Trauma, Compassion Fatigue, and Burnout in Nurses: The Nurse Leader's Response

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Within health care, trauma-informed care has become an embedded approach in caring for patients; however, nurse leaders are not always prepared to lead nurses with a background of trauma. Nurses' past trauma, coupled with workplace stressors, may result in compassion fatigue, burnout, and secondary traumatic stress. Nurse leader engagement and trauma-informed leadership approaches are imperative to mitigate and mediate the effects of trauma in nurses as the COVID-19 pandemic recedes.

When I attended nursing school in the early 1990s, trauma-informed care was not a defined concept. I learned about trauma-informed care in 2017 as a nursing faculty member while participating in a colleague's undergraduate course lecture. Although my own undergraduate education included instruction on empathy, compassion, and patient advocacy, I realized trauma-informed care was the link I had been missing in my approach to patients as both a faculty member and a practicing emergency department nurse. In recent discussions with other nurse leaders and colleagues, I have found that there are gaps in knowledge on trauma-informed care for those who attended nursing school more than 10-15 years ago. This article will give a synopsis of what I have learned about trauma-informed care, the impacts of trauma and trauma-informed care on nurses, and the development of resilience in nurses. As a new hospital-based nurse manager, I will also discuss how I am learning to translate trauma-informed care practices into the leadership role.

WHAT IS TRAUMA-INFORMED CARE?

Trauma-informed care has emerged and evolved over the past 20 years as a response to the landmark Adverse Childhood Events (ACEs) study.[1] Felitti et al.[2] defined ACEs as "childhood emotional, physical, or sexual abuse, and household dysfunction during childhood." Household dysfunction was further delineated as witnessing violent acts against one's mother, living with a family member who used illicit substances or alcohol, having a household family member who was imprisoned, or living with a family member who had a mental illness or who was suicidal.[2] ACEs are pervasive, and it is estimated that 55%-90% of the current U.S. population has experienced at least one form of childhood trauma.[3] Of the 55%-90% who have experience childhood trauma, many have experienced as many as five traumatic events in their lifetime.[3] Long-term outcomes of ACEs are an increased risk of developing chronic illnesses such as cancer, ischemic heart disease, and chronic lung disease, as well as higher rates of depression, alcoholism, drug abuse, and suicide in trauma survivors.[2]

The Substance Abuse and Mental Health Services Administration established the National Center for Trauma-Informed Care in 2005 after recognizing a need for care delivery which includes a trauma-informed framework at its core.[1] This framework assists health care professionals in viewing patients and clients through the lens of past trauma, using the mindset and verbiage of "what has happened to you,"

KEY POINTS:

1. **Nurses and healthcare professionals may be impacted by Adverse Childhood Events and trauma, both personally and professionally.**
2. **Adverse Childhood Events and trauma play a role in compassion fatigue, burnout, secondary traumatic stress, and resilience in nurses.**
3. **Trauma-informed approaches and self-care in nurse leaders are imperative for effective leadership.**

rather than "what is wrong with you."[4] A trauma-informed approach also allows the trauma survivor to define his/her own traumatic experience and resultant stress.[1] This shift in patient approach and health care provider mindset serves to decrease retraumatization of the patient and provide psychological safety in patient care.[1]

HOW ARE NURSES AFFECTED BY TRAUMA AND TRAUMA-INFORMED CARE?

Nurses and health care providers are not immune to ACEs, trauma, and traumatic stress. Current literature postulates that ACE scores among nurses mimic those of the population, with some studies suggesting that nurses may have higher rates of ACEs than the general population.[5,6] Nurses who have a history of childhood trauma and who work in high-acuity settings are at risk of being retraumatized through exposure to stressful situations, leading to anxiety, depression, post-traumatic stress disorder, compassion fatigue, and burnout.[7] The implementation of trauma-informed care by nurses, particularly in patient populations with high levels of trauma, can also lead to compassion fatigue and burnout.[8] These feelings of compassion fatigue and burnout are associated with negative work performance, nurse turnover, increased financial burden for employers, decreased patient satisfaction, and worsened quality of care delivery.[7,9,10]

Compassion Fatigue

Compassion fatigue is the "phenomenon of stress resulting from exposure to a traumatized individual rather than from exposure to the trauma itself."[11(p1)] Signs of compassion fatigue include physical and emotional exhaustion, increased anxiety, anger, irritability, intimacy issues, and irrational fears.[11,12] Nurses may display decreased sympathy and/or empathy toward patients and coworkers and may express dread in working with certain clients or patients.[11,12] Negative coping behaviors, including drug and alcohol abuse, may emerge along with decreased job satisfaction. Nurse leaders may notice that staff members demonstrate increased use of sick days and/or paid time off and higher rates of absenteeism.[11,12] In contrast to absenteeism, *presenteeism* is the physical presence of a nurse or health care provider on the job when they should not report for duty due to illness or job-related stressors.[13] Nurses have the highest rates of presenteeism in the workforce, which is linked to poor patient outcomes and decreased patient safety.[13]

Health care providers at the highest risk of experiencing compassion fatigue are younger nurses and nurses with 2-5 years of experience.[14] Compassion fatigue in younger or inexperienced nurses may lead to decreased retention, increased turnover, and the intent to leave the nursing profession entirely.[14] Nurses who are exposed to chronic stressors and traumatic patient experiences are also at an increased risk for experiencing compassion fatigue, as are nurses who work in medical-surgical and pediatric inpatient departments, outpatient home health, and those who practice in rural settings.[15–17] Workplace incivility and higher patient-to-nurse staffing ratios are also associated with higher rates of compassion fatigue and burnout in nurses.[15]

Burnout

Dr. Beth Hudnall Stamm's original research on Professional Quality of Life proposed that burnout is a byproduct of compassion fatigue, yet the two are not synonymous.[18] Burnout tends to have a gradual onset, whereas compassion fatigue may present more rapidly or suddenly.[19] Burnout, or burnout syndrome, is often characterized by feelings of hopelessness, emotional exhaustion, lack of self-efficacy, depersonalization, and decreased productivity in the workplace and is thought to be caused by prolonged exposure to workplace stressors and events.[20,21] Studies have demonstrated that burnout is present in as many as 40%-75% of health care professionals and is not isolated to nurses.[12] The literature estimates that as many as 12% of physicians suffering from burnout syndrome struggle with suicidal thoughts, and the rate of completed suicide among medical students is twice that of the general population.[12]

Nurses at an increased risk for burnout are often those working in high-acuity, high-intensity environments such as critical care, oncology, and emergency nursing.[14,22–25] Prior to the COVID-19 pandemic, The Joint Commission[9] surveyed over 2000 nurses and found that 15.6 of those surveyed had feelings of burnout, with even higher rates among emergency room nurses. Charge nurses working in oncology and critical care also reported higher rates of burnout and secondary traumatic stress than staff nurses.[22]

Secondary Traumatic Stress

Secondary traumatic stress or secondary trauma, like burnout, is another outcome of untreated or unresolved compassion fatigue.[18] Secondary traumatic stress develops from exposure to patients with a significant history of trauma, similar to vicarious trauma.[14] Secondary traumatic stress in nurses is associated with sleep disturbances, anxiety, intrusive thoughts, and avoidance behaviors around reminders of trauma suffered by patients.[14]

Resilience

Resilience is thought to be a positive and protective mechanism for survivors of trauma,[26] described as one's ability to overcome, bounce back, or rebound from adversity.[7,13] In nurses, resilience provides a buffer from the stressors and challenges of the

workplace, increasing adaptability and ability to cope within the work environment.[7,9] The first step for nurses in developing resilience is recognition of their own ACEs along with past trauma and stressors.[6] This may be facilitated by nurse leaders mindfully educating nurses on ACEs and trauma-informed care. Nurses must then provide consideration to the impact their own past trauma has on their knowledge, skills, and attitudes in patient interactions and care delivery.

Resilience in nurses has become so crucial that the Future of Nursing 2020-2030 committee has included resilience in their work, recognizing that nurse well-being and resilience are vital parts of quality health care delivery.[27] Prior to the COVID-19 pandemic, The Joint Commission[9] authored their safety brief, *Developing Resilience to Combat Nurse Burnout*, discussing that nurses often provide care to others at a high personal cost. Additionally, many nurses report feeling a lack of support by administration and health care systems in addressing effective methods to reduce burnout.[9] The Joint Commission[9] recommended the focus of organizational leadership move to that of developing and improving resilience in nurses to combat burnout.

HOW DO WE TRANSLATE TRAUMA-INFORMED CARE INTO LEADERSHIP?

In a recent editorial, Dr. Rose Sherman recently challenged nurse leaders to consider the effects of primary and secondary trauma on nurses, instituting the same trauma-informed approach that nurses use when engaging patients and clients.[28] This approach is demonstrated by viewing nurses' attitudes and behaviors through the lens of "what has happened to you" instead of "what is wrong with you."[4,28] By implementing a trauma-informed leadership approach, the nurse leader has the opportunity to have a significant influence on nurse compassion fatigue and burnout.[19] Research has demonstrated that low levels of nurse manager support are significant predictors of burnout and compassion fatigues.[14,19] In contrast, authentic leadership, as exhibited through qualities of trustworthiness, compassion, reliability, and genuineness in nurse leaders and health care administrators, is associated with workplace satisfaction in nurses.[14,19]

Dr. Dawn Emerick recommends that nurse leaders view the COVID-19 pandemic as a form of trauma for frontline nurses and staff members.[29] I have observed that acute care nurses, now over two years into pandemic care, are exhibiting signs of compassion fatigue, burnout, and moral exhaustion, particularly after caring for COVID-19–positive patients who have had increased lengths of stay. Nurses are discussing moving out of high-acuity hospital settings, leaving their current place of employment for lucrative travel assignments, or even leaving the nursing profession entirely. A nurse who worked in the food service industry prior to graduating from nursing school told me that she missed her previous job and was picking up restaurant shifts during the pandemic, stating "At least when I work there, no one tries to die on me."

Nurse leaders must provide nurses and frontline staff encouragement and resources to help them process workplace stress and trauma and to engage in self-care. Recommended trauma-informed leadership approaches include the following:

- Encourage staff participation self-care activities while at work (e.g., journaling, walking, mindfulness, meditation, and gratitude activities)
- Invite a staff member to go on a walk at work and listen to his/her stories
- If staff members volunteer information about their own past trauma and its subsequent effects, consider their story in interactions with them, particularly in those showing signs of compassion fatigue and burnout
- Have crucial conversations with staff members who are exhibiting signs of compassion fatigue and burnout, offering a change of job duties or work assignment if possible
- Diversify or decrease staff workload, particularly in dealing with patients experiencing traumatic events or those admitted with COVID-19
- Support staff in having time off work, particularly on evenings, nights, and weekends, and have minimal work-related contact with staff on their days off
- Allow staff to take vacations and use paid time off when possible
- Encourage participation in debriefings after difficult or traumatic patient care experiences
- Educate and encourage staff to have professional boundaries with patients and their families
- Provide positive recognition of staff in ways that are personally meaningful to the individual staff members
- Acknowledge and reward staff members who are loyal to the organization (e.g., retention bonuses, extra shift bonuses)
- Encourage peer support, teamwork, and collaboration
- Empower and encourage staff in pursuing education, training, and professional development
- Support employee autonomy, shared decision-making, and sense of control in the workplace.[15,16,30,31]

Work-Related Injuries

Compassion fatigue and burnout, if left untreated, may lead to long-term emotional trauma, depression, and suicide in health care providers.[32] Therefore, compassion fatigue, burnout, and secondary traumatic

stress should be treated as on-the-job injuries or work-related injuries.[16,30] Nurse leaders should first attempt to mitigate the effects of compassion fatigue and burnout in employees by using approaches and strategies such as those listed earlier in the study.[30] If unable to mitigate, workplace mental health resources such as employee assistance programs should be instituted as soon as possible.[30]

HOW DO I DEAL WITH TRAUMA AS A LEADER?

Nurse leaders must first acknowledge their own past trauma and its impact on their mental health and leadership style. Additionally, nurse leaders must take time for self-care and find a healthy work-life balance.[33] I have found that walking 30 minutes each day, either on a treadmill or during breaks at work, has significantly improved my mindset and allows time for mental processing. Recognition of my own self-care deficit and work-life imbalance has served as a barometer in managing my compassion fatigue. Similarly, this same self-awareness in nurse leaders will help in recognizing signs and symptoms of compassion fatigue and burnout in staff members and other leaders, allowing for early intervention, offering of resources, and increased support.[12]

CONCLUSION

Many nurses have experienced trauma in their lives, including working through the COVID-19 pandemic. When previous trauma is combined with current workplace stressors, nurses are at risk of experiencing compassion fatigue and burnout, and the quality of patient care suffers. Hospital and health care leaders can positively affect nurse well-being through a trauma-informed leadership approach and by promoting practices to decrease compassion fatigue and improve employee resilience. Leadership behaviors that foster self-care and nursing resilience are imperative to maintain and strengthen the nursing workforce.[9]

REFERENCES

1. Wilson C, Pence DM, Conradi L. Trauma-informed care. *Encycl Soc Work*; 2013:1-23. https://oxfordre.com/socialwork/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1063. Accessed December 8, 2019.
2. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *Am J Prev Med*. 1998;14(4):245-258.
3. Fallot RD, Harris M. Creating Cultures of trauma-informed care (CCTIC): a self-Assessment and Planning Protocol. *Community Connections*. 2009;(Version 2.2):1-18.
4. Beattie J, Griffiths D, Innes K, Morphet J. Workplace violence perpetrated by clients of health care: a need for safety and trauma-informed care. *J Clin Nurs*. 2019;28(1/2):116-124.
5. Cogan RM. The relentless school nurse: ACEs impact nurses more than we realized! ACES in Education. 2019. Available at: https://www.acesconnection.com/g/aces-in-education/blog/the-relentless-school-nurse-aces-impact-nurses-more-than-we-realized. Accessed November 15, 2020.
6. Girouard S, Bailey N. ACEs implications for nurses, nursing education, and nursing practice. *Acad Pediatr*. 2017;17(7):S16-S17.
7. Ying LY, Ramoo V, Ling LW, et al. Nursing practice environment, resilience, and intention to leave among critical care nurses. *Nurs Crit Care*. 2021;(26):432-440.
8. Sales JM, Piper K, Riddick C, Getachew B, Colasanti J, Kalokhe A. Low provider and staff self-care in a large safety-net HIV clinic in the southern United States: implications for the adoption of trauma-informed care. *SAGE Open Med*. 2019;7:1-11.
9. The Joint Commission. Developing resilience to combat nurse burnout. Quick Saf. 2019. Available at: https://www.jointcommission.org/-/media/tjc/newsletters/quick_safety_nurse_resilience_final_7_19_19pdf.pdf?db=web&hash=552B3D44D99B02373F48D1FF464BFF27. Accessed November 15, 2020.
10. Girard SA, Hoeksel R, Vandermause R, Eddy L. Experiences of RNs who voluntarily withdraw from their RN-to-BSN program. *J Nurs Educ*. 2017;56(5):260-265.
11. Cocker F, Joss N. Compassion fatigue among healthcare, emergency and community service workers: a systematic review. *Int J Environ Res Public Health*. 2016;13(6):1-11.
12. Powell SK. Compassion fatigue. *Prof Case Manag*. 2020;25(2):53-55.
13. Bouchard L, Rainbow J. Compassion fatigue, presenteeism, adverse childhood experiences (ACES), and resiliency levels of Doctor of nursing practice (DNP) students. *Nurse Educ Today*. 2021;100:1-6.
14. Kelly L, Todd M. Compassion fatigue and the healthy work environment. *AACN Adv Crit Care*. 2017;28(4):351-358.
15. Bleazard M. Compassion fatigue in nurses caring for medically complex children. *J Hosp Palliat Nurs*. 2020;22(6):473-478.
16. Slatten LA, Carson KD, Carson PP. Compassion fatigue and burnout: what managers should know. *Health Care Manag*. 2020;39(4):181-189.
17. Sorenson C, Bolick B, Wright K, Hamilton R. Understanding compassion fatigue in healthcare providers: a review of current literature. *J Nurs Scholarsh*. 2016;48(5):456-465.
18. ProQOL. Secondary trauma. ProQOL. Available at: https://proqol.org/secondary-trauma. Accessed June 9, 2021.
19. 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):186-194.
20. Najib Kawar L, Radovich P, Valdez RM, Zuniga S, Rondinelli J. Compassion fatigue and compassion satisfaction among multisite multisystem nurses. *Nurs Adm Q*. 2019;43(4):358-369.
21. Cavanagh N, Cockett G, Heinrich C, et al. Compassion fatigue in healthcare providers: a systematic review and meta-analysis. *Nurs Ethics*. 2020;27(3):639-665.
22. Al-Majid S, Carlson N, Kiyohara M, Faith M, Rakovski C. Assessing the degree of compassion satisfaction and compassion fatigue among critical care, oncology, and charge nurses. *J Nurs Adm*. 2018;48(6):310-315.
23. Fahey DM, Glasofer A. An inverse relationship: compassion satisfaction, compassion fatigue, and critical care nurses. *Nurs Crit Care*. 2016;11(5):30-35.
24. Jakimowicz S, Perry L, Lewis J. Insights on compassion and patient-centred nursing in intensive care: a constructivist grounded theory. *J Clin Nurs*. 2018;27(7-8):1599-1611.
25. Storm J, Chen HC. The relationships among alarm fatigue, compassion fatigue, burnout and compassion satisfaction in critical care and step-down nurses. *J Clin Nurs*. 2021;30(3-4):443-453.

26. Pletcher BA, O'Connor M, Swift-Taylor ME, DallaPiazza M. Adverse childhood experiences: a case-based workshop introducing medical students to trauma-informed care. *J Teach Learn Resour*. 2019;15:10803. https://doi.org/10.15766/mep_2374-8265.10803.

27. The National Academy of Medicine. The Future of nursing 2020-2030. National Academy of medicine. 2020. Available at: https://nam.edu/publications/the-future-of-nursing-2020-2030/. Accessed November 15, 2020.

28. Sherman RO. Using a trauma-informed leadership approach. *Nurse Lead*. 2021;19(4):321-322.

29. Work Wellness Institute. Trauma informed leadership and change Management in support of work Wellness: thoughts to Inspire. 2021. Available at: https://www.youtube.com/watch?v=7NhDLFDjOb0. Accessed February 19, 2022.

30. Copeland D. Brief workplace interventions addressing burnout, compassion fatigue, and teamwork: a pilot study. *West J Nurs Res*. 2021;43(2):130-137.

31. Chapman G, White P. The 5 Languages of Appreciation in the Workplace. Northfield Publishing. 2019. Available at: https://www.5lovelanguages.com/store/the-5-languages-of-appreciation-in-the-workplace. Accessed March 20, 2022.

32. Kelly L. Burnout, compassion fatigue, and secondary trauma in nurses: recognizing the occupational phenomenon and personal consequences of caregiving. *Crit Care Nurs Q*. 2020;43(1):73-80.

33. Kelly L, Lefton C, Fischer SA. Nurse leader burnout, satisfaction, and work-life balance. *J Nurs Adm*. 2019;49(9):404-410.

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