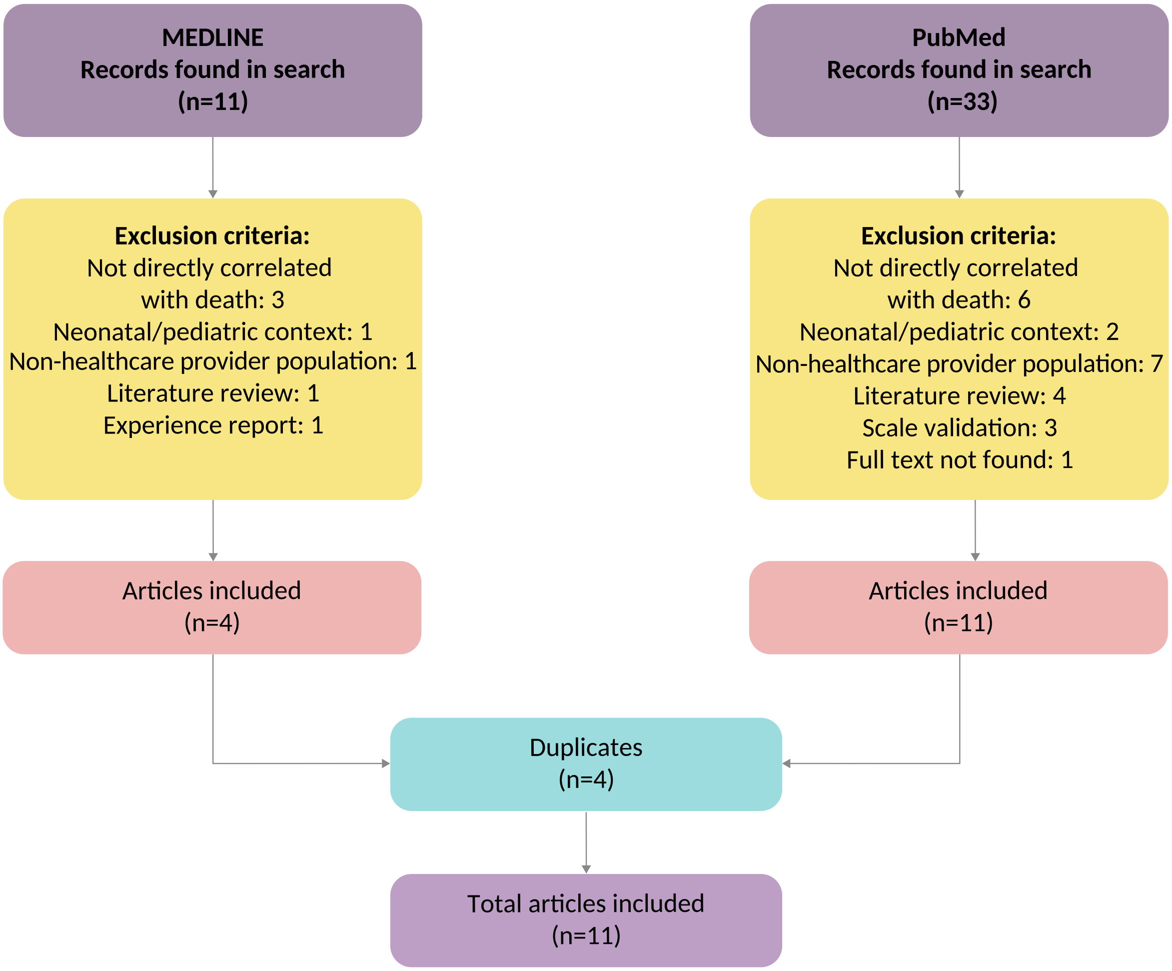

Chart 1. Breakdown of selected articles

Authors; year	Type of study	Sample/method/site	Objectives
Oliver and collaborators; 2021[16]	Qualitative and quantitative descriptive cross-sectional study	817 palliative care professionals from Spain, Argentina and Brazil answered the open-ended question: "Have you ever had specific training to cope with suffering and death?". Scales used: Professional Self-Care Scale (PSCS), Mindful Attention Awareness Scale (MAAS) and Professional Quality of Life Scale (ProQOL).	To offer evidence on the generalization of the self-care awareness model developed by Kearney and possible compassionate attitudes of participating professionals.
Laor-Maayany and collaborators; 2020[17]	Quantitative correlational cross-sectional study	64 Israeli oncologists completed self-administered questionnaires on compassion fatigue, compassion satisfaction, sadness, exposure to suffering and death, and feelings of failure.	To explore associations of compassion fatigue and compassion satisfaction with oncologists' grief and feelings of failure, as well as reported exposure to suffering and death.

continues...

Chart 1. Continuation

Authors; year	Type of study	Sample/method/site	Objectives
Pattison, Droney, Gruber; 2020 [18]	Quantitative descriptive cross-sectional study	The Maslach Burnout Inventory was administered to 63 members of an intensive and palliative care team in the United Kingdom, who were also interviewed with open-ended questions about support measures.	To explore the occurrence of moral distress in areas of high risk of physical and emotional exhaustion with oncology professionals, in addition to possible measures to deal with moral distress.
Phillips, Volker; 2020 [19]	Qualitative exploratory cross-sectional study	Semi-structured interviews with seven nurses from the United States who work in oncology.	To explore emotional development during nursing work in oncology.
Chang; 2018 [20]	Quantitative correlational exploratory cross-sectional study	Analysis of 323 questionnaires answered by nursing professionals from Taiwan, corresponding to the administration of the Death Coping Self-Efficacy Scale and the Social Support Scale.	To explore how social support impacts the nursing team's ability to cope with death at work.
Grech, Depares, Scerri; 2018 [21]	Qualitative exploratory cross-sectional study	Semi-structured interviews were carried out with five nurses who work in hematologic oncology in the US.	To explore experiences of hematologic oncology nurses who work directly with patients undergoing end-of-life care.
Ko, Kiser-Larson; 2016 [22]	Qualitative and quantitative descriptive cross-sectional study	40 nurses and nursing assistants from an oncology outpatient clinic in the United States participated in an open interview, demographic questionnaire and administration of a scale (Nursing Stress Scale).	To identify stressors in nurses working in oncology, exploring coping behaviors.
Pereira and collaborators; 2016 [23]	Quantitative comparative cross-sectional study	Nationwide study carried out in Portugal using the following instruments: Maslach Burnout Inventory-Human Services Survey, questionnaire on work experiences and ethical decisions, and questionnaire on sociodemographic and professional characteristics. 355 healthcare providers from ten intensive care units and nine palliative care units took part in the study.	To identify and compare burnout levels among professionals working in intensive and palliative care units and assess which work experiences are associated with burnout.
Sansó and collaborators; 2015 [24]	Quantitative exploratory cross-sectional study	Analysis of an online survey with 387 Spanish palliative care providers, using demographic data and the Mindful Attention Awareness Scale, Coping with Death Scale and Professional Quality of Life Scale.	To better understand the relationship between professionals' psychological aspects through the evaluation of an adaptation of Kearney's model of consciousness.
Mason and collaborators; 2014 [25]	Quantitative correlational descriptive exploratory cross-sectional study	26 nurses working in an intensive care unit in the United States took party in the survey by the total/partial administration of four scales.	To examine the effect of compassion satisfaction, compassion fatigue, moral distress and level of nursing education on the engagement of nurses in critical care.
Zambrano, Chur-Hansen, Crawford; 2014 [26]	Qualitative exploratory cross-sectional study	Seven Australian physicians specializing in palliative medicine took part in an open interview, individually.	To investigate experiences, coping resources and impact on dealing with death and dying in palliative care physicians.

Results and discussion

Forty-four articles were found in the aforementioned databases by using the descriptors. The PubMed database presented the highest number of results, with 33 articles, followed by MEDLINE, with 11 articles. Following the exclusion of four duplicate articles, also discarded were literature reviews, scale validations, research with non-healthcare provider populations and articles that did not address compassion fatigue associated with end of life. In total, 11 articles were compatible with the goal of this study.

Of the articles included, only three used a qualitative approach; the other eight were quantitative studies, the most commonly used method for the reviewed subject. Although all articles found were in English, the studies were conducted in different sites: four in the United States; a multicenter study that included Spain, Brazil and Argentina; one in Australia; one in Israel; one in Taiwan; one in Spain; one in the UK; and one in Portugal. Of the 11 articles, six were predominantly carried out with women, two mainly with men and the other three studies did not consider the “gender” characteristic in their samples. (Table 1).

Table 1. Breakdown of characteristics

Articles	Profession (participants)	Working area	Women	Men
2021[16]	Physicians (339) and nurses (198)	Palliative care	652	154
2020[17]	Psychologists (138) and nursing assistants (18)	Oncology	N/A	N/A
2020[18]	Social workers (59) and others (65)	Intensive care unit (39)	14	48
2020[19]	Physicians (74)	Palliative care (24)	6	1
2018[20]	Physicians (18), nurses (39) and others (7)	Oncology	306	17
2018[21]	Nurses (7)	General practice (142) e intensive care unit (52)	5	0
2016[22]	Nurses (323)	General surgery (65)	40	0
2016[23]	Nurses (5)	Palliative care (9)	271	121
2015[24]	Nurses (40)	Oncology (24) and gynecology (7)	N/A	N/A
2014[25]	Physicians (100) and nurses (292)	Nephrology (24)	N/A	N/A
2014[26]	Physicians (169) and nurses (128)	Hematologic oncology	2	5

Most participants are nurses (49%), followed by physicians (33%). The other professions, such as psychologists (9%), social workers (3.6%), nursing assistants (1.6%) and others (3.3%), accounted for just over 1/6 of the interviewees, considering all studies. The working area with the highest recurrence was palliative care (62.4%), followed by intensive care units (ICU) (19.5%), oncology (6.7%) and general practice (6.6%). General surgery, gynecology, nephrology and hematologic oncology had a percentage of less than 3% of respondents.

After a comprehensive reading of the articles, three main categories emerged that correlate with the goal of this study: 1) feelings experienced when faced with the death of patients; 2) correlation between compassion fatigue and end of life, differences and comparisons; and 3) personal and institutional self-care proposals and death competence.

Feelings experience when faced with the death of patients

The following behaviors and feelings were identified in healthcare providers faced with dying patients: helplessness[17,21], resilience[21], cynicism[18,23], insensitivity[18], difficulty in expressing emotions[18], burnout[18,22,23], crying[21,22,26], sadness[21,22], distress[22], depressive symptoms[22,23] and guilt[26]. One notes a range of feelings and behaviors reported by the authors, with slight variation in the studies. Sadness and subsequent crying to be more frequent, in addition to job burnout.

The emotional reactions described in the results are in line with several studies on emotional reactions to dying [27,28]. It is understood that feelings of failure, sadness and distress are directly linked to professional unpreparedness, due to faulty academic training and difficulty in managing emotions in the intense bonding with patients in the end-of-life process. On the other hand, it is worth highlighting that in Brazilian culture, bonding is intense and suffering is forbidden.

Crying was not perceived as a negative reaction, even in the presence of the patient and family, and it was observed that being aware of patients' characteristics and prognosis helped with emotional reactions [26]. Patient age was highlighted as a trigger for suffering, especially due to personal identification and the notion that patients had "a whole life ahead of them" [21]. However, such personal identification can be considered a negative or neutral aspect, depending on the professional' self-care management [26].

Viewing crying and suffering as natural reactions reveals emotional readiness and death competence. It also demonstrates that healthcare providers who are capable of coping with death are equipped not only with practical and theoretical knowledge, but also with their self-knowledge of experiences and feelings triggered by dealing directly with death, reflecting their own finitude and that of people they care for.

The negative aspects of performance included management of relationships and contexts that are considered hard, such as: difficulty in achieving total control of patients' symptoms in the process of dying in some cases, decisions related to dysthanasia, lack of advance directives of patients and family members, and invalidation of notes regarding patient care by the medical team [21,22,26]. Exclusively medical therapeutic decisions are still negative triggers of compassion fatigue, which is corroborated by studies, revealing that centralizing decision-making on physicians, ignoring other professions, causes frustration and a feeling of impotence [29-31].

Guaranteeing quality of life for terminally ill patients requires considering interventions by a multidisciplinary team and their diverse knowledge. Their multiple perspectives make it possible to address the totality and complexity of human suffering, with technology focused on healing while the patient is placed at the center of care [32].

Therefore, centralizing decision-making on physicians means perpetuating the doctor-centered culture, which also causes suffering to this professional category due to its intrinsic limitations. In this sense, a more comprehensive view, empathetic listening and co-responsibility are required, not only with other healthcare providers, but also with patients and families, through discussions and dialogue [30-33].

High workload, lack of support and inadequate preparation were also identified as stressful factors, but to a lesser extent [22]. The issues make people leave their jobs, generating costs with the training of new professionals [21]. Thus, poorer quality of work, absenteeism and professional turnover are viewed as harmful to companies in financial terms and to the actual state health system, with early withdrawals and public spending on health [30].

Correlation between compassion fatigue and end of life

Few studies significantly characterized the studied sample, but those that did reported contrasting results. One of the studies pointed out that professional experience showed no significant difference regarding "coping with death" [1], yet another identified that, at the beginning of the professional career, there is greater difficulty in dealing with the death of patients, increasing the risk of developing compassion fatigue [19]. Therefore, it is not possible to determine trait differences, such as gender or age, that relate to the greater or lesser probability of experiencing this type of suffering.

In investigating the hypothesis that compassion fatigue and burnout are interconnected—with compassion satisfaction remaining independent, without no interconnection with compassion fatigue—it became clear that the generalization of this relationship can be conflicting. Cultural aspects interfere in the coping process and, consequently, in job satisfaction, with the possibility of both situations being experienced simultaneously, compassion fatigue and compassion satisfaction [16].

The studies [16,18,23,24] showed relationships that should not be generalized, especially regarding specific training for death-related care and the simultaneous experience of compassion satisfaction and burnout. Subjective and cultural aspects may be associated with the outcomes, so that despite healthcare providers experiencing suffering, with feelings of guilt and failure, they do not necessarily present compassion fatigue, perhaps because they do not recognize such characteristics as being negative to professional practice, but rather as expected in the context [17].

Linked to the previous hypothesis, it is also worth highlighting the assumption that belonging to a palliative care team enables greater satisfaction due to compassion in relation to other areas. On the other hand, although intensive care staff have greater chances of experiencing burnout, especially in terms of exhaustion and depersonalization, they also present greater compassion satisfaction in their work [18,23]. The authors were unable to define possible factors, but they considered that the work environment and social support between professionals are indicators of the sense of reward experienced by intensivists in their everyday professional lives, influencing their ability to cope with death [16,20].

The main reasons reported by participants regarding job burnout were night work, conflicts with other professionals, patients and family members, and the experience of patient death [23]. On the other hand, palliative care staff stressed that professional fulfillment depends mainly on the possibility of a comprehensive view of the patient, symptom control and a peaceful death, that is, without unnecessary invasive measures, enabling emotional support for patients and families [26].

In research carried out in Brazil, one notes that cultural factors significantly interfere in the way in which healthcare providers manage care when faced with end of life, considering that medicine in South America is characterized by a strong paternalistic component, as happens in the south of Europe. According to Lago and collaborators [33], the culture of these countries, including Brazil, inclines to the view that life must be preserved at any cost, undervaluing patient autonomy and privileging decisions made by the medical team.

Thus, performance is based on the concept of beneficence and motivated by the cultural and moral values of each team when faced with *complex decisions that involve cultural conflicts, emotional trauma, questioning of personal values and even fear of legal action* [34].

The practice of dysthanasia can be avoided if healthcare providers have technical and emotional training and competence, as well as flexibility to discuss dying and adopt more appropriate behavior towards end-of-life patients. To this end, the actual treatment plan can be discussed with the multidisciplinary team, including the points of view of each professional, from an expanded care perspective [35]. Empathetic and genuine dialogue with the patient, family and team is an important tool to avoid harmful practices, not only for the patient but also for everyone involved in providing care.

Self-care and death competence proposals

The studies suggested psychological interventions, such as therapeutic groups, discussion spaces and debriefing [18,22,26], as a way to alleviate distress and improve the relationship between healthcare providers and patients [17,21]. Appreciating professional performance and constructive leadership were also highlighted [17,18], as well as psychological support from co-workers, moments of relaxation with patients and staff, improved sleep and nutrition, practicing spirituality, meditation and recreational activities [18,20,22,26].

The construction of meaning about the life cycle, personal learning and participation in funerals were described in a study and considered important aspects for the provision and continuity of support and comprehensive care. The possibility of dealing with professional grief by attending funerals with the family proved to be an opportunity to reflect on professional and personal experiences and an appropriate closure for the relationship between healthcare provider, patient and family, contributing to better quality of self-care [26].

Once again, the cultural aspects involved in palliative patient care and their characteristics, such as age, are highlighted. The moral perceptions that pervade suffering in the face of death, especially of younger patients, raise questions about the ideal of death. This is mainly related to theories that say that children are incapable of coping with their death, due to their cognition and the fact that adults *had the opportunity to enjoy life and achieve fulfillment, while the same condition was not possible for the child* [36], generating strong emotional reactions.

Specific training for palliative care made it possible to improve understanding and behavior related to care for end-of-life patients. Most studies suggest continuing professional training and introduction of new professional self-care strategies, including constant updating and evidence-based health practices, as a way to provide quality care. Thus, the team is helped to develop coping skills in contexts of intense suffering in order to reduce the possibilities of burnout and fatigue [16,19,20,23,25,26].

Only two studies mentioned that specific training in palliative care showed no significant difference in coping with end of life. However, the cultural aspect should once again be brought to bear, as such results came from Spanish healthcare providers [15,23]. In Spain, palliative care is more widespread and, according to the authors themselves, extensive training for healthcare work in higher education, associated with a culture that addresses death-related issues more often, helps professionals feel properly qualified and not associate their suffering with a lack of theoretical knowledge.

According to research by Chan and Tin [37], death competence is considered a skill that involves practical, personal, existential, emotional and environmental competence. It can be said that professional experience, initiative in learning, teamwork, expanded perception, creativity, concern, flexibility and compassion are key to the development of this soft skill, to which is associated the understanding of the inevitability of death and the limits of human existence.

The studies in this review emphasize that competence in coping with death led to higher levels of compassion satisfaction, providing a shield against fatigue and burnout [16]. The findings confirm the idea that self-care and expanded perception are important factors in coping with death and directly linked to the quality of life of healthcare providers and patient care [24]. Also stressed is the need for more studies on the subject and functional strategies.

Generally speaking, Brazil and the other countries involved in the reviewed studies emphasize the importance of continuing training and studies in palliative care and thanatology. The end-of-life process requires healthcare providers to be prepared not only in terms of practical skills, but also of other skills related to death with the aim of enabling a comprehensive view of end of life and the care of patients, family and staff [38].

In this sense, it is noteworthy that the lack of teaching of and educational approaches to palliative care in health-related undergraduate studies prevents the acquisition of essential knowledge [38] at both professional and personal levels. Therefore, these topics should be urgently introduced in curricula, providing empathy and required skills.

Final considerations

It is concluded that coping with terminally ill patients on a constant basis may trigger compassion fatigue in healthcare providers, especially when dysthanasia measures are associated with care. Futile measures raise moral misgivings in professionals and a feeling of invalidation when faced with decisions that are still predominantly medical.

The main coping strategies adopted were debriefing (a moment of reflection and discussion of practices and cases) and integrative practices such as meditation, moments of relaxation as a team and support from colleagues, in addition to constructive leadership. Professional training for the care of dying patients is highlighted as an important aspect in the prevention of compassion fatigue and care management, especially in countries that are still developing effective palliative care practices, considering their cultural context. Finally, the need for more studies on the topic is highlighted, especially in Brazil.

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Aline Aparecida Cardoso did the research, wrote and analyzed the paper during the multidisciplinary residency in Intensive Care at Universidade Federal de São Paulo. Samantha Mucci revised the the research, and Daniere Yurie Vieira Tomotani co-supervised the research; both made pertinent corrections to the text and approved the final article.

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