LIBERTY UNIVERSITY
JOHN W. RAWLINGS SCHOOL OF DIVINITY

Compassion Fatigue and Burnout:
When Caring Becomes Too Much

Submitted to Professor Brent Kelly
In fulfillment of the requirements for the completion of
the Doctor of Ministry Degree

by

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March 2022
THE DOCTOR OF MINISTRY THESIS PROJECT ABSTRACT
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Liberty University John W. Rawlings School of Divinity, February 20, 2022
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The purpose of this DMIN thesis is to provide resources and education for clinical staff to recognize and reduce compassion fatigue and burnout. Compassion fatigue and burnout in hospice clinical staff is a sizeable issue. Clinical staff was defined as doctors, nurses, social workers, chaplains, and aides due to their direct and constant contact with dying patients. By providing resources and education on what compassion fatigue and burnout look like and the primary causes, the study aimed to help clinical staff in the hospice care setting to reduce the damage caused by compassion fatigue and burnout. Resources including counseling sessions, peer conversations, and a calming room were provided as outlets for staff to decompress stressful matters related to end-of-life care of patients and families. Research was collected through surveys and questionnaires by participants.
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ACH Ashland Community Hospice

DMIN Doctor of Ministry

IDT Interdisciplinary Team
CHAPTER 1: INTRODUCTION

Introduction

Compassion fatigue and burnout amongst clinical professionals is an abundant and pressing issue. However, within the context of end-of-life care, the problem becomes more concentrated. Because of the overwhelming presence of suffering, dying, and death, those working in the context of hospice are continually bombarded with the emotional, physical, and spiritual pain of others. In turn, the clinical staff becomes desensitized or over-stimulated, causing burnout and compassion fatigue. Due to the overwhelming amount of compassion fatigue and burnout present in Ashland Community Hospice, Inc., attention to this matter is pressing.

Chapter one will explore the ministry context of Ashland Community Hospice, Inc. (ACH), including the patients and their families, served locations, and clinical staff. The chapter will also discuss the problem to be explored and the purpose of exploring the issue. In addition, the study will address the limitations, delimitations, and assumptions. Finally, the chapter will conclude with the thesis statement.

Ministry Context

The ministry context for the project is Ashland Community Hospice, Inc. ACH is a team that provides care to the terminally ill. ACH is in Ashland, Kentucky, a city situated in the tri-state area of northeastern Kentucky, southern Ohio, and western West Virginia. The geographical location contains rolling hills, smaller mountains, and plentiful rural land. Ashland is a community housing over 20,000 people, with 92.5 percent of those residents describing their ethnicity as white, non-Hispanic.\(^1\) With the median household income just a little under $41,000,

Ashland has a poverty rate of 24.5 percent. In addition, Ashland has a solid Protestant representation among those who attend church. Over 54 percent of all residents attend a Protestant faith community.

Established in 1978, ACH is the first Medicare Certified Hospice Program in Kentucky. The care center was also the first inpatient freestanding hospice facility in Kentucky, which opened in 2004. In 2021, ACH was recognized as one in 57 hospices nationwide to receive the Hospice Honors Elite Award from HEALTHCAREfirst. ACH consists of two buildings, the main office and the care center. The care center is the inpatient facility with around-the-clock nursing, where hospice patients may be cared for at end-of-life, residentially, or symptom management. The clinical staff also serve in nursing homes and patient homes. Approximately 125 staff and 200 volunteers are a part of ACH. The staff number represents the clinical staff, the administrative staff, and the support staff. The two divisions of the clinical staff are the care center staff and the homecare staff. The administrative staff consists of an executive director, department directors, team leaders, payroll and billing, and other administrative positions. Support staff encompasses secretaries, cleaning, maintenance, and others within the home office departments. The volunteers serve in multiple locations, including the office building, the care center, nursing homes, and patient homes. The ministry context of ACH consists of three parts: the patients and their families, the locations, and the clinical staff. In addition, specific factors related to compassion fatigue and burnout are present in the ACH community.

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4 HEALTHCAREfirst awards Hospice programs nationwide the Hospice Honors title. Within those chosen, there is a sub-category of programs that receive the Elite status. For more information on these honors, as well as the list of recipients, see https://www.healthcarefirst.com/hospice-honors/.
The Patients and Their Families

The patients served in ACH are deemed to have six months or less to live based on a terminal diagnosis by their primary care physician. The primary determinate factor for being placed under hospice care is if the patient were to die in six months if their terminal illness ran the normal course with no aggressive treatment. Two doctors are involved in the decision to assess appropriateness for placement. Families decide to enlist hospice care when they do not wish for the patient to seek aggressive treatment any longer. If the patient can make that decision independently, he or she can do so under his or her authority. The only exception to not receiving aggressive treatments is pediatric patients, who may receive aggressive treatments while remaining under hospice care. Patients have varying diseases, including cancer, heart failure, and Chronic Obstructive Pulmonary Disease (COPD). Though the life expectancy is six months or less, some patients exceed that length.5 Also, while the expectation is that patients will die under hospice care, some patients are deemed no longer terminally ill by the interdisciplinary team and are therefore discharged from hospice care.

Patients’ ages also vary. According to the 2020 Annual Report for ACH, almost 91% of patients served were sixty years of age or older.6 The term for patients’ families encompasses parents, children, grandchildren, aunts, uncles, significant others, and friends. All are considered part of the patient-family support system. Due to the ever-changing structure of families in the United States, ACH accommodates whomever the patient calls family, though a power of attorney (POA) is always honored.

5 Information is collected from the personal census of Chaplain Ruth Cole at Ashland Community Hospice, Inc.
The patients served in the ACH are of all cognitive and physical abilities. Many patients are non-verbal or minimally verbal, partially or entirely incontinent, unable to feed or provide care to themselves, or have other physical and developmental limitations. The majority of the patients also have cognitive limitations, including dementia, Alzheimer’s, and brain deficiencies from cancer or injury. Despite this significant number, patients with complete awareness and ability are also in ACH care, even with diminished strength that comes with age or terminal illnesses.7

The demographics within the region the ACH serves, as mentioned above, are predominantly white, Protestant, and middle to lower class. The religious affiliation throughout the service area is primarily a variant of Baptist (Freewill Baptist, Southern Baptist, Independent Baptist), Pentecostal, and mainline Protestant. The political face of the area is overwhelmingly Republican and strongly conservative.8

Locations Serviced by Ashland Community Hospice, Inc.

Three locations receive care from ACH. These three areas are nursing homes, patient homes, and the care center. The nursing homes primarily comprise patients with limited cognitive and physical abilities, often having dementia or Alzheimer-related issues. Due to the strong reliance on others to provide personal and medical care, these patients reside in nursing homes. Nursing home patients receive weekly nursing visits, aide services two or three days a week unless more is needed, and once monthly social worker and chaplain visits. All are through hospice clinical staff.

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7 Information is collected from the personal census of Chaplain Ruth Cole at Ashland Community Hospice, Inc.

The patient homes are patients caring for themselves, families caring for patients, or in-home caregivers providing care for patients. While most hospice patients do not live alone, a few choose to live alone for as long as possible. During hospice care, patients residing at home receive once-a-week visits from a nurse and monthly visits from chaplains and social workers. Aide services vary significantly for in-home care patients based on needs, independence, and family ability. Patients can have aide services as little or as much deemed necessary between the families and interdisciplinary team (IDT), up to and including seven days a week.

The care center is an inpatient facility with fifteen beds, with one being a bariatric bed and another being a zero-pressure room. The admissions team can admit patients to the care center in three categories. First, the admissions team can directly admit patients from the hospital or from home for end-of-life care or symptom management. Patients directly admitted cannot immediately be managed at their homes or nursing home location and require more acute attention to their medical needs. The care at the hospice center includes around-the-clock nursing staff, daily aide services, intravenous medication, and a doctor present during daytime hours to make daily rounds and medication adjustments. Families can stay at the facility. During the onset of the coronavirus/COVID-19 pandemic, visitor restrictions were in place, varying from one visitor who was unable to come and go to four visitors at a time, with no limits on rotating in of other visitors. Patients who were COVID positive could have visitors, but they had to enter and exit from the back entrance. Assigned nurses could only care for patients who were COVID positive.

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9 The coronavirus pandemic reached the initial heights in the Ashland, Kentucky area in January of 2021. A continued down trend occurred as people followed mask mandates and stay-at-home requests. September 2021 saw a resurgence of the coronavirus pandemic as the delta strain arrived in the Ashland, Kentucky area.
Second, the admissions team can send patients to the care center from the hospital or from home to manage medicine or symptoms before returning to a home care or to a nursing home setting. As with the previous group, the patients cannot receive needed care in the home or nursing home settings they reside to properly manage their medical issues; therefore, the patient group requires admission to the care center for acute management. The around-the-clock supervision of nurses and aides with the daily rounding and medication monitoring by the doctor assists with symptom management. After achieving control of the symptoms, the patients return to the nursing home or their homes once again. Families can still visit the same patients admitted for symptom management as the previously mentioned group, with the same restrictions.

Third, patients receiving respite care are also residing at the care center. Respite care is a period of up to five days every benefit period that a patient may stay at the care center. With the respite benefit, family members can rest or address emergency issues. A benefit period is a time approved through Medicare stating that a patient has a terminal diagnosis that, following the normal course, would cause death within six months. Every benefit period, the IDT recertifies a patient following Medicare guidelines. The care provided to a patient residing at the care center for respite varies from the previous two categories. First, though the doctor is present and still does rounds to assess the patient, rarely are medication adjustments made. Though not usually needed, adjustments are possible. Second, aides still provide daily bathing. Nurses provide daily care, but acute care is not as necessary. Family is also allowed to visit, though it does not often happen. Because respite is needed to provide a break in care for the family, families often rest during these stays instead of visiting patients. Throughout the length of care with hospice, many patients encounter several of these contexts of service, if not all.
The service area ACH covers are nine counties, with an occasional outlying area. Three teams provide care within the hospice community: Team Greenup, Team Boyd, and Team Ohio. Team Greenup covers Greenup and Carter counties in Kentucky. Team Boyd covers Boyd, Elliot, Lawrence, Martin, and Johnson counties in Kentucky. Team Ohio covers Lawrence and Scioto counties in Ohio. The occasional West Virginia or outlying county patient will be admitted and cared for by the closest area team. These areas are similar in demographics, races, religion, and political stature to Ashland, Kentucky, in Boyd County. As mentioned above, Ashland and these surrounding counties are predominately rural areas with a high percentage of white ethnicity and the Protestant religion. In 2020, the average daily census for ACH was 172 patients, with 1126 patients served the entire year.\textsuperscript{10} The locations the patients receive care spread throughout the counties with in-home care and nursing home settings and the care center.\textsuperscript{11}

\textbf{Clinical Staff of Ashland Community Hospice, Inc.}

As mentioned before, ACH consists of three teams: Team Greenup, Team Boyd, and Team Ohio. Comprising each team is the IDT, which contains one doctor, three to five nurses, three to five aides, two social workers, and one chaplain. On Team Greenup and Team Boyd, the patient numbers for each IDT member are higher than Team Ohio; therefore, Team Ohio has fewer members of each category in the IDT. For Team Greenup and Team Boyd, each nurse has ten to fifteen patients at any given time. Each aide is assigned to a nurse and maintains a census of the same patients. The social workers on each team have a census of thirty to thirty-five


\textsuperscript{11} Ibid.
patients. The chaplains for these two teams have a caseload of sixty to seventy patients on average. Team Ohio has numbers close to half of the other two teams. The clinical staff has homecare patients and nursing home patients in each team. For the continuance of care, nurses, social workers, and chaplains stay connected to patients sent to the care center from home and nursing homes for symptom management, end-of-life, or respite, from their censuses. In addition, social workers and chaplains are assigned new direct admission patients to the care center that have not been assigned to home care clinical staff.

An on-call rotation for doctors, nurses, administrators, and chaplains is in place. For much of the nurse on-call rotation, a set team of nurses field all after-hour and weekend issues. Administrators and social workers work one weekend every six to eight weeks as on-call staff, and they are off work the Friday before the weekend. The social worker must work the Saturday morning for a four-hour shift during their on-call. Lastly, since only two full-time chaplains are serving ACH patients, the chaplains are on-call every other weekend, and often more if the other chaplain is unavailable that weekend. Chaplains are also on call every day throughout the week.

Specific Factors Within Ashland Community Hospice, Inc.

Within ACH, the factors that contribute to the growth of compassion fatigue and burnout among clinical staff are consistent patient turnover, high caseloads, and the inability to decompress as needed. The addition of the COVID-19 pandemic has also compounded the stress of the ACH staff. Due to the area’s nature, admission of patients often occurs when death is imminent. Because hospice care is a last resort to many, entry into the services is often too late. Instead of having the opportunity to provide patients with a positive dying experience and death with dignity, hospice clinical staff must provide imminent death care. Patients die within a short period of being admitted, often within weeks of admission, and the cycle of the new admissions,
death, new admissions, and death repeat over and over. COVID-19 diagnoses are so different that doctors are unsure of when to refer to hospice care in the first place. A constant need to learn new patients and their needs while seeing death consistently is a huge demand on hospice clinical staff. Clinical staff struggles to keep consistent care due to the continuous turnover of patients. Due to the compassionate nature of the majority of clinical staff, the persistent exposure to dying and death can cause a substantial burden on the emotional health of said clinical staff. The considerable burden can be a physical, emotional, or spiritual weight that pulls down the clinical staff, causing compassion fatigue and burnout.

The clinical staff also have high caseloads, requiring them to be in a compassionate state for an extended time. The high caseloads coupled with long driving times for many clinical staff members, with some patients being as far as an hour and a half drive from the office, provide a higher probability for exhaustion. With a high census, a long drive to each patient or between patients, an added strain is placed on the clinical staff to meet the requirements for seeing patients. For Team Boyd members who travel to Johnson, Lawrence, and Martin counties, patients live an average of thirty minutes away from one another and are at least an hour from many of the office and home place of many of the staff. Consistent travel and high caseloads provide a breeding ground for exhaustion, causing burnout and compassion fatigue to develop quickly.

Lastly, and most pressing, is the inability of clinical staff to decompress as needed. Within ACH, the staff has nowhere or no one to turn to when their compassion has led them to fatigue and burnout. Because of the constant need to care for patients and the time took to drive to patients and to document each visit, the clinical staff struggles to find time to work through the mental and emotional toll this type of compassionate care can cause. When the clinical staff’s
compassionate care becomes overwhelming, little to no time is available to take a break between patients due to the high caseloads. When those clinical staff members do have a moment, no outlet is accessible for the staff to turn. Often, the emotional and mental toll has nowhere to escape. Clinical staff often does not want to put undue stress and emotional toll on their families, and due to HIPAA issues, they are unable to share details of their patients’ that could help them decompress. When the COVID-19 pandemic began, restrictions added to workplaces would not allow the clinical staff to visit with one another as well. Unable to be in a break area together or ride in personal cars to patients’ homes together lessened the time available for the clinical staff to decompress to one another.

Problem Presented

The problem is that ACH clinical staff lack the methodology to recognize and to reduce compassion fatigue and burnout. Within Ashland Community Hospice, Inc., compassion fatigue and burnout are a common phenomenon due to the high level of exposure to suffering, dying, and death, as well as constant emotional and spiritual turmoil. The high turnover rate of patients due to death and the high caseload adds to the circumstances that produce compassion fatigue and burnout. Because death is physical, emotional, and spiritual, the clinical staff’s whole being is affected. Compassion fatigue, the emotional aspect of care, and burnout, the physical element related to care, are both serious issues that need to be recognized and addressed. In the ACH family, compassion fatigue and burnout is a possible reality, and the lack of an outlet for this reality causes it to flourish.

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Though familiar to most work areas, burnout is exceptionally high in elevated stress work environments. Though ACH provides excellent care for families during end-of-life, clinical staff have consistent stress related to the work environment. Some can be controlled, such as caseload, but others cannot, such as the compassionate care required of hospice clinical staff. Once the emotional aspects of watching those cared for die compound with the everyday stress, clinical staff in a hospice setting cannot fully work through or cope with the weight of the job. ACH experiences the uniqueness of this versus other healthcare settings because of the high death rate of patients. In addition, no resources exist for the staff to decompress, nor are there educational outlets on how to recognize and cope with compassion fatigue and burnout provided to staff who suffer from these issues. The clinical staff is left to assess their issues and find ways to cope. Due to the consistent turnaround of patients in one’s care, the staff member cannot adequately address the problems to continue working on the high caseload and demanding work responsibilities. Because there is no protocol in place, clinical staff face an incredibly high level of compassion fatigue and burnout.

Compassion fatigue and burnout present workplace problems, including lack of compassion and care for the patients, apathy for the job, and high turnover rate. When clinical staff members cannot cope, their care begins to decline. The clinical staff simply does not have the emotional capacity to put forth the effort in care. Clinical staff can then become frustrated with their job situation. High turnover rates can quickly compound due to the frustrations and inability to provide the care needed for their patients. ACH cannot handle the emotional and spiritual turmoil regularly facing death can cause within the clinical staff, and they lack the resources to help the staff with these needs. In addition to the workplace problems, compassion
fatigue and burnout can cause psychological effects on the workers, including depression, exhaustion, withdrawal, and lack of self-worth.

When clinical staff members face death and dying daily, the reminder of the finality of life can become heavy. People handle that heaviness differently, but the exhaustion of many forms set in without an outlet to express and decompress. While some may withdraw into themselves, others will express anger or emotional outbursts. The weight of compassionate care provided can pull on the clinical staff’s emotional, spiritual, and physical health, providing devastating effects. All these issues can be resolved or lessened by addressing the problem causing compassion fatigue and burnout. Education and resources build a strong foundation in combatting the issue of compassion fatigue and burnout.

**Purpose Statement**

The purpose of this DMIN thesis project is to provide resources and education to clinical staff to recognize and to reduce compassion fatigue and burnout. Hospice care is an essential aspect of providing dignified end-of-life care to those in the terminal stages of their lives. Being a clinical staff member of a hospice care team can severely burden the compassionate caregiver’s spiritual, emotional, and physical well-being. Providing resources and education that allow staff to recognize the signs of compassion fatigue and burnout in themselves and others will allow the staff to reduce the damage caused by these two issues. When a person can see the signs that point to compassion fatigue and burnout, he or she will be able to combat the oncoming matters more quickly.

Compassion fatigue and burnout are avoided and not addressed in many settings, including ACH. People are afraid that they are weak or unequipped for the job by addressing their stress from compassionate care. Not addressing the issues leads clinical staff to believe they
are alone in their feelings. The rewards can be monumental by providing the knowledge and resources for the clinical staff to recognize and to address these pivotal problems in their clinical context. Clinical staff will be aware that others are experiencing the same symptoms and issues, but they will feel more equipped to continue their work line. With better work ethic and motivation and better mental and emotional health of all those involved, the compassionate care provided by the clinical staff of ACH will provide effective end-of-life care. The clinical staff will provide adequate self-care to prevent or to lessen compassion fatigue and burnout in the future. By acknowledging the existence of compassion fatigue and burnout in their own lives and the lives of their coworkers, teamwork can strengthen among staff.

By the end of this thesis, clinical staff in the hospice care context should be able to identify compassion fatigue and burnout in themselves and their coworkers and address those issues appropriately and helpfully. The resources and education developed will provide this ability and empower the clinical staff to be better holistically, providing adequate emotional, spiritual, and physical care to themselves and to other clinical staff.

**Basic Assumptions**

The study makes three basic assumptions. One, the sample providing the information indicates hospice clinical staff as a whole. Though the clinical staff at ACH is limited to one geographic area, the assumption is that the work field is similar enough to those working in a hospice in other geographic regions to be pertinent to them. Despite the differing demographics of patients served and clinical staff providing the care, the setting is similar to end-of-life care. Providing care to those with terminal illnesses deemed to have six months or less has a common thread throughout hospices across the country. Also, hospice communities follow the same Medicare guidelines and accreditation expectations, making the workplace structure similar.
The second assumption is the staff providing the answers are providing honest feedback. Because of the personal nature of the questions, clinical staff will be providing answers based on their reality. While subjectivity comes into play in this type of research, an expectation of honesty of the participants is also present. With the nature of open-ended questions, the assumption also extends to whether the clinical staff understands the terms with given definitions, despite the subjectivity. Providing adequate education will explain the terms so that this assumption can remain.

The third assumption is that the clinical staff feel compassion fatigue and burnout is a real problem within the ACH community and needs addressing. To have honest and authentic participation, participants must see the reality of the issue at hand. Through the education portion, the hope is the overwhelming evidence of the presence of compassion fatigue and burnout will be apparent.

Definitions

Definitions necessary to explore are compassion fatigue, burnout, clinical staff, and census.

Compassion fatigue. Compassion fatigue is “negative cognitive and emotional consequences for the empathizer of feeling empathy.” The term refers to the emotional breakdown caused by continuous compassion, usually classified through physical exhaustion, headaches, indifference, emotional fatigue, and self-medication. In ACH, constant compassion is the care shown to patients with terminal illnesses through end-of-life care.

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13 Eric M. Hansen, Jakob Hakansson, Anna Hallen, Carmen Stockman Bjurhager, Emil Norrstrom, Adam Viman, and Eric L. Stocks. "Does Feeling Empathy Lead to Compassion Fatigue or Compassion Satisfaction? The Role of Time Perspective." The Journal of Psychology 152, no. 8 (October 2018); 632.

**Burnout.** Burnout refers to “a general construct describing a reaction to work-related stress.”\(^{15}\) Burnout is the disillusionment of the workplace, characterized by a lack of work ethic, no longer caring about work responsibilities, non-compassionate care, and anger.\(^{16}\) The high census and patient turnover rate illustrate burnout in the ACH context.

**Clinical staff.** Clinical staff, in the case of this paper, refers to the following:

- Doctors, whether it be the medical director or assistant medical director
- Nurses, whether in the home care setting or the care center setting
- Aides
- Social workers
- Chaplains

These staff members have direct patient care and direct contact with patients and their families.\(^{17}\) The clinical staff does not include the administrative staff due to minimal contact with patients. The support staff also has an inconsistent connection with patients and families.

**Census.** Census refers to the caseload in which the administrative staff assigns patients to the clinical staff. The census consists of every patient that clinical staff member provides are to physically, emotionally, or spiritually.\(^{18}\) The number varies depending on the discipline.

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\(^{15}\) Kathleen LeDoux, "Understanding compassion fatigue: understanding compassion." *JAN* (2015); 2043.

\(^{16}\) LeDoux, “Understanding compassion fatigue,” 2043.

\(^{17}\) Ashland Community Hospice, Inc. Employee Handbook.

\(^{18}\) Ashland Community Hospice, Inc. Employee Handbook.
Limitations

The limitations of this study are as follows: 1) the demographics of survey participants, 2) the work ethic mentality of the area, and 3) the taboo of mental health in the area.

In Eastern Kentucky, the culture is strong conservative Protestant Christian, and the area is predominately farm and rural. Due to the area’s demographics, the demographics of the clinical staff available are also limited. The clinical staff at ACH is also highly female and Caucasian. Diversity within the ACH community is limited. In the high rural and country areas, the mentality is that one can “sleep when they die” and work sun-up to sun-down. Even when clinical staff members state they believe in self-care, the practice is often discouraged. While this can be helpful to the economy and to the paycheck, this provides a bias that harbors compassion fatigue and burnout. According to this view, a person should not worry about burnout, but rather continue working despite the negative consequences. Many people view devastating exhaustion as a badge of honor, showing they were a hard worker and worthy of praise for tearing themselves down emotionally, physically, and mentally. This view can shade the results of a study due to not wanting to appear “weak” or have a low work ethic.

A taboo exists against addressing mental health. Because much of the demographic views mental health issues as a weakness or something only mentioned “behind closed doors,” a person suffering from mental health issues may keep it hidden so as not to be shunned. According to the culture, mental health issues in one’s life show a person to be weak. While readily addressed in more developed areas of the country and where access to mental health care is a norm, mental health is unimportant in rural and conservative areas. Mental health care is not readily available, and without adequate access to this form of care, people fail to see its importance. People learn to work without complaining in rural areas and never ask for help. People must work for all they
have, and if they cannot obtain it through hard work and the sweat of their brows, they do not need it. Asking for help or expressing concerns show weakness. Working hard cannot fix mental health issues; therefore, the problems are a myth in this view. Because of this overarching view in the culture, being emotional or being drained due to showing sympathy is something to “just get over” or work through. One must “leave it at work” and not bring the emotional baggage home; yet people do not have an outlet to discuss the emotional weight they carry anywhere else. If a person cannot “get over it” and move past the compassion fatigue, he or she has nowhere to turn for help. This mentality causes even more mental and emotional stress, depression, and high suicide rates. Mental health in rural areas tends to address only hot topic issues, such as post-traumatic stress with veterans and opioid addiction, and people are seen as “crazy” if they seek out mental health help. These factors contribute to building a wall to prevent others from reaching out for help.

**Delimitations**

The delimitations of this study are the demographics of survey participants and the specific topics of compassion fatigue and burnout to be addressed. Within the study, participants include clinical staff in ACH. The clinical staff is doctors, nurses, aides, social workers, and chaplains. The clinical staff title excludes administrative staff, volunteers, housekeepers, and other staff members. Also excluded are other hospices in the service area and those in other diverse populations. The study examines those who have been with the company and working with patients for a month or longer. Though people are faced with compassion fatigue and burnout quickly in the end-of-life care setting, providing the basis of a month of work within the ACH community gives a foundation to provide that the compassion fatigue and burnout are
primarily due to work with ACH. The study will explore the ministry context of ACH due to accessibility and the degree of participation.

The study will address the specific topics of compassion fatigue and burnout to understand that many other factors can play into staff displeasure and a hostile work environment. Therefore, education defines compassion fatigue and burnout to help clinical staff identify specific issues in themselves and the work environment. In addition, education provides the ability for clinical staff to identify compassion fatigue and burnout in themselves and others.

**Thesis Statement**

Compassion fatigue and burnout are substantial problems facing the clinical staff of ACH. Due to the inability to recognize the issue, many staff members must fend for themselves in their compassion fatigue battle. In addition, the incapability to share matters with family because of HIPAA restrictions and having no outlet within ACH, the clinical staff is left to repress and ignore the symptoms of compassion fatigue and burnout. The lack of education and the company’s inability to address the issue leaves a devastating hole in the care of the clinical staff. While the staff continues to care for the sick and dying and their families, the care they provide for themselves is severely lacking. Therefore, a necessary and pressing need arises to show the importance of recognizing, addressing, and educating on compassion fatigue and burnout.

By providing resources and education on what compassion fatigue and burnout look like and the primary causes, clinical staff in the hospice care setting can reduce the damage caused by compassion fatigue and burnout. The clinical staff will also be aware of how to combat the onset of compassion fatigue and burnout in the future. In addition, the clinical staff will be able to recognize the issues in the coworkers of the IDT. Finally, the clinical staff can identify and
reduce compassion fatigue and burnout by providing positive, consistent end-of-life care with resources and education provided.
CHAPTER 2: CONCEPTUAL FRAMEWORK

Chapter two explores literature addressing the issues of compassion fatigue and burnout in clinical staff, including doctors, nurses, aides, social workers, and chaplains. The literature explored covers various topics related to compassion fatigue and burnout. Also addressed are the gaps and needs to be discussed in the current literature. The literature review will also discuss the grief process and how it affects caregivers and clinical staff.

This chapter will discuss the theological foundations, including how compassion fatigue and burnout connect to Biblical truths and how Jesus calls us to rest. The overview will include scripture references related to self-care and compassionate caring as a call and command of Jesus.

Lastly, the chapter will discuss the theoretical foundations. Also, the section will cover the two structures of compassion fatigue and burnout in clinical staff, specifically in a hospice context.

Literature Review

In the hospice care context at ACH, the clinical staff is inundated with suffering, dying, and death. With the constant bombardment of grief caused by the exposure of death and dying, the clinical staff—including doctors, nurses, aides, social workers, and chaplains—can be pressed down by the weight of the job, making that job feel heavier than other caregiving roles or contexts. Death alone is a complicated process to witness, but the clinical staff deals with the daily decline of patients in their dying days. The grief process affects those beyond the immediately connected—the family and friends—to those providing care. The family has expected grief, which makes sense and is the norm. Families also experience grief as a group and can support one another throughout the process. Even though compound grief can occur, one can
anticipate grief by those close to the one who died. However, caregivers in the hospice setting have grief that often compounds along with that of those they are providing care. Aside from their grief, the emotions involved with those that provide compassionate care are deep. The emotional struggle builds up and takes hold.

Caregivers often experience the grief of the patients and their families. Still, once the patient has died and the family has moved from the caregiver's care, the clinical staff is left to deal with the grief emotions alone. All too often, staff suppresses those emotions altogether. In addition to all the grief experienced, the burden of the COVID-19 pandemic added even more weight. Restrictions on visitations, the anguish of lost time with family members, and providing care covered with personal protective equipment (PPE) cause an overwhelming distraction from compassionate care. The effects the clinical hospice staff experience are holistic, extending out to the physical, emotional, and spiritual realms of a person's being. The literature to be explored will discuss the grief process, the compassionate care process, and compassionate fatigue and burnout.

Grief Process

Henri Nouwen, professor of pastoral care at Notre Dame, Yale, and Harvard Universities, states, "the emptiness of the past and the future can never be filled with words, but only by the presence of a human being."\(^{19}\) Nouwen knew that caregivers have a unique role in another person's grief process. Grief comes in many shapes and forms, just like human beings. Since people are all different, people are also affected differently by devastating circumstances. The process for one person is unparalleled to another's. Much of the literature that addresses grief expresses this phenomenon. As Stephen Freeman, professor of Counseling at California State

University, many authors suggest that grief is "fluid" and reflected as a journey that people experience in different ways.\textsuperscript{20} No clear-cut path to what a person can experience can be found. Though experiences tend to overlap and connect with others, the journey one covers is never a specific path.

The idea that there was a specific path to follow for grief was first brought to light through Swiss-American psychiatrist Elisabeth Kubler-Ross in her book, \textit{On Death and Dying}, in 1969.\textsuperscript{21} She addressed five stages of grief. The five stages include 1) denial and isolation, 2) anger, 3) bargaining, 4) depression, and 5) acceptance.\textsuperscript{22} In the first stage, denial and isolation, a person refuses to accept the severity or reality of the grief-causing situation. The grieving person isolates either physically or emotionally, separating his or herself even more from the reality of grief. Often, he or she shut others out to avoid dealing with emotions. If the grief is related to him or her, such as his or her dying process, the person may avoid doing anything or being around anyone that would remind him or her of such realities. Kubler-Ross advocates that this response is temporary and short-lived, but almost all grief patients experience denial.\textsuperscript{23}

When a person is in the anger stage of grief, this person believes the reality is present, such as death, but cannot cope with the realness of the grief. He or she is so discouraged, sometimes to the point of being enraged, that all emotion boils to a tipping point. Questions like, "why did this happen to me?" and "what did I do to deserve this?" form in the mind of the


\textsuperscript{22} Ibid., \textit{On Death and Dying}. The various stages of grief are covered in multiple chapters throughout the book.

\textsuperscript{23} Ibid., \textit{On Death and Dying}, 26.
grieving person. Spiritual questions like, "why did God let this happen?," "what did I do to deserve this?," and "does God even care?" occur during this stage. Kubler-Ross asserts that anger is often harder on those around the grieving person because he or she lashes out at others. The grieving person throws anger towards family, friends, caregivers, and anyone who challenges his or her feelings.24

In the third stage, bargaining, a grieving person does just that; one bargains for a different outcome. This bargaining is often spiritual, asking God to prolong life, take away cancer, or make someone healthy again. In exchange, the grieving person promises to be a better person or better Christ-follower. Kubler-Ross likens this to a child bargaining with a parent, hoping for an outcome that he or she knows to be unlikely. However, this does not stop one from negotiation. The author also mentions that this stage often goes unnoticed due to the private nature of a conversation with God.25

Depression is the fourth stage of grief, and perhaps most people are familiar with this stage. Kubler-Ross discusses the importance of this stage for acceptance as well. If a person can express extreme sadness in connection with the grief, he or she can adequately accept that the suffering is present and occurred. The author asserts that attempting to cheer up someone in this stage can hinder the process rather than help in acceptance.26

The final stage of Kubler-Ross' five stages is acceptance. The author states that the grieved person is not in a state of happiness, but rather a state of numbness in this stage. The feelings are almost absent at this point because the grieving person has concluded that the grief

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25 Ibid, 46.
26 Ibid, 48.
has or will occur, and nothing can prevent the outcome. Acceptance is, perhaps, most straightforward when one has had time to prepare and reflect on the grief process, such as an elderly person dying of natural causes; however, acceptance is harder to reach when one is facing sudden and unexpected grief.²⁷

Over the last fifty years since Kubler-Ross wrote her book on the grief process, much conversation has occurred over the step process and the individual griever. The idea that every person goes through the same process has received significant feedback of disagreement. The process is not so easy to decipher as one step at a time. The process has overlaps, crisscrosses, and messy tracks. Tim VanDuivendyk, System Executive for Chaplaincy at Memorial Hermann Health System, disagrees with the orderly process; he states that not all experience grief in a step-by-step fashion, noting that the process does not "unfold in predictable pathways."²⁸ He even asserts that grief does not follow stages as Kubler-Ross believed.²⁹ Instead, grief is more of a journey, flowing from one step to another, back and forth, and sideways, in a fluid motion. Freeman agrees with this assertion, stating that there is no timetable in which people are to follow or expect others to follow.³⁰ People will experience various stages, but those stages may not follow a crisp, predictable fashion. Times occur when a person will encounter a stage repeatedly, moving back and forth between stages as he or she grieves. To give a time frame in which a person will overcome or work through grief is nearly impossible. So many factors and issues are present to consider. A timeline cannot be made for when one will move on to the next

²⁷ Kubler-Ross, On Death and Dying, 60-61.


²⁹ VanDuivendyk, Unwanted Gift, 138.

³⁰ Freeman, Grief and Loss, 74.
stage. All who experience grief enter the process differently, no matter how similar the event. Even those who experience anticipatory grief cannot assume that the post-mortem grief will be any less.\(^{31}\) Grief is a messy and complicated process, and "the bereaved should not travel alone" through this progression.\(^{32}\)

**Holistic Grief Process**

Though the pushback is evident in the systematic approach of the grief process, the literature is in agreement over the holistic experience of grief. Grief is more than an emotion. Grief includes other manifestations, such as physical, spiritual, and mental. Freeman joins with others, such as Bruce Epperly, Frank Dattilio and Arthur Freeman, Thomas Plante and Allen Sherman, in asserting the physical aspect of grief compounds with the spiritual and emotional aspects.\(^{33}\) Freeman's insistence on the "holistic reaction to loss"\(^{34}\) is reflected in Plante and Sherman's findings that crisis prompting grief can cause one to reevaluate one's spiritual practices.\(^{35}\) Even if the grief appears to follow the predictable patterns in the emotional state, grief's physical and spiritual expressions may complicate the healing process. Grief's physical manifestations can include stomach aches, headaches, and aches in the shoulders, back, and body.

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31 Freeman, *Grief and Loss*, 59.

32 Ibid., 74.


34 Freeman, *Grief and Loss*, 52.

Spiritual expressions of grief can include anger with God, feeling a sense of guilt due to illness, or a lack of faith altogether. The anger is related to why a person would become sick or die if God was a loving God. The guilt can come when someone sees the death or dying process as a punishment for sin or not having enough faith to be healed. The loss of faith is due to the feeling God has left them in their time of sadness and grief and no longer cares about them.36 Grief amid a medical crisis can have holistic effects. Grief is more than a physical reaction to loss or trauma but can also include "the psychological and emotional aspects that surround the medical affliction."37 The grief process not only breaks down a person's emotional or physical existence, but that grief also has the power to build up or to tear down spiritual well-being in one's life.38 The reality that grief is more than crying and tears but goes deeper into the soul and emotional well-being of the griever is evident. As presented in the literature, grief is a powerful force that affects those directly connected and those providing care for grieving individuals.

Compassionate Care Process

What, then, does one see in the literature about those providing care in a constant context of grief? The work environment constantly immerses hospice clinical staff in grief—anticipatory grief, complicated grief, and "normal" grief—and dealing with their grief process. Hospice staff are also called to be empathetic at all times, showing care and compassion to all they meet. Empathy plays a significant role in being a compassionate caregiver. In the hospice context, clinical staff is called on to be consistently empathetic to the dying and the loved ones of the

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38 Bruce Epperly, Twenty-First Century Clergy Self-Care (Lanham, MD: Rowman & Littlefield, 2014), 133.
dying. While most caregivers may agree that compassion is why they are a part of the caring community, the literature suggests that caregivers bring their own emotional "baggage" into the caregiving context. Most people have experienced a strong sense of grief in their own lives, which, in turn, informs their actions and interactions. Unresolved grief, characterized by "the absence of a normal grief reaction, prolongation of a normal grief reaction, or distortion of a normal grief reaction," can cause concern for hospice caregivers. A unique phenomenon happens that families and caregivers experience more in the hospice, end-of-life setting other caregivers do not share called the Lazarus Syndrome. The Lazarus Syndrome is related to when someone is in the dying process, the family is anticipatorily grieving, and that person becomes no longer terminally ill. While this is typically a joyous event, the current grief process shuts to a stop.

Many hospice caregivers themselves go to work each day, still dealing with their pain and unresolved grief. In this caregiver clinical context, the moment will never be "perfect" for a caregiver to provide care to one in need. As David Switzer, professor for Pastoral Care and Counseling at Southern Methodist University, states, "we can't wait until we're 'perfectly' adjusted, 'perfectly' emotionally healthy…before we are called upon to respond to a person in need." As the saying goes, if one waits for the right time, he or she will never begin. A caregiver brings in his or her grief and life stories to the caregiving context. While experiencing grief in one's own life can help one extend sympathy to another going through grief, the repercussions of dealing with consistent grief can be devastating.

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39 Freeman, *Grief and Loss*, 86.

40 Freeman, *Grief and Loss*, 60.

Positive Aspects of Providing Compassionate Care

Providing compassionate care can extend positive benefits to those providing the care. Multiple recent journals have shown how providing the care reflects to those providing the care. As one shares compassion with others in need, the caregiver can feel great value and accomplishment through compassionate interactions. The recent journals reflect on how compassion draws one person to another, helping them walk together in the grief journey.\textsuperscript{42} Compassion also provides stronger satisfaction in the work environment due to the sense of value and worth one feels by doing meaningful and caring work.\textsuperscript{43} Evidence is present of decreased burnout and workplace conflict when showing empathetic, compassionate care.\textsuperscript{44} The research suggests that though most caregivers can provide compassionate care, a dissonance can appear between when the compassionate care ends and when compassion fatigue begins. The fine line between when the caregiver can deal with the amount of grief in the care and when he or she cannot is where the research tends to lean most recently.

Compassion Fatigue and Burnout

While the literature has obvious benefits on the positive aspects of compassionate care, the negative benefits are also very evident. Exploring the difference between these two issues is vital before addressing the literature writing concerning compassion fatigue and burnout. Most authors believe the difference between burnout and compassionate fatigue is the trigger. The

\textsuperscript{42} Shekoofeh Mottaghi and Hanieh Poursheikhali. "Empathy, compassion fatigue, guilt and secondary traumatic stress in nurses." \textit{Nursing Ethics} 27, no. 2 (2019); 495.

\textsuperscript{43} Maria Dolores Ruiz-Fernandez, Juan Diego Ramos-Pichardo, Olivia Ibanez-Masero, Jose Cabrera-Troya, Maria Ines Carmona-Rega, and Angela Maria Ortega-Galan. "Compasion fatigue, burnout, compassion satisfaction and perceived stress in healthcare professionals during the COVID-19 health crisis in Spain." \textit{Journal of Clinical Nursing} (29, 2020); 4322.

\textsuperscript{44} LeDoux, "Understanding compassion fatigue," 2047.
literature considers burnout more directly connected to workplace-related stress, while compassion fatigue links more closely to the effects of providing compassionate care regularly. The literature suggests that those who are strong in compassionate care are most likely to face the negative impact of that care. Though compassion fatigue and burnout can appear similar, one does not necessitate the other, nor do they manifest in the same way.

**Burnout**

Burnout, unfortunately, proves to be a common problem in the hospice clinical world, and according to literature, staff mainly experience burnout through exhaustion and lack of caring. First coined in relationship with caring roles in an article by Herbert Freudenberger, burnout then became seen as a term to address mental and physical exhaustion at work. Until that point, burnout was a term that referred to someone who had lost interest in life due to drug and substance addictions. While burnout is common in caregiving roles, the issue is not distinct to the hospice caregiver or medical caregiver. People in every job and field of work can experience burnout related to work stress. The distinction between burnout and fatigue is between compassion-related pressure versus work-related stress. Burnout is "a general construct describing a reaction to work-related stress" instead of the compassionate care-related stress of compassion fatigue. Burnout is most often linked to exhaustion, whether physically or

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48 Ibid., 102.

49 Ledoux, “Understanding compassion fatigue,” 2043.
emotionally.\textsuperscript{50} Work-related stress causes constant exhaustion, reflected through burnout. The factors that cause burnout include "work overload, lack of control, insufficient reward, unfairness, breakdown of community, and value conflict."\textsuperscript{51}

In helping professions, such as hospitals, nursing homes, and hospices, the amount of work an employer requires an employee to do is high. Clinical staff in these settings have a high level of tasks to complete, patients to care for, and documentation to complete. The constant need to work at all moments, without rest or break, can push an employee to be emotionally and physically overwhelmed. One can become disillusioned by the jobs because of the continued stress. During the COVID-19 era, the clinical staff has found the demands even more substantial due to high staff turnover and heightened restrictions. The clinical staff must take care of more people while following more regulations. Their already depleting energy is hitting rock bottom.

Lack of control over the regulations and how others react add to the compounding stress. Through it all, clinical staff often feel under-appreciated. The COVID-19 era also saw quite a bit of conflict with values when clinical staff had to choose between caring for patients and caring for themselves. All the factors add to burnout very quickly in an already stressful environment.\textsuperscript{52} As a result, the caregivers follow through a pattern of emotional exhaustion, depersonalization with those the staff are caring for, and a lack of self-worth or value concerning the work environment.\textsuperscript{53}


\textsuperscript{51} Skovholt and Trotter-Mattison, Resilient Practitioner, 105.

Compassion Fatigue

On the other hand, compassion fatigue is "negative cognitive and emotional consequences for the empathizer of feeling empathy." According to recent journals, compassion fatigue manifests through a lack of desire to work, exhaustion, irritability, body aches, and self-medicating. A person who experiences compassion fatigue due to the bombardment of grief and suffering in his or her work context is dealing with more than work-related stress. The stress on the person is more profound. While many symptoms can appear the same, especially the physical symptoms, a substantial difference in the contributing factors exists. The high empathy causes higher stress on the caregiver. Compassion fatigue has in its underlying cause the consistent, compassionate care required as part of the job, not the job itself. As mentioned before, compassion fatigue is much more common in caregiving due to the consistent messages of grief, suffering, and pain that caregivers experience through their work context. Seeing those they care for slowly declining and dying causes stress on their emotional self. Clinical staff feels this emptiness after every patient. When the high caseload couples with this feeling, the consistent stress with no outlet overwhelms the emotions of the clinical staff. Many in caregiving roles or caring professions deal with compassion fatigue due to the overload of traumatic stimuli without time to refresh and reset. Hospice caregivers deal with death and...
dying in addition to the previously mentioned issues, compounding the compassion fatigue triggers even more.

Literature addresses the issue of compassion fatigue a great deal, discussing the effects on work and a person's well-being. Compassion fatigue is due to giving more compassion than a caregiver's reservoir can provide. A person can only give so much and cannot deliver from an empty emotional tank. Once the caregiver reaches his or her limit, compassion fatigue can transpire. When a person comes to work with a full reservoir to provide a foundation of coping, the foundation can also influence the caregiver's ability to deal with the fatigue that may occur. The caregiver's trauma history can compound with the patients' experiences. In a controlled environment without unneeded or compounding pressures, caregivers can typically withstand the stresses of the job. Compassion is not something that causes negative issues in itself. Compassionate care can give a person a sense of worth and importance. Compassion fatigue occurs when the caregiver cannot return to the state of normalcy and be resilient.

Hospice caregivers must often express emotions that they are not feeling to soothe the family. Because the expectation is for a person to show compassion in the hospice community, the sentiment is often a simulation when a clinical staff member does not have that reserve or ability. Being workers in a professional field, clinical staff cannot share negative emotions with patients and families and are often discouraged from doing so amongst co-workers and administration. Compassion fatigue can link to faking or holding in negative feelings when the caregiver cannot express his or herself authentically. Not being open with grief and loss can be

58 Mottaghi and Poursheikhali, “Empathy,” 495.


60 Michael D. Barnett, Kathryn N. Hays, and Christina Cantu. "Compassion fatigue, emotional labor, and emotional display among hospice nurses." Routledge (2019); 5.
damaging to the emotional and spiritual self.\textsuperscript{61} As creations of God, the lack of expression of emotions causes a disconnect from the Creator. God created emotions and being able to experience emotions is connected to our spiritual self as well.

Lastly, compassion fatigue can be seen in caregivers because of an inundation of emotional demands, requiring the caregiver to give more than he or she can consistently.\textsuperscript{62} The most substantial downfall of caregivers that causes compassion fatigue is the lack of self-care and internalizing trauma to the point that one can no longer cope or work effectively.\textsuperscript{63}

Gaps and Need for Expansion in Literature

Though recent research explores the presence of compassion fatigue in caregivers, a gap is seen in addressing this prevalent issue. Compassion fatigue and burnout are widespread and well-known in the caregiver context, and yet, little discussion is had on what to do with this information. The literature also does not address how to reduce its impact. The little literature presenting compassion fatigue and burnout discusses the importance of spiritual strength or support system to combat the compounded grief. If compassion fatigue and burnout are such a common phenomenon in the hospice community, more studies should be conducted, and conversations should be held about what to do when the symptoms surface. Because COVID-19 is a recent pandemic, research is lacking on overcoming or lessening compassion fatigue and burnout in its presence.

\textsuperscript{61} Oden, \textit{Classical Pastoral Care}, 177.

\textsuperscript{62} Igor Portoghese, Maura Galletta, Philip Larkin, Salvatore Sardo, Marcello Campagna, Gabriele Finco, and Ernesto D'Aloja. "Compassion fatigue, watching patients suffering and emotional display rules among hospice professionals: a daily diary study." \textit{BMC Palliative Care} (2020); 20.

\textsuperscript{63} Vidette Todaro-Franceschi, \textit{Compassion Fatigue and Burnout in Nursing: Enhancing Professional Quality of Life}. (New York, NY: Springer Publishing Company, 2013), 76.
Studies suggest that religion and spirituality strengthen a person's ability to combat grief. Bruce Epperly, professor at Lancaster Theological Seminary, goes further as to say a person needs a village—"friends, family, and professional companions"—to help us through times of "scarcity" and grief. With this knowledge, the literature needs an expansion on what it means to be a village and strength for caregivers experiencing compassion fatigue.

Some conversation centers in the literature about the need to rest, the need for Sabbath, insisting on a day of rest to be emotionally healthy. Unfortunately, a hurried environment can prevent proper time to work through personal grief. A lessening effect happens when one has time to work through grief appropriately; however, the opposite is true. When one does not allow the appropriate time to work through the grief, the cost can be far higher when one ignores the "shadow" in his or her life.

Lastly, minimal, if any, conversation is had on possibly avoiding the strong presence of compassion fatigue altogether. As mentioned before, having a solid balance in one's life and a resilient support system allows for combatting the onset of compassion fatigue. How might the work field, the administration, and the co-workers help facilitate this? Having a community within the workplace is fundamental, and "support networks are essential" when faced with devastating and grieving news. Death and grief are something that no person avoids in life.

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64 Plante and Sherman, *Faith and Health*, 170.


66 Peter Scazzero, *The Emotionally Healthy Leader* (Grand Rapids, MI: Zondervan, 2015), 32.


70 Dattilio and Freeman, *Cognitive Behavioral Strategies*, 204.
a shared experience, the literature fails to address such a significant part of human existence. Learning to manage loss could greatly help the whole person adapt, grow, and overcome grief. The caregiving field could avoid the appearance of compassion fatigue altogether and find a way to combat the issues before they begin; then, the caregivers will efficiently manage the battle against the concerns. Studies consistently point to the importance of addressing the exposure of compassion fatigue and burnout to caregivers and the causes. Still, the studies and research do not point to how to solve or lessen the strength of this problem plaguing hospice caregivers.

Summary

Compassion fatigue and burnout are strong forces at work in the Community Hospice of Ashland clinical staff. Because of the high volume of patients dealing with grief, death, dying, pain, and suffering, caregivers are continually bombarded with emotional mountains in which they must climb—whether their own or those in which they accompany on the journey of grief. Grief is an unavoidable reality in life. The process in which one grieves, however, can vary. As a caregiver in a compassionate, end-of-life context, clinical staff must find ways to address their grief as well as the secondary grief of those they care for to combat compassion fatigue and burnout. While literature does address grief from every angle and recognizes the strong presence of grief placed on caregivers, the literature fails to address the "what now?" factor. Compassion fatigue and burnout plague the clinical staff of the hospice context, forcing the caregivers to fend for themselves in emotional valleys. The literature, from this point, needs to address how clinical staff in the hospice community can combat, or at least lessen, the shadow cast from the grief they continuously shoulder, and provide resources and education on how to bring the caregivers out of the valley to the mountain of caregiving again.

Oden, Classical Pastoral Care, 177.
Theological Foundations

Compassion is one of the most vital characteristics seen in Jesus throughout His entire life and ministry. Jesus showed compassion to all He met, whether they reflected the same heart to Him or not. He showed mercy to the outcast when He healed the lepers and those bleeding, not caring that others would see them and Him as unclean due to the contact. In the time Jesus lived and ministered on Earth, to touch an unclean person meant to become unclean one's self, and "to touch a leper was to be defiled." To allow human contact with those who were unclean, the listeners of Jesus' preaching and followers of His ministry were "encouraged to trust in Jesus' compassion and authority to heal." Not only that but also by touching the leper, the unclean, Jesus Himself was showing His love made one clean. By physically touching the leper, not only did Jesus not become unclean, but the man became clean as well. Jesus set an example for compassion despite the outward consequences to His followers. They were encouraged to step out of the confines of the stringent religious rules and follow the love of God first.

Jesus showed compassion to women and children as well. Children were considered important in the time of Judaism, but they were not to interrupt the work of leaders and other adults. By Jesus inviting children to come to Him and not ignoring their presence, Jesus was showing the compassion and love He extended to everyone. Jesus greatly loved children, and

76 Ibid.
77 Matthew 19:13-14 (NIV).
He showed great compassion towards them. Children were low in stature in that time but "are of
great importance to Jesus, as he demonstrates in [H]is correction of the disciples." Jesus knew
that children are the future. He knew that their hearts could show love and compassion beyond
anything logical. He knew that children could show adults how to be Christ-like with their blind
faith and soft hearts.

Women were seen as unimportant and of no value in that culture. Their value depended
on continuing the family, procreating, and carrying on the family name. Jesus also showed
women compassion in a time and in a culture where women were second class or property. He
spoke to women with respect and dignity, understanding their time but pushing past those
norms. When Jesus spoke to a woman, He spoke to her as an important person, often surprising
the disciples. Despite their surprise, the disciples did not question Jesus' tactics. The disciples
knew of His compassion. To show dignity to her was commonplace in Jesus' ministry. Instead of
treating women like property, He included them in His ministry. He gave them pivotal roles in
His ministry. Many women, such as Joanna, supported Jesus and the disciples financially
because of the excellent care and compassion He showed for them.

Jesus showed His compassion to women when others were determined to condemn, as
evident with the woman caught in adultery. In this situation, to not condemn the woman was to
go against the law of God in that time; however, to condemn her meant Jesus was showing

78 Brown, “Matthew,” 222.
79 John 4:7-16 (NIV).
80 John 4:7-26 (NIV).
82 Ibid.
Himself to be like the judging religious leaders of that time and not be compassionate whatsoever.83 By His actions, by stating that the person who was without sin could be the first to condemn the woman, Jesus gave no reason for anyone present to blame her but Himself.84 Yet, because of His great compassion for all people, Jesus chose to forgive. All who were present for the scene were quickly able to see how Jesus honored the law yet rose above it.

He even showed compassion to blatant sinners and those ridiculed by society.85 Tax collectors, like Zacchaeus, were "classed with murders and robbers" and considered the lowest of low in the Jewish world.86 Zacchaeus was known for his cheating, stealing, and general dishonesty. However, when He encountered Jesus' compassion, he became a changed man. Because Jesus extended a hand of mercy, even going so far as to eat in Zacchaeus' house, Zacchaeus was willing to offer four times repayment to those he committed misdeeds and giving a substantial payment to those in need.87 In Jewish society, not only did one not converse with someone of his stature, but one also did not eat and make friends with a person such as him. Jesus pushed past the societal norms to extend the arms of love and compassion to all those He encountered.

One of the most prominent scenes of Jesus' compassion was at the death of Lazarus.88 Jesus, being so profoundly moved by the death of Lazarus, wept. Jesus did not just mourn

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84 John 8:7 (NIV).


because of Lazarus' death, knowing that he was to resurrect him once more. Jesus also wept after seeing those who cared for Lazarus crying about his death. The sisters' tears and the other mourners' tears brought tears to the eyes of Jesus. His sisters and those who knew Lazarus cried for his death, and upon seeing this, Jesus also cried. Jesus had compassion for those hurting, those who had lost someone they deeply loved. Therefore, He reflected that compassion to them through His tears. Even Jesus as the son of God, knowing that Lazarus would live again, wept for Lazarus and those who mourned his death. He did this because of the great compassion He has for all people.

Jesus also, however, showed the price of compassion. Compassion is a beautiful emotion and action to share with others, but it is costly. If anyone understood the pain that accompanied compassionate care, it was Jesus. His entire ministry centers around His great compassion for all humankind. Jesus' adversaries show ridicule and mockery throughout His ministry. He is eventually beaten and killed for showing compassion to those who others did not. Throughout His ministry, Jesus faces the religious leaders attempting to catch Him in the act of something wrong to punish Him. When Jesus showed compassion through healing, the religious leaders were indignant. The Pharisees were angered and began plotting to kill Jesus because of his compassionate care. The Pharisees did not care for the healing, and they did not find joy in His compassion. However, the price that He faced for His compassion was beyond the physical.

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90 Matthew 22:23 (NIV).


92 Matthew 12:9-13 (NIV).

93 Evans, “Matthew,” 222.
When Jesus faced His death, the ultimate sign of compassion, He faced extreme mental and emotional turmoil. The internal anguish was so great that Jesus even sweated blood.\(^{94}\) As He prays to God over the events to come in His crucifixion, Jesus' "inner torment manifests itself in physical trauma."\(^{95}\) While physical abuse and trauma litter much of Jesus' road to the crucifixion, the pain from the compassion He shared ran much deeper. He ached so much for those He loved, the people of the world, that He was willing to be beaten, made into a bloody mess, and die for them to experience the grace His compassionate care brings fully. The toll that His body had been under even to that point was monumental.

Jesus also knew the importance of rest, physically, emotionally, and mentally. He understood that the work of Christ, the work of compassion and love, was hard. He understood the need for rejuvenation through rest. Jesus said Himself in the book of Matthew that He was the ultimate rest: "Come to me, all who labor and are heavy laden, and I will give you rest. Take my yoke upon you, and learn from me, for I am gentle and lowly in heart, and you will find rest for your souls. For my yoke is easy, and my burden is light."\(^{96}\) How Jesus shows love and compassion is lighter than the way of the world. Jesus's yoke is "easy in comparison with the alternatives: suffering under the yokes of humans who do not care for one's well-being."\(^{97}\) When the disciples had become weary due to the constant care and compassion of those following Jesus to hear his words, Jesus reminded them of the importance of rest. He told them to find a place of solitude and rest.\(^{98}\) Being constantly bombarded by the pressures and stress of


\(^{96}\) Matthew 11:28-30 (English Standard Version).

\(^{97}\) Evans, “Matthew,” 218.
compassionate ministry, the "disciples craved solitude and rest in the company of Jesus." Jesus knew the exhaustion that came from consistent, compassionate care and reminded others of the need to rest and reset.

Entirely too often, a compassionate person gives so fully of his or herself that he or she has nothing left to give. The concept of "one cannot pour from an empty cup" is beyond the scope of a truly compassionate person because there is always one more person needing care. Clinical staff in a hospice setting understand this phenomenon well due to the constant rotation of patients and the mortality rate of patients. However, as Jesus states, "I desire compassion and not sacrifice." Jesus made it clear that compassion was His first and foremost priority. He showed love to the outcast, the unimportant, the rejected. He knew firsthand that compassion could lead to pain. He also knew, though, the importance of refilling His cup, resting, and rejuvenating His spirit so that He could give compassion from a full heart again. Jesus never stated that being compassionate would be easy and free of pain. He provided many examples of the opposite to be true. Jesus did, however, remind us again and again, through words to the disciples and His example, that rest and Sabbath were necessary.

**Theoretical Foundations**

Compassion fatigue and burnout among clinical staff in hospice is a substantial reality. Unfortunately, no attempts are indicated in the research of compassion fatigue among hospice workers addressing the issue. Many studies completed show awareness of the problem, indicating the high risk of compassion fatigue and burnout with hospice clinical staff. These

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98 Mark 6:30-31 (*NIV*).


100 Matthew 9:13 (*New American Standard Bible*).
studies suggest that "ongoing exposure to and empathetic concern for the suffering of others leads to deep physical, emotional, and spiritual exhaustion, hopelessness, disconnection from others, and decreased capacity for and interest in empathetic attunement with clients." Yet, even though there is a strong indication of compassion fatigue and burnout among clinical staff in strong caring professions such as hospice, little assistance or suggestion is made on how to decrease the possibility.

While research suggests a strong indication of the awareness and struggle that compassion fatigue and burnout have provided, little indication is seen of attempts to correct or lessen the problem. In "Predicting the Risk of Compassion Fatigue: A Study of Hospice Nurses," the authors mirror this sentiment, stating, "nurses in this specialty are especially vulnerable to the risk of CF" due to their high rate of helping others facing traumatic events. Because of the traumatic atmosphere that inevitably comes with caring for dying patients and their families in hospice care, the clinical staff encounters a bombardment of intense emotional and physical distress. Despite this, the authors realize the research does little to offer answers for those in high trauma areas, such as hospice care settings. Within the study conducted by Abendroth and Flannery, around eighty percent of hospice nurses were at increased risk for compassion fatigue. Research has failed to address the issue despite this high-risk factor and the over-abundance of research stating the risk. To fully engage and determine a solution to this issue, the research must begin acknowledging the subject itself. But more than that, suggestions


102 Maryann Abendroth and Jeanne Flannery, “Predicting the Risk of Compassion Fatigue: A Study of Hospice Nurses,” Journal of Hospice and Palliative Nursing 8, no. 6 (November 2006), 347.

103 Abendroth and Flannery, “Predicting the Risk,” 347.

104 Abendroth and Flannery, “Predicting the Risk,” 351.
must be provided and tried, reevaluated and reassessed, and further educated recommendations made until there is a discovery of some solution. As Jesus indicated with His words and actions, rest is needed. Jesus insisted on rest in His caring ministry because He knew the overwhelming emotional and spiritual taxation compassionate caring can have on a person. Because of the demanding needs of the caring profession, clinical staff in the hospice setting need solutions for compassion fatigue and burnout. A person cannot continue to provide compassionate care every moment and expect to do so without rest and further answers. Acknowledgment that there is a problem in the system is the first step in deciphering a solution.

Once the problems are acknowledged, the next step is to provide education and resources to stop the issue from developing further. While it may not be plausible to stop compassion fatigue or burnout from occurring altogether, the ability to lessen the onset or recognize the signs early can prevent mental or spiritual anguish. Education is the first step. By providing knowledge on what compassion fatigue and burnout look like and their causes, a workplace or individual can be more apt to recognize the onset of compassion fatigue and burnout. The clinical staff needs resources to address the issues that cause compassion fatigue and burnout. The clinical staff also needs outlets for emotional and physical rest. The workplace of clinical staff members struggles to build an environment conducive to rest at any point. The workplace can prevent or reduce the onset of compassion fatigue and burnout if the signs are recognized. One way research does suggest the prevention is through lowering the patient census for nurses and providing a supportive work environment. Nurses, especially in the coronavirus pandemic, have been overwhelmed with high patient counts, long hours, and strenuous work environments.

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105 Rebecca Graystone, “Prevent Compassion Fatigue and Burnout With a Magnet Culture” *Journal of Nursing Administration* 49, no. 5 (May 2019), 231.
While the census is not always something in anyone's control, the environment in which they work can provide more significant support to the clinical staff. The supportive work environment includes empathetic supervisors who offer positive reinforcement and an engaging atmosphere. When nurses, or other clinical staff, received recognition for achievements, experienced lower workload, and had uplifting leadership, the risk for compassion fatigue and burnout were much lower. These factors can also prevent high job turnover or low job satisfaction. Unfortunately, the opposite is also true. With high work demands and leadership who does not recognize or acknowledge the demands on the clinical staff, the workers develop compassion fatigue and burnout much quicker, and the company faces even more job turnover.

An important aspect that needs to be reflected on and implemented is the normalization of emotional outlets and mental health. The stigma on mental health in the United States indicates that asking for emotional help is weak. In rural areas especially, as is the case with ACH in Eastern Kentucky, to ask for help, no matter what type, is not to be done. People work for what they need. To be worn out is a sign of hard work. "I'll sleep when I die," a common phrase indicates the view. Jesus was regularly open with His emotions, crying when He lost His friend, angry at the injustices, and showing love to all. Jesus' willingness to share how He felt should serve as a basis for others to express emotions healthily and openly while not being judged or ridiculed by others.

The rural community can overcome the mental health stigma if there is a consistent threat to its logic. The normalization of seeking mental health could strengthen the workplace and lessen job turnover, especially in compassionate care settings like hospice. Seeking connection

106 Graystone, “Prevent Compassion Fatigue,” 232.

and "perceptual maturation" is needed, meaning that one should connect with others on deeper issues, such as emotional, mental, and spiritual concerns while being content with one's conclusions. Clinical staff should be encouraged to express emotions in a safe setting and affirm the normalcy of being fatigued emotionally and compassionately. In a culture where having feelings, expressing emotions, or seeking help due to emotional issues are seen as a weakness, hospice needs to pave the way for normalizing the conversation. Hospice, as a workplace that fosters the emotional, spiritual, and physical health of patients and families, the holistic view should also be extended to those providing the care. The conversation, then, should be more than expressing the emotions but providing healthy outlets, as well as periods of rest. Stating the need is not enough. Providing the outlets also encourages continued mental and emotional health.

To move beyond this small level of research, steps need to be taken. First, of course, is to provide more research that establishes the issue and the sources and signals. Conversing about emotional outlets can provide normalcy because of the taboo of mental or emotional health. Clinical staff will be more readily open to the conversation of compassion fatigue if they realize the predominance of the issue in their workplace. When people realize they are not the only ones facing compassion fatigue or burnout symptoms, the conversation and admission come more freely. Also, a sense of a lightened emotional load occurs, knowing that they are not alone in how they feel. Understanding the prevalence of the problem cannot be known if there is no open forum available to communicate the issues. The disciples' openness and bluntness with Christ during His ministry is indication enough of the importance that Jesus placed on open communication of emotions and feelings. Jesus encouraged and fostered the need for emotional

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communication and showed loved, compassion, and acceptance to those who expressed how they felt. Clinical staff in the hospice setting need to have the outlet to foster their emotional expression.

Second, education and resources can help clinical staff recognize the signs of compassion fatigue and burnout. Once the conversation has begun on the prevailing problem of compassion fatigue and burnout, the exchange must turn to how to identify what is happening, when it happens, and what causes it to happen. Symptoms can be widespread, but the clinical staff will struggle to realize what is happening without knowing what they are. Knowledge of when it happens can help clinical staff and the workplace provide ways to reduce the onset in the first place. Pinpointing the causes allows for providing and exploring solutions. As Jesus showed through His ministry, indications of what causes bad fruit is in the roots. If the roots within a person are suffering and exhaustion, the fruit they produce will be half-hearted and emotionally disconnected. No workplace wants nor needs half-hearted caregivers. No compassionate caregiver wants to do so in a disconnected way. To recognize the signs of unhealthy roots in the emotional being before it penetrates too deeply means quicker healing and better growth.

Thirdly, a "what now?" factor must be presented, answering what a person can do to combat or lessen the onset of these issues. Once the conversation begins about the reality of compassion fatigue and burnout and the signs can be recognized, the exchange must turn to the solution. Establishing the awareness of a problem, the clinical staff and the workplace in which they work explore ways to foster the mental and emotional health of the compassionate caregivers. While acknowledging that it can be challenging to completely abolish compassion fatigue and burnout, the issues can be lessened or repaired. The process quickens if there is a
plan of action to rest and reset. Knowing what combats the issue beforehand, one can implement them more freely and quickly when the issue arises.
CHAPTER 3: METHODOLOGY

The study conducted was a multi-faceted project used to determine compassion fatigue and burnout before, during, and after the study. Due to the ever-changing patient census within the hospice clinical staff community, the staff began with varying compassion fatigue and burnout levels. The methodology for communication used included surveys and questionnaires. The methodology used to address the issue of compassion fatigue and burnout was counseling sessions, peer conversations, and a calming room.

Intervention Design

The purpose of this DMIN thesis is to provide resources and education to clinical staff to recognize and reduce compassion fatigue and burnout. The resources and education were a two-fold method to address the tremendous reality within the hospice community, and more specifically, the ACH clinical staff. The project schedule allowed the flexibility needed for the ACH staff to implement resources and return feedback in the form of surveys and questionnaires.

Resources for Project Within ACH

The first of the two elements, the resources, consisted of the counseling sessions, peer conversations, and calming room. In addition, the resources provided various types of outlets suitable for decompressing and managing through the stress of work that causes compassion fatigue and burnout in the clinical staff.

Counseling Sessions

Counseling sessions are one of the three resources provided during the study. The counselor was a trained and certified bereavement counselor for ACH, [name]. The services were provided free of charge. All of the bereavement counseling services provided by ACH are free of charge and open to the community. Ms. [name] offered her services for the
project during office hours, free of charge as well, with the approval of the executive director. Her private office offered the space needed for confidentiality. Due to her office location being in the main office building of ACH, the location was central to the study participants. Times of availability were decided based on the regular work schedule of the clinical staff, with the knowledge that morning hours were usually the best for staff to use the resource. The counseling sessions provided a way for clinical staff to have a structured counseling session to discuss the devastating emotional effects of compassion fatigue and burnout on hospice clinical staff with a trained counseling professional. The initial response with the counseling sessions was of a positive nature. Participants agreed having the opportunity to discuss any symptoms they were feeling due to the work stress would be a helpful way to ease the anxiety.

**Peer Conversations**

The resource of peer conversations provided a more informal approach to talking about compassion fatigue and burnout symptoms. While a few participants did have formal counseling training, the conversations were more of a "venting" session rather than counseling. Clinical staff participants overwhelmingly agreed that having someone to talk to who understood the job in which they are a part would be helpful; therefore, the initial response to peer conversations was receptive and appreciative of the resource. The peers available were not limited to anyone other than those participating in the study. To appropriately gauge the level of compassion fatigue and burnout, conversations with study members was necessary. Those involved covered all disciplines, including chaplains, social workers, nurses, doctors, and aides. Those involved were also throughout the coverage area of ACH. Due to this, peer conversations were the most readily available resource, especially for the participants consistently driving to houses or nursing homes. Not only did the participants use the peer conversations the most due to the convenience,
but also because of the trust level found in one another. Surface-level conversation is an everyday occurrence for hospice clinical staff when interacting with families and patients; however, rarely does conversation go deeper than shallow waters. In this study, peers were pushed to talk about profounder topics than they were accustomed. Having conversations of a vulnerable nature, about emotional shortcomings and lack of emotional coping skills, can only happen when the person sharing feels he or she can trust the listener. Therefore, the peer conversations were well received. The participants were able to talk to someone they already had a trust and rapport with, and they were not afraid the conversations had would be shared elsewhere. In the day and age when people divulge personal information without concern for etiquette, others can be resistant to share sensitive information. Having a foundation of trust and faith in a person’s character and ability to keep private information to themselves is critical for peer conversations to be effective.

**Calming Room**

The calming room resource had the clearest reception from the clinical staff participants at ACH at the initial stage of the study. The hospice care center for ACH, the location of the calming room, had many COVID-19 precautions throughout the study. The precautions included many rooms closed to families, such as the family meeting rooms, kitchen, and lounge room. The room customarily utilized by families of patients was closed to the public due to the COVID-19 pandemic, and therefore, able to be utilized for the study. The room was a smaller room with dim lighting supplied by lamps. A couch and two chairs, a coffee table, and two small side tables were also present in the room. One side table contained a reflection book with Bible verses and calming mantras. The small diffuser was on the other side table, adequate for the room size. Included with the diffuser were instructions on how to operate and the quantity of
water and lavender oil to put in the diffuser, a bottle of lavender oil, and distilled water for
refills. Also on this table was a CD player with a collection of CDs provided with calming music
and hymns. A marking showed a preset calming volume level on the CD player. Finally, on the
coffee table were coloring sheets with Bible verses and sayings of calming nature. The coloring
sheets contained the following verses:

- "In quietness and confidence is your strength" (Isaiah 30:15).\textsuperscript{109}
- "When you pass through the waters, I will be with you; and when you pass through the rivers,
  they will not sweep you over. When you walk through the fire, you will not be burned" (Isaiah
  43:2).\textsuperscript{110}
- "The eternal God is your refuge and underneath are the everlasting arms" (Deuteronomy
  33:27).\textsuperscript{111}
- "'I know the plans I have for you,' declares the Lord, 'plans to prosper you and not to harm you,
  plans to give you hope and a future'" (Jeremiah 29:11).\textsuperscript{112}
- "For I can do everything through Christ, who gives me strength" (Philippians 4:13).\textsuperscript{113}
- "This is the day the Lord has made. We will rejoice and be glad in it" (Psalm 118:24).\textsuperscript{114}
- "Trust in the Lord with all your heart and lean not on your own understanding" (Proverbs 3:5).\textsuperscript{115}
- "Those who hope in the Lord will renew their strength" (Isaiah 40:31).\textsuperscript{116}

Included with the coloring pages were an extensive collection of coloring pencils and a battery-
powered pencil sharpener. The supplies were checked and replenished regularly, the diffuser

\textsuperscript{109} Isaiah 30:15, \textit{English Standard Version}.
\textsuperscript{110} Isaiah 43:2, \textit{New International Version}.
\textsuperscript{111} Deuteronomy 33:27, \textit{New International Version}.
\textsuperscript{112} Jeremiah 29:11, \textit{New International Version}.
\textsuperscript{113} Philippians 4:13, \textit{New Living Translation}.
\textsuperscript{114} Psalm 118:24, \textit{New King James Version}.
\textsuperscript{115} Proverbs 3:5, \textit{New International Version}.
\textsuperscript{116} Isaiah 40:31, \textit{New International Version}.
refilled, the music CDs reset, and the coloring supplies maintained. In addition, the room had a door with a sign saying the room was closed due to COVID-19 precautions. All participants were aware of the sign-up sheet at the desk and the ability to utilize the space as needed.

The room provided a way to escape the momentary stresses of the workplace and the emotional strain that comes along with caring for dying patients and their families all day, every day. The relaxing lighting and other elements were designed to bring participants back to a level of composed and peaceful state, allowing focus to shift back to compassionate care of their patients. The elements provided by the study in the calming room covered the senses, including smell, touch, sight, and hearing. Immersing the participants in quietening rituals through the senses allowed a richer tapestry of relaxation to be formed.

Education for Project Within ACH

The education component was the first and foremost aspect of the project. Though the clinical staff was aware of the pressures and emotional damage that seeing dying and death on a routine basis can cause, the terms, the devastating nature, and the ways of combatting the issues were largely unknown by the clinical staff. The education allowed the clinical staff to have a more knowledgeable approach and a productive view of dealing with the issues.

Clinical staff members are educated and knowledgeable on many physical facets because the nature of being a clinical staff member require it. Hospice nurses knows every detail about the body shutting down. The nurses explain to families how when a person is dying, the body pulls blood to the center to preserve the organs as long as possible. This is causes mottling, a discoloration of the skin usually on the hands, feet, legs, and knees. The nurses tell the families how the breathing will change, and those present will begin to see apnea, or long periods of not breathing. The nurses know and share all the signs and symptoms of imminent death of a
physical body. However, hospice nurses are not trained on how to recognize compassion fatigue and burnout in themselves or others. The staff are not told to look for symptoms such as lack of compassionate care, numbness, or exhaustion, that can be cause by caring too much, for too long, without a way or time to decompress. The education of this project was to bring to light the signs and symptoms the clinical staff experience but were unable to pinpoint the reasoning or cause.

The educational instruction session consisted of the PowerPoint presentation and question and answer session.

**PowerPoint Presentation Educational Component**

In the initial session, education provided a base knowledge of compassion fatigue and burnout in the context of ACH clinical staff. In addition, the education session included a PowerPoint (Appendix D). In this PowerPoint, the participants received the beginning survey. The survey asked the following questions:

1. Are you tired?
2. Do you feel overwhelmed?
3. Do you feel underappreciated at work?
4. Do you struggle caring for your patients?
5. Do you feel like shutting off your emotions, so you don't have to deal with your feelings?

The questions offered set the frame of thinking on the emotional state related to working in the context of death and dying. Due to the continued moving nature of the clinical staff job, starting the education portion out with a set of questions as mentioned allowed for a resetting of the frame of mind. This resetting permitted the participants to focus on the content covered during the remainder of the education session.

The first question, “are you tired?” is a question most adults would most readily answer yes. While the context starting out was rather vague, the present clinical staff could begin
thinking about their emotional and physical state in relation to one another. Clinical staff often express being tired at ACH, but rarely do they connect it to emotional factors. This question was to spur that line of thinking.

The second question, “do you feel overwhelmed?” was a question that brought to life the working or home life factors that were putting pressure on the clinical staff. By answering the question of whether they were overwhelmed, they were pushed to think how they felt in that moment rather than repressing. As hospice clinical staff, emotions are expected to a certain point. As mentioned, many emotions are fabricated in order to provide care that seems genuine. Other times, the care is so heavy or so close to a personal tragedy that the emotions are projected on to those they are caring for. When the staff reflected on whether they were overwhelmed, they were forced to put their feelings into perspective.

The third question, “do you feel underappreciated at work?”, allowed for a deeper reflection on how the workplace can influence one’s emotional and physical state. Though it is likely that everyone feels unappreciated at work at some point, bringing to the forefront the concept of being undervalued in the workplace was critical. Showing the need to feel validated and that one’s work was of value is a serious factor in the ability to cope with work stress. When people feel they are needed in their jobs, they are more likely to handle larger or more stressful workloads.

The questions took a deeper turn with number four, which asked, “do you struggle caring for your patients?”. The questions before required some self-reflection on a physical and emotional level, but the fourth question pushed even further. The knowledge that caring for patients is important work but being unable to do so well or at all can take a toll on compassionate clinical staff. For the participants to reflect on how their exhaustion level affects
the work that they do or should be doing pulls forward in the mind the repercussions that can come from compassion fatigue being unchecked.

In the last question, the participants answered, “do you feel like shutting off your emotions, so you don’t have to deal with your feelings?” The question was another way for the clinical staff participants to reflect on the devastating effects from pushing through emotional trudges in order to complete a caseload. Doing this or going from patient to patient without decompression causes a person to decide whether to face the emotional turmoil or shut it off. Participants reflected on this question as a way to see how they typically respond to overstimulation of the emotions.

Next, the PowerPoint moved to a series of comparisons and contrasts of compassion fatigue, showing the differences and similarities of the two elements. Though the clinical staff is aware of their exhaustion and emotions, perhaps more than an average person due to the nature of their work, the ability to assign the issues to work-related compassion fatigue and burnout is limited. The descriptions of compassion fatigue and burnout allowed clinical staff participants to gauge their emotional expressions, or lack thereof, through the process. In the realm of hospice, clinical staff members are inundated with tears, sadness, disbelief, and guilt, from patients, their families, and other staff members. While this is commonplace, the constant bombardment by the extreme emotions can cause severe emotional trauma if not faced or acknowledged. The taboo of pursuing help for mental health also puts a hinderance on the clinical staff. Because they chose a

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career in a somber field, a higher expectation is placed on clinical staff to be able to cope with the negative emotions. By bringing to the spotlight the distressing effects of the routine aspects, the clinical staff is impelled to focus on how their coping skills are or are not successful.

The PowerPoint presentation then moved to explaining the study and resources provided throughout the study. Descriptions of the counseling sessions, peer conversations, and the calming room given helped participants fully understand what was available. Clinical staff participants needed to be aware of the availability of resources, because resources were not currently available before the study to address the specific aspects of compassion fatigue and burnout. Being aware of the resources and the importance of engaging in them allowed the participants to have a comfort level with the usage of such resources. Review of confidentiality in forms, conversations, and counseling sessions ensured the participants had the freedom to express the issues causing compassion fatigue and burnout. The confidentiality was necessary but also helpful in encouraging participants to be open with how they are feeling with no threat to their employment. Also, as mentioned before, clinical staff are accustomed to communicating to others on a regular basis; however, barriers are in place to prevent oversharing or divulging of personal matters. Providing the assurance of confidentiality and trust in secrecy of conversation matters was imperative to the success of the resources. Without faith that their words would not travel elsewhere, clinical staff would not be able to open up about the difficulties they faced in the workplace.

Finally, the PowerPoint and education portion provided all contact information for the project implementor and an overview of the project schedule. Once again, the schedule was needed to assure the participants that the resources were available. The contact information was also vital so that the participants were aware of the transparency of the study implementor. The
study implementor needed to be available for conversation, suggestions, and feedback on the study, and providing the various forms of contact encouraged the participants to contact as needed.

**Questions and Answer Educational Component**

One of the most critical aspects of the educational piece was the question-and-answer session. Introduction of new terms to describe an emotional and physical state the participants had experienced before or had been aware of opened up conversation for the participants. Clinical staff had the opportunity to ask questions in an open forum, communicating with the study implementor and fellow participants about the study and information. The conversation, geared towards sharing experiences and common concerns, allowed the participants to see how much they all faced the same situations and feelings at one time or another. The participants were able to engage in conversation about what compassion fatigue and burnout look like for the clinical staff of the ACH, taking the conversation beyond the textbook terms to their real-life experiences. Those experiences shared with one another urged others to share as well, providing a comradery amongst the participants. The question-and-answer time also provided an opportunity for participants to determine the details of the project resources and provide initial feedback.

The initial feedback on the project was overwhelmingly positive. Participants expressed a strong awareness of the detrimental breakdown of emotions and physicality in their work as hospice clinical staff. In addition, the participants stated a consensus that compassion fatigue and burnout were immensely evident in their work and lives. The emotional deficit that hospice clinical staff experience with the care of dying patients was evident to all participants and they expressed the desire to find a solution with the study. Due to this evidence and excitement, those
present were exceedingly willing to participate and provide feedback for the study. Though the numbers at the initial session were small, the excitement was high. All were grateful for a chance to work through their compassion fatigue and burnout symptoms and aid in the evolvement of future resources.

**Educational Resources for Later Participants**

As mentioned, the number of participants in the initial education session was small. Six people attended the educational and question-and-answer session, with two unable to participate. The two who could not participate was due to the qualifiers of clinical staff only. The clinical staff, as mentioned before, was described as doctors, nurses, social workers, chaplains, and aides. The two staff members unable to participate in the study, however, expressed the importance of this education in ACH and participated in conversation about compassion fatigue and burnout in the clinical staff.

Word-of-mouth provided a more significant number to participate after the session. The initial group who had participated in the first session served as informal recruiters to have additional staff members join the study. Four other clinical staff members requested to join the study within the same day as the first session. The newly joining participants were able to discuss issues with the education portion they received. The participants received a copy of the PowerPoint and the study implementor reviewed the content. The study implementor remained available for questions and conversation as well. The remaining two of the final ten participants received a copy of the PowerPoint, walked through with the study implementor individually, and addressed questions. While conversations with many other staff members throughout ACH indicated the presence of compassion fatigue and burnout within the organization, and the agreement that education and resources for the staff was necessary, the numbers of participants
able to engage in the study indicated an already known issue. Clinical staff members were unable to participate due to the high patient caseloads and working responsibilities, such as long drives.

While the larger groups were much more willing to discuss issues due to feedback, the individual conversations also provided fruitful input on the importance of addressing compassion fatigue and burnout in the hospice clinical setting. The fact that the larger groups were able to engage in more conversation about their experiences within their job showed the encouragement received from relating to one another. Shared experiences promote unity and comradery, commanding a sense of trust among the participants. All participants had agreed to participate by the day following the initial education. Participants signed the consent form before beginning implementation of any resources of the remaining study (Appendix B).

Scheduling of Project Resources

The scheduling of the project resources was flexible due to the ever-changing nature of the clinical staff workplace. At the beginning of every shift, clinical staff within ACH plan for the day. The times for visits and documenting vary every day. Plans made in the morning also change as emergencies arise. Flexibility was a key factor to implement in the study to accommodate the needs of those involved. While the feedback sessions were specific times, the staff had the option of meeting at another time. The hospice care center staff, especially, required flexibility in this matter, because they were unable to leave their work post all at the same time. The feedback sessions were, then, held with those who worked for the care center later in the day from the meeting held at the office. In the counseling sessions, flexibility was built in as well. The times were set but they participants could sign up for the session during the time period that suited their schedule best. The ability to be adaptable provides less stress, and therefore, a lower
chance of adding to burnout for the ACH clinical staff participants. The goal was not to add more stress to an already stressful work regime.

**Feedback Sessions Scheduling**

The participants' feedback sessions allowed them to reflect on the previous time period concerning compassion fatigue and burnout. The first initial session, as mentioned above, provided the foundation education and initial questions. The session also provided distribution of the initial survey and questionnaire (Appendices G and H). Participants returned all forms within a day of receiving the documents, including those distributed the following day. The project implementor entered the questionnaire results into an Excel spreadsheet to determine percentages marking each number, one through five. The surveys were kept in a folder in a locked drawer to provide confidentiality throughout the entirety of the study.

The secondary session was a refresher, a check-in with participants to discuss the time occurring since the initial meeting. Participants received surveys and questionnaires and returned within a day of the session (Appendices G and H). An opportunity was provided for follow-up questions and discussion about compassion fatigue and burnout, the study, and the resources. At this halfway point of the project, the participants were able to reflect on their usage of resources, giving feedback on how the study was progressing, and how it could be adjusted. The session also served as a reminder of the signs and symptoms to look for and what resources were available. The participants were consistently going about their work caring for those who were dying, and triggers could be easily forgotten. Providing a check in allowed for the clinical staff participants to reset their mentality to include self-reflection and self-care. The project implementor entered results for the secondary questionnaire as well into the Excel spreadsheet parallel to the first results to calculate percentages and provide a comparison between the two.
The survey forms were placed in a separate labeled folder in the locked drawer for confidential keeping.

The final session was quite like the first, providing forms for participants to fill out and return by the following day, as well as a question-and-answer discussion time. However, the conversation provided more encouragement to engage in what was helpful in the study, what was not, and what was needed to improve in the area of compassion fatigue and burnout. The feedback provided was enthusiastic and compelling. The results for the questionnaire were then added to another column parallel to the first two, showing the progression of the three sets of results. Finally, the study implementor compiled all the results of the questionnaires into comparison bar graphs, shown below.

**Scheduling of Peer Conversations**

As mentioned before, peer conversations were very flexible in nature, not requiring a specific time or location to implement this resource. Due to the flexibility, however, the study relied on feedback to know the effectiveness. Within the feedback from the participants, they were able to say how many times they engaged in conversation with peers about their compassion fatigue and burnout, the helpfulness of those conversations, and any information they were willing to share for the benefit of the study. The noted difference was that most of the participants engaged in peer conversation with clinical staff members not engaged in the study. The fact that this occurred provided two new factors into the study. One, people were brought into the conversation about compassion fatigue and burnout who had not received the formal education portion. The importance is that new people were learning about the signs and symptoms and this education was carried further throughout the organization. Second, the participants showed the importance they placed on sharing deep matters with someone they trust
and can relate. As mentioned before, no person will be willing to share important information with someone if they cannot keep the information to themselves. The study implementor recorded the discussions in a notebook kept always locked in the drawer to ensure confidentiality. No notes were taken on content unless the participant specifically allowed their part of the conversation to be included. Overall, the participants reported a total of ninety-two peer conversations about compassion fatigue, though nearly all of these conversations were outside of the study participants.

**Scheduling of Counseling Sessions**

The counselor and implementor scheduled counseling sessions when they would be adequate for the participants to engage in this resource. The following schedule was agreed upon and implemented by the study director and the counselor:

- November 10, 2021  8:30 a.m. to 9:30 a.m.
- November 18, 2021  2:00 p.m. to 4:00 p.m.
- November 26, 2021  8:00 a.m. to 10:00 a.m.
- November 30, 2021  8:00 a.m. to 10:00 a.m.
- December 7, 2021  8:00 a.m. to 10:00 a.m.
- December 14, 2021  8:00 a.m. to 10:00 a.m.

Clinical staff at ACH usually come into the office for general office work, pick up supplies, and discuss patients and schedules with the other staff members of their teams. With the implementation of COVID-19 protocols, the office was no longer an area open for typical office activities. ACH required staff to be in the office as little as possible to avoid spreading the virus. Due to this change, counseling hours were set for the morning, when staff was more likely to gather supplies in the office. The implementation of the work-from-home model for ACH
required less clinical staff interaction with their peers. Due to this, staff had less opportunities to
discuss their concerns and frustrations and to vent and to decompress.

The study implementor provided the counselor sample questions to gear conversation
towards compassion fatigue and burnout in the ACH clinical setting. These questions served
simply as a guide, due to the qualifications of the counselor for ACH. The questions were as
follows (Appendix F):

1. What feelings have you experienced related to your work?
2. What events in your work have caused these feelings?
3. Are there outside factors contributing to these feelings?
4. How is this all affecting your work?
5. What are ways you can work through these feelings?
6. What have you tried? What has been helpful? What hasn't?

The counselor provided the counseling sessions at the previously listed times at thirty-minute
increments. The participants were directed to sign-up with the counselor or bereavement
department secretary for those time periods. The study requested the participants do so a day in
advance. However, the participants were also aware that the sessions were available during that
time frame and could be utilized on a last-minute basis if no one was present in the session at the
time of arrival. The counselor signed a confidentiality form to ensure the privacy of all
participants. Feedback was to be provided on a generalized basis by the counselor to share how
many participants utilized the resource and if the counselor felt the sessions were helpful.

**Implementation of the Intervention Design**

To begin the process, the study implementor held a meeting with the executive director of
Ashland Community Hospice, Inc. Appendix A reflects the consent for training, research, and
the calming room that [Redacted], Executive Director of ACH, signed (Appendix A). This
meeting consisted of the detailed layout of the project, including allowed participants for the study, what the role was to be of all involved, and how to implement the study. The implementor presented a full presentation for the executive director to make an informed decision on the importance of the research and implementation of outlets for the hospice clinical staff. In addition, documents were provided, including the consent forms for all those involved (Appendix B), the timeline of study (Appendix C), and a copy of the PowerPoint to be used for the education session (Appendix D). Once the executive director approved, the process began with implementing the project. The other approval required was from the bereavement counselor, verifying confidentiality in conversations (Appendix E). The recruitment flyer used can be seen in Appendix F. Times and locations for the counseling sessions and restrictions for peer conversations were provided to not add to clinical staff stress, and therefore, not increase compassion fatigue and burnout. The sessions were limited to thirty-minute increments and were available once a week during a two-hour block. The sessions were provided for the bereavement counselor and the participant to discuss compassion fatigue and burnout issues as they see in their own current situation. Questions that the counselor can explore were provided as suggestions (Appendix G).

Implementation began with the consent of participants; the study required this to be received before any further action could occur. Participants received the consent once the initial informational session finished. Appendix B is the consent form used in this study. Next, a presentation provided a thorough explanation of the project, the purpose, and the design to all interested in determining the desire and ability to participate. Those interested needed to receive a complete view and explanation of participation to assess willingness. The more educated the participants were in the process, the less likely they were to drop out of the study later. Next, a
question-and-answer session was held for potential participants to voice concerns or questions. This session lasted approximately thirty minutes to explain and address concerns adequately. After the participants signed consent forms, the participants remained for the education portion. This part of the session was to educate participants on compassion fatigue and burnout, the causes, and the possible ways to address the issues. The education provided stated the signs and symptoms of compassion fatigue versus burnout and what causes the problems in the first place. The training session provided detailed information on what was available to them should they face signs of compassion fatigue and burnout and how to access those outlets. Those outlets, as mentioned before, would include the counseling sessions with the bereavement counselor, the peer conversations, and the calming room with art therapy, aromatherapy, and music therapy provided. Also, in training, the participants were reminded of the follow-up surveys and questionnaires. A schedule was provided for when those follow-ups will be and all contact information for the project implementor (Appendix C). Lastly, the study implementor provided a beginning survey (Appendix G) and questionnaire (Appendix H) for the participants to provide a baseline for their compassion fatigue and burnout level at the beginning of the project.

Once initial training was complete, a six-week period commenced where the participants had the opportunity to use the resources provided. These resources included counseling sessions, peer conversation, and a calming room. This six-week period allowed for the ebb and flow of the census of each clinical staff member so that an adequate, consistent view of their emotional levels was available. Each of these outlets provided to the clinical staff members was required to have an area specified for the sessions, to limit interruptions and provide easy access for the participants. The bereavement counselor has her own office in which counseling could occur. The participants were provided a sign-up sheet with the bereavement department secretary to
schedule their sessions with the bereavement counselor. These sessions were available on a first-come-first-serve basis due to the schedule demand of the bereavement department.

The peer conversations had a more informal structure in which clinical staff experiencing signs of compassion fatigue and burnout could have an outlet for discussion. The peer conversations were to be held, with permission from the executive director, in a quiet area where interruptions were limited, such as personal offices, cubicles, cars, or other various work locations. In addition, social workers and chaplains, and other co-workers of the clinical staff were available on an agreed time between the peer and the clinical staff member during regular working hours.

The third outlet, the calming room, was implemented in a room specified between the executive director, the Hospice Care Center director, and those conducting the study (Figure 1). Due to office space demands and the COVID-19 pandemic limiting in-office access, the Hospice Care Center provided the space for the calming room. The room provided also had a sign-up sheet at the nurses' station. In addition, participants could use an initial or pseudonym for their identity should they wish to remain anonymous to passersby.

This room was available as needed during business hours so that participants had the outlet available for immediate calming. Supplies, including coloring supplies, aromatherapy supplies, and musical therapy supplies, were provided and displayed in an accessible and reasonable way by the study implementor. Coloring books centered on calming themes, specifically encouraging phrases, scripture references, and mandalas. Coloring pencils and a battery-powered pencil sharpener were provided, with regular checks made on supplies. Diffusers filled with lavender oil provided aromatherapy. The study implementor provided extra water and oil for refills and checked supply levels regularly. Musical therapy consisted of
calming music and sounds, including piano and violin with hymns and other relaxing music should a participant wish to listen.

Figure 1. “Calming Room.” Developed using www.smartdraw.com

During the six-week window, two surveys and questionnaires were provided that were identical to the initial for participants to respond. The answers provided a picture of where participants began and where they were presently with compassion fatigue and burnout levels, as
well as how they were working to implement the outlets available. These were disseminated two weeks from initial and four weeks from initial to provide a sense of the compassion fatigue and burnout levels at those points. The only difference between the questionaries and the initial was the additional question related to the resources provided and if they have been used (Appendix J). These were given to participants in short meetings, allowing them the chance to voice any concerns or ask any questions they may have at that point. The participants had the option to fill the forms out at that point or return them by the end of the week when they had more time to focus on the questions. At the end of the six weeks, the group filled out the final survey and questionaries (Appendix K). The survey once again remained the same, but the questionaries added an area for suggestions for future outlets that may help with compassion fatigue and burnout.

During the implementation stage, much of the intervention design proceeded as planned. The initial group meeting had four participants, though six more requested individual orientation into the study due to worktime constraints. Ten participants continued throughout the project, though only six returned surveys and questionnaires for the secondary and final meetings. The initial meeting lasted an hour, where the implementor gave the presentation about how to recognize compassion fatigue and burnout. Participants engaged in conversation and a question-and-answer session about the project implementation, participation, and overarching themes of the project. The other six participants received a copy of the training and an opportunity to ask questions of the project coordinator. Due to the straightforward nature of the participation required, participants in the study were eager and willing to begin.

Immediately following the first group meeting, the implementor set up the calming room. The calming room location was in the Hospice Care Center. Families of patients customarily
used the room; however, due to the COVID-19 pandemic, the room had been closed for safety and health purposes. The director of the hospice care center and the executive director of ACH allowed the usage of the room due to the individual nature of the activities. Throughout the course of the six-week project, the room had regular checks to maintain supplies and resources.

As the COVID-19 pandemic continued to increase in numbers of positive cases, the project took on a more individualistic approach. Unable to meet in groups for the meetings, smaller number groups had short sessions. The participants received surveys and questionnaires on a particular day. A folder located on the nurses' station at the Hospice Care Center and the coordinator's cubicle desk at the main office building allowed participants to place the completed forms. Participants returned all documents by the end of the week to one of the two locations, only viewed by the project implementor. This occurred three times throughout the six weeks, once at the two-week mark, once at the four-week mark, and once more at the end.

The bereavement counselor and study coordinator also established times for sessions (Appendix L). The times were provided based on the counselor's schedule and the likelihood of clinical staff availability. Due to the nature of the job, where most staff are on the road all day, the morning hours tended to be the best option. Rachel Swindler, the bereavement counselor for ACH, provided her office and time for the project. She signed the confidentiality waiver and used the agreed-upon suggested questions (Appendices F and I).

Peers determined the times for the peer sessions on an individual basis. Conversations tended to be more informal, happening between visits through phone calls or in-person debriefing. Many of the discussions occurred in the morning time while discussing the previous day's work and what was to come on the current day. The participants informed the project coordinator of many conversations. The implementor maintained the confidentiality of content.
Those participating in the study could share details in their surveys and questionnaires of the content and helpfulness as desired.
CHAPTER 4: RESULTS

Compassion fatigue and burnout are imperative concerns that must be addressed in the overall health of hospice clinical workers in ACH. The results from the study showed a correlation between the work and their mental and emotional health. Though some of the data was inconclusive, the survey open-ended statement results provided the most significant insight into the compassion fatigue and burnout working as a hospice clinical staff member can cause.

Results from Questionnaire

The questionnaire had ten statements for each participant to rate on a level of one to five, one being "definitely not" and five being "definitely so" (Appendix G). The participants completed the questionnaire three different times. The first time was at the initial meeting and is referred to as the initial questionnaire. The second instance was during the mid-study check-in and is referred to as the secondary questionnaire. The last time participants filled out the form was during the final session, and it is referred to as the final questionnaire. The importance of filling out the same form at three points during the study is to show any changes that occurred throughout the length of the six weeks.

The first statement stated, "I enjoy my work." The participants varied on the degree to which they enjoyed their job, though 40% answered "definitely so" (Figure 2). The clinical staff participants reported enjoying their work at a higher level on the second survey, with 83% answering with a four or five. Some varying differences arose in the final survey, with a few participants feeling strongly that their work no longer brought enjoyment. Being inundated with dying patients, watching them slowly shut down and take their last breath, is not an easy task to endure. Hospice clinical staff are compassionate, loving people, and steadily showing those feelings while providing care is not easy. Clinical staff can find that the constant view of death...
can cause the satisfaction of work to lower. If the messages and images one’s brain is receiving compiles without adequate decompression, the effect is numbness or emotional instability. As a coping mechanism, the staff can use the numbness to push through the emotional carnage they have to deal with day in and day out, until they have time to decompress. Often, however, the decompression can be of a negative nature including projecting on others or self-medicating with alcohol. The changes of pleasure in their work showed the ebb and flow of the emotional toll of the work. The workload and emotional pressure they feel being a hospice clinical staff member causes changes in their ability to enjoy their day-to-day work. While the work they do is the same, the caseload may vary. Also, outside factors like family stress, schoolwork, or secondary jobs can compound with their normal work stress. These factors can stack precariously higher like a game of emotional Jenga until they, the clinical staff, no longer has a foundation of coping on which to rely. Then, all of the precarious foundation comes tumbling down in a heap of emotional and physical turmoil.

Figure 2. Statement 1, “I enjoy my job” Results.

Statement two the participants rated stated, "I feel tired when I arrive at work." For the initial survey, the clinical staff had a wide range of beliefs about how tired they felt when they arrived at work (Figure 3). Out of the staff members who participated, six worked Monday through Friday from 8:30 a.m. to 5:00 p.m. During the six-week time period, five worked at least
one on-call shift. Three were on varying day time schedules at the care center, some of the days through the week and some on the weekend. The last worked Monday through Friday and was on-call consistently throughout a large portion of the study.

Though 80% rated not being overly tired at work with a three, four, or five, the answers were still quite spread out. Being tired is a routine part of life, especially when one is a working adult. What constitutes the question being vital to the study is the consistent nature of the tiredness. Clinical hospice staff members, when faced with returning to work for another day of compassionate caring, expressed they felt tired before work even began. While it is typical for adults to feel some sleepiness when working early morning shifts, the numbers indicate that the caring work in which the clinical staff participants were a part of eventually caused the exhaustion level to steadily weigh down on them. With the secondary and the final questionnaires, an increase in the initial exhaustion level was seen within the clinical staff participants on arrival to work, with no one stating they were "definitely not" tired when they arrived at work. These results indicate the presence of death and dying can have on the exhaustion level of the caregivers.

Though clinical staff enjoys their work regularly, the emotional toll caused by working in hospice has physical effects. The tiredness felt by the participants could have been caused by more than the idea of going to work. The participants often stay up late into the evening documenting their heavy caseloads. The clinical staff also had the on-call shifts previously mentioned that prevented effective sleep. A phone does not need to ring for it to disturb sleeping patterns. Waiting on a call at all hours can avert a positive sleep experience. Also, staff reported worrying about specific patients throughout the night, causing sleep disturbances as well. The consequence of being a person who has a sympathetic heart is that the emotions cannot be left at
the workplace. Clinical staff carry those burdens home, effecting sleep, home life, and other factors.

In Figure 4, the results for statement number three are shown. The statement read, "I feel appreciated at work." (Figure 4). The results to this question were primarily grouped in the center, showing a high number of hospice clinical staff were ambivalent towards the work appreciation level. With 90% for the initial and secondary questionnaire and 100% for the final questionnaire, the clinical staff felt they were not wholly appreciated or unappreciated. Compassion fatigue and burnout increase when a person feels unappreciated in the workplace. In correlation with the previous question, these results indicate that the more unappreciated they feel in their workplace, the more exhausted they become. The feedback is another example of how the emotional toll of working in the ACH hospice care setting causes physical symptoms to surface.

Appreciation in the workplace is imperative to keeping current effective staff members in the job. When people feel that what they do is appreciated, they are more willing to work higher
caseloads or harder hours. In return, that caseload or hours can be manageable at a higher level when they believe they are appreciated for the work they are completing. When they do not, often they find themselves not caring about their work because they believe no one else does. Continuing to work hard seems pointless if there is no positive reinforcement.

![Statement 3](image)

**Figure 4. Statement 3, “I feel appreciated at work” Results.**

In the fourth statement, "I can maintain my composure at work when I am mad or sad.", the clinical staff presents the strong ability to control their emotional outbursts in the workplace (Figure 5). However, throughout the study, a steady decrease in the ability to maintain composure, going from a high "definitely so" representation to spread along the axis of ability, is seen. By the final questionnaire, the clinical staff felt less skilled at controlling their emotions in the workplace. Once again, there is an evident correlation between emotional and physical issues. The issues of physical exhaustion, feelings of unappreciation, and emotional lack of control all increase together. While there is a difficulty in determining which causes the other, they are strongly related.
Maintaining emotional composure is necessarily for those in caring professions. While composure does not mean showing no emotion at all, a level of control is expected of those in charge of caring. Tears and empathy are appreciated but projecting their own sadness on the patients or their families not only shows unprofessionalism but lack of control of one’s emotions. Strong outbursts of sadness or anger when caring for others is often a compounding of emotional factors without an outlet to decompress.

Figure 5. Statement 4, "I can maintain my composure at work when I am mad or sad" Results.

The clinical staff also rated statement five, which read, "I have a hard time separating my personal life and my work life.". The idea of being able to have a work-life balance is important in the overall care of patients, families, and clinical staff themselves. However, work-life balance is not a one of the other, but rather on a continuum that changes from day to day. One day, clinical staff may feel that they have a good balance between the two, able to focus on work during the scheduled hours and not take the work home at the end of the day. On other days, work maybe so strenuous emotionally that they must document for the rest of the evening at home. While there will always be days like those that occur in any jobs, but especially medical
caring professions where documentation is a requirement in addition to visits, the consistent,
unchanging inundation of this could bring a person down to emotional wreckage if not
appropriately addressed.

The results, as shown in Figure 6, are very widespread. While some clinical staff felt they
had a decent separation of work and home life, others thought they did not. Little change was
noted throughout the study with this particular statement. The participants varied greatly
throughout. Various factors influence this, especially the subjectivity of the statement. What one
clinical staff may consider a balance between work and home life, another may not. Some
participants may have believed it acceptable to document while eating dinner, while others felt
this took away from personal time. Some participants were married or had children, which
already is a hinderance to self-care. The importance of home life changes with these dynamics.
The inconvenience may seem more substantial when the home life is more significant.

Another factor that influenced the work and home life balance was the COVID-19
pandemic. The staff began working from home as much as possible, leaving from their home to
make visits, documenting at home instead of in their cubicles at work. When the home becomes
an office, separating work from home becomes even more difficult. Tasks for home and work
become interwoven, and there is essentially no separation between work life and homelife. While
clinical staff are home more, they are doing work tasks. Then home is no longer a solitude from
the emotional baggage of compassionate care, but rather another place to store that baggage.
Figure 6. Statement 5, “I have a hard time separating my personal life and my work life” Results.

In statement six, the numbers take on an interesting process. The clinical staff rated the statement that read, "I am able to manage my workload." Though a higher number of staff believed they were able to manage their workload by rating this statement a four, the other answered various numbers. In the secondary questionnaire, however, every person surveyed marked a four, signaling a high ability to manage their assigned caseload. Finally, a spread of coping ability appears with work level in the last questionnaire. Yet, in all three, no one answered a five, or "definitely not," in being able to manage their workload. Once again, these markings show evidence of the ebb and flow that comes with working in the hospice setting. Compassion fatigue and burnout can come and go depending on many factors, including workload, personal stresses, and coworker dynamics. Even if they are physically tired and feel unappreciated, the clinical staff still thought they were adequately able to manage their workload. However, even if they can handle the workload, the results from other statements indicate that that workload causes pressure on their ability to cope emotionally.
Managing a caseload is not the same as thriving or doing extraordinary work. Managing means as simple as being able to handle all the patients when they need to be seen with adequate care. The term is almost ambivalent as to say, the work is enough and nothing else can be given. In compassionate care jobs, very rarely can a person only manage the caseload, but rather must go beyond that point. Staff feeling that they are not, at times, even able to sufficiently manage the caseload means that so much more is left undone emotionally in their work care. Self-preservation and coping skills often kick in strongly when the caseload feels too heavy and too difficult to handle, causing the clinical staff to muddle through their daily tasks with no heart or emotional energy.

![Graph](image)

**Figure 7. Statement 6, “I am able to manage my workload” Results.**

Statement seven on the questionnaire stated, "I feel supported by the leadership in my workplace." The rating provided by the participating clinical staff showed a great deal of ambivalence (Figure 8). The clinical staff marked towards the center of the numbers on all three, especially in the final questionnaire. Though a few did not match, the majority pointed to the staff feeling somewhat supported by the leadership. As mentioned before, the clinical staff felt
unappreciated in the workplace. That result is again reflected in this statement's results. If the clinical staff felt supported fully by leadership, they would feel more appreciated at work. However, the ambivalence of feeling support from the leadership is reflected in the exhaustion level, emotionally and physically, of the participants. COVID-19 also impacted the support of leadership due to the inability of contact with the leadership. While the administration worked in the office, clinical staff members could not be in the office for prolonged times. Therefore, the virus reduced communication to emails and phone calls, which causes a decline in feelings of support. The inability to sit down in the office of a team leader or administrator to discuss work issues not only caused staff members to feel a lack of support but also reflected in the exhaustion levels they reported. Also, when conversations were held in the office, emotions were hidden behind masks required due to the COVID-19 pandemic. A person can hide nonverbal cues much easier when the face cannot be seen, or the tone heard as well through a thick mask. Much can be said about small talk and body language that is lost when communication is over electronic devices versus in-person, or when the in-person visit is altered. Those elements were lost due to the COVID-19 pandemic. Whether the leadership realized the importance of the communication that was lost or if it was unable to be compensated for is unknown; however, the lack of intimate conversation was missing.
Figure 8: Statement 7, “I feel supported by the leadership in my workplace” Results.

Statement eight, which reads, "I make a difference at my work," is reflected in Figure 9 (Figure 9). Overwhelmingly, the ACH clinical staff felt they made a difference at their work, even if it was at a lower level. Yet, no questionnaire answered one, or "definitely not" through the project's entirety. Compassion fatigue is often unique to caregiving roles and professions due to the overwhelming compassion they show on an everyday basis. The calling to care for someone else requires a level of kind-heartedness that many cannot understand. Feeling that one makes a difference in this role is vital; however, wanting to make a difference and pushing oneself to do so can have devastating emotional, physical, and spiritual implications. As reflected in the questionnaire results, despite the positive aspect of feeling like they made a difference, the clinical staff participants struggled with exhaustion and feelings of unappreciation. The push to help everyone caused damaging effects on the participants.
Figure 9. Statement 8, "I make a difference at my work" Results.

Statement nine on the questionnaire read, "I make time for self-care.". While there was a great deal of spread in answers for all three instances, the final questionnaire showed a decline (Figure 10). Less of the clinical staff answered positively on finding time for themselves to provide resetting self-care. Once again, a correlation appears between the exhaustion level of the clinical staff participants and the ability to provide self-care. The less time the clinical staff found to provide self-care in their lives, the more exhaustion and lack of emotional control they felt. Self-care is vital for all people, but those in caregiving roles, like the ACH clinical staff, need time to decompress from the stresses of the job. While caring for others is essential, the clinical staff found themselves spending more time on the caseloads, caring for others than working on themselves. The ACH clinical staff participants, as mentioned, felt differing opinions on how they handled their work life and home life balance; yet, as indicated with this statement's results, even when they have the balance, the home life comes before self-care. The compassionate heart that comes from being a clinical staff member in hospice indicates caring for others before, or instead of, oneself. Self-care is often the last thing clinical staff think of in their lives. The
differences vary based on how many things come before the self-care in the first place. The more items or people to care for on a list, the farther down self-care is pushed.

Figure 10. Statement 9, "I make time for self-care" Results.

The final statement stated, "I know how to calm my emotions when work becomes too difficult.". The secondary questionnaire found the strong confidence in the clinical staff's confidence in their calming abilities, while the final questionnaire found the most substantial decline in confidence (Figure 11). However, no one rated any questionnaire with a one, showing at least some self-control. As mentioned before, the ACH participants felt they could control their emotions, though the ability declined throughout the continuance of the study. This mirrors that result, in that the participants felt that when they had strong emotions, their ability to calm them decreased as the study continued. However, the positive view is that even if the participants had strong outburst, they were able to calm themselves after the outburst.

The correlation between all these factors shows an interesting dynamic. Physical exhaustion, the inability to control or calm one's emotions, the lack of appreciation, and the lack of support by leadership all increased together. Due to this correlation, there is an apparent link
between the physical, emotional, and mental toll caused by hospice clinical staff work. Clinical staff in a hospice setting are constantly bombarded with strong emotions of patients and families. The clinical staff feel deep compassion for those their patients and families. They are piled on with large caseloads, hours of documentation, and job requirements that take away from personal and home life. Their time needed to decompress is not available due to the time constraints on them. The cycle, then, continues to the point that clinical staff become so burdened or disillusioned that they are driven to quit their job, or at the very least, quit providing quality care to their patients. Compassion fatigue and burnout are evident in the results.

![Chart](image.png)

Figure 11. Statement 10, "I know how to calm my emotions when work becomes too difficult"

**Results from Survey**

In the initial survey, participants finished open-ended statements related to their work, emotional well-being, and coping mechanisms (Appendix C). The survey presented the questions to the participants to spur them to elaborate and expand on the topic as they saw fit. The first open-ended statement began, "In the past month, work has made me feel…". The answers to this
question immediately showed the emotional burden caused by work in a field of continual death. The terms used were most negative in connotation, with only two adding rewarded and appreciated to other descriptors. The consensus of terms included frustrated, overwhelmed, unappreciated, overworked, tired, undervalued, underpaid, emotional, sad or depressed, useless, and aggravated. The collection of terms on the initial survey indicates a high level of compassion fatigue and burnout among the clinical staff participants already. In addition, the clinical staff have the emotional and physical exhaustion caused by the stressors of their jobs.

As mentioned before, compassionate care work is difficult to do daily. When a hospice clinical staff member does not have the appropriate ways or outlets to decompress, the feelings are amplified. Frustration becomes anger, underappreciated becomes unappreciated, and undervalued and underpaid becomes unemployed. Staff members chose to walk away from the job or to provide mediocre care to preserve self, leaving the organization to scramble to fill the positions, train, and attempt to keep new staff. All the while, no attempt is made to help the staff through emotional turmoil that is naturally caused by this type of work. The initial survey answers to question one indicates that the staff participants were coming into the study with a foundation of exhaustion and compassion fatigue.

The second statement was to open more conversation about the emotional well-being of participants. The open-ended statement said, "In the past month, I have had the following concerns with my emotions in relation to work...". Participants reported a disconnect related to compassion with their work. Numbness, feeling a lack of compassion, and not being able to appropriately express emotions were all concerns of the participants. The questionnaire results indicated that due to the high volume of dying and death the clinical staff deal with on a routine basis, they were more likely to disconnect from their emotions altogether. Once again, these
results were from the start of the study, and therefore, indicative of the toll the hospice work had on clinical staff already. Though the questionnaires indicated ambivalence in many factors, the open-ended questions told a bolder story.

The third statement reflected the project participants' workload, stating, "In the past month, my workload has been...". The participants reported high and heavy caseloads, calling it "excessive," "exhausting," and "stressful." A strong link is seen between the emotional well-being of the clinical staff and the work demands. As larger caseloads pressure clinical staff in the hospice setting, the staff is pushed past their emotional capabilities, causing them to be numb or disconnected. Seeing more and more patients die with no outlet for emotions causes the workload to be more difficult to bear. As these results were at the beginning of the study, indication of more necessary outlets can be seen. Staff has already come to a point of compassion fatigue and burnout before the study even began. High cases and increased expectations are the norm for clinical hospice staff.

In the fourth statement, "In the past month, when I struggle with my workload or my emotions, I...", the participants had the opportunity to reflect on their coping mechanisms. The answers given to this statement were very polarizing, showing various ways in which people choose to cope, whether they are healthy or detrimental. Many participants mentioned talking to a friend or family member or praying as a means of coping. This coping mechanism boded well for the peer conversations in the study with the realization that conversation with someone they trusted and admired was a positive means of emotional expression. Others discussed ways of self-medicating with alcohol or shopping. While occasional drinks or shopping trip is not bad in of itself, the use of these elements to cope with unwanted emotional devastation can leave to addiction and death. Another mention, however, from several participants was how they distance
themselves from the actual emotional issue by compartmentalizing. While temporarily pushing aside emotions to complete necessary tasks may be needed in order to provide effective care for patients and their families, the emotions need to be dealt with eventually. Continually compartmentalizing can cause physical effects like headaches and ulcers.

The fifth and final statement on the questionnaire was a direct statement, requesting how the clinical staff see their emotions, physicality, and spirituality at that beginning moment of the study. The participants were able to particularly address their role as a clinical staff member for hospice. The statement read, "Please describe what physical (sleeplessness, overeating, no appetite, etc.), emotional (crying, anger, no emotions, etc.), or spiritual (disconnected from God, anger with God, etc.) issues you have encountered, if any, in the past month, due to your role as a hospice clinical staff member." The physical issues reported by the participants were overwhelmingly sleep disturbances and negative eating habits, explicitly overeating. Sleeplessness, insomnia, and restlessness at night were reported by 70%, and overeating was reported by 50%. The reasons noted were the on-call schedule and worrying about whether the clinical staff were providing compassionate care. While only a few of the participants in the study worked required on-calls, as shown in the questionnaire, most of the participants were tired. Often, clinical staff worry about what they need to do the next day or how to care for someone in their caseload. This can provide the restlessness and sleeplessness the participants reported. Overeating, or stress eating, is also a strong indication of the emotion stress the staff is experiencing. Aside from the emotional eating, staff often miss meals because of the heavy caseload. When the staff is able to eat, they over-indulge, causing health issues to follow them home.
Emotionally, the participants expressed the same issues listed before. The answers reflected an inability to control emotions, whether through disconnecting and numbing or over-emotional outbursts and crying. The spiritual problems mentioned by the clinical staff participants were angry with God, questioning God's sovereignty, and feeling distance from God. Of the participants, 60% felt that disconnect or questioning God due to the overwhelming amount of death and dying they see in their work. Unfortunately, in the clinical hospice realm, many staff become disillusioned with God for a number of factors. One, the clinical staff may feel that the sheer total of people they see die throughout their career proves God does not care. Two, they see ministers and Christian family members stating hurtful things or fighting with their families. The negative example set by the Christian family members and friends can be detrimental to the faith of clinical staff workers.

The participants had the same questions on the secondary survey, except for the added question about the resources provided during the project. Participants answered many of the statements with the same terms and tone as the first. However, the second statement about the emotions concerning work had more mention of indifference, numbness, and disconnection than the prior questionnaire. All discussed the overwhelming workload, and how much pressure is on them, yet the emotions had expanded past crying and anger to being despondent. These results showed the increasing level of work and emotional toll continued to push against hospice clinical staff. Throughout the study, their awareness of compassion fatigue and burnout in their own lives and care increased, while finding means of coping stayed the same. While the participants continued to use peer conversation with a co-worker as a means of venting and decompressing, the other resources, such as the calming room and counseling sessions were not used. Time constraints and travel issues put even more pressure on the staff to not use these resources.
On this secondary survey, as well, statement five asked, "Have you used the counseling sessions, peer conversations, or calming room provided in this study? If so, what was useful and what could be improved upon? If not, what has prevented you from using the resources?". No participants had used the structured counseling sessions, citing difficulty making time in their day to use the resources. No participants used the structured peer sessions but reported that talking to coworkers during their day about their emotional struggles and workload had been helpful for them. Of the participants, 30% had used the calming room. While they all reported they appreciated the time and the resources, they also indicated that they still worried about being in the calming room "on the clock." Most clinical staff members have no problem documenting and fielding questions from patients. However, clinical staff see using fifteen or thirty minutes for self-care while on the clock as bad practice. Of those unable to use the room, the participants primarily gave two reasons. One, they were homecare clinical staff and had no chance to visit the calming room at the care center. Some drive as far as an hour and a half away, so utilizing this resource was difficult. The other reason was that families of patients used the room and did not allow access. Even though the room was off-limits for families, the staff did not enforce this rule.

On the final survey, the term "exhaustion" was the key. Of the participants, 90% stated they were overwhelmed and exhausted with the continued workload. Many mentioned the emotional toll of the COVID-19 pandemic and attempting to care for others with heightened restrictions. Every clinical staff member mentioned the high workload and constraints put on them as members of the hospice clinical staff. Though many expressed understandings that the
leadership cannot control all factors, the prime reason for the high caseload related to taking on the workload of other coworkers due to restrictions with the COVID-19 pandemic.¹¹⁸

The final statement reflected the usage of the resources provided during the project once again. The answers were much the same as the previous questionnaire. Many participants, 80%, thought the idea of a calming room or counseling session was beneficial but were unable to utilize the resources due to driving for work and time constraints with the caseload. However, 90% of clinical staff members stated that they had used "venting" and conversations with coworkers as a means of coping with the compassion fatigue and burnout feelings that occurred. Due to the work conditions of ACH, staff members found the time to escape the emotional toll was best with coworkers and peers. The staff members were unable to do so by utilizing other resources.

¹¹⁸ The COVID-19 pandemic caused many restrictions to be placed in healthcare facilities and workplaces. ACH required staff to be vaccinated to enter nursing home. Also, if a staff member was exposed, he or she was required to quarantine from five up to fourteen days based on current recommendations. Many staff members were required to take on the work of those quarantined or sick with the COVID-19 virus. Others had to take on more patients in nursing homes due to their vaccination status.
CHAPTER 5: CONCLUSION

What, then, can be deciphered from the results? What is indicated that can be discussed and interpreted? First, the apparent link between working in the ACH clinical setting with compassion fatigue and burnout is present. The continual caring of dying patients and the high visibility of death, coupled with personal issues and coping problems, weigh heavily on the clinical staff in the hospice setting. Much research has been done on this phenomenon, but there is still little to combat the issues. While the resources provided during this study were adequate, more must be done.

What Was Learned From This Study

First and foremost, the study indicates the presence of compassion fatigue and burnout among clinical staff at ACH. Emotional and physical damages from actively caring for the sick and dying and their families are strongly evident. If unchecked, the damage can be devastating. If uncared for, the caregiving professional faces high employee dissatisfaction or turnover. At the worst, having compassion fatigue and burnout unnoticed can cause self-disillusionment. Clinical staff workday in and day out to meet the needs of those who are dying and their families. Family members who have never experienced death can burden the staff with doubts and accusations. This causes strong frustrations. If the clinical staff has not slept or has a personal issue, they carry with them to work, they can feel even stronger frustrations. Without the support of leadership and not feeling appreciated, the clinical staff’s emotional health can be kicked aside.

The self-disillusionment the clinical staff feels can leads to self-medicating, addictions, self-isolating, and suicidal thoughts or actions. Self-medicating by means of alcohol, food, drugs, or other forms of escape does not help the clinical staff deal with issues. Rather it temporarily compartmentalizes the pain, making it even more difficult to deal with later. Then, staff complete
mediocre work, self-medicate as a result, and the cycle continues into an addiction. Also, many clinical staff members struggle having someone to talk to about their work outside of their peers due to HIPPA mandates and the lack of understanding in the emotion toll of their job. Because of this they self-isolate, pushing the emotions deeper or letting them take over completely, not appropriately dealing with them as they come. Suicidal thoughts and actions can occur due to the addictions or self-isolation, or even the deep emotional stress caused by seeing death and dying on a regular basis. Even the frustration with doing mediocre work when accustomed to caring as a means of self-preservation can make a clinical staff member feel useless as a caregiver. As indicated in the participants' results, even a period as short as six weeks can have explicit changes in emotional and physical state. Prolonged periods of time under the pressure of caregiving can trigger more substantial and more unbalanced results emotionally, physically, and spiritually.

Secondly, the correlation between feeling appreciated and supported by leadership with the symptoms of compassion fatigue and burnout was tremendous. The clinical staff needs to feel validated in their work, feel the support of those in charge, and handle the burden the workload causes. The participants reported feeling tired and emotionally challenged most when they did not feel support from the leadership. This correlation is connected to feelings of underappreciation in their workplace. During the COVID-19 crisis, leadership and the clinical staff experienced a disconnect, resulting in the appearance of a lack of concern or support. The best way to overcome this is to adjust strategies. What worked in ordinary circumstances did not work in a time of a worldwide pandemic. Those in leadership positions need to find ways to support their staff from a distance, to be creative in their approach. A simple word of encouragement in the emails assigning caseloads can provide a great deal of positive
reinforcement to a clinical staff member struggling with emotional pressure. While leadership and administration deal with stress in their work as well, they do not have the hands-on experience with dying patients that clinical staff do. They need to encourage their charge in their work, remind them they are appreciated, and allow for adequate self-care. If not, the administration is faced with employees who do work half-heartedly or who quit, because they cannot keep up with the emotional demands of the clinical staff.

Next, the inability for staff to find adequate ways to decompress with the present work structure is high. The reality was shown through the lack of interaction with the resources provided. The counselor reported no utilization of the counseling sessions at all. Not one participant partook in this resource, despite encouragement to do so. The boundaries that made the counseling sessions unused were various. First, the sessions were in the main office, where COVID-19 restrictions prevented staff from lingering or coming into the office. Most of the clinical staff only went into the office on the days when ACH required testing for COVID-19. For many, that meant only once a week. Also, the office is administrative as well. While the administration is aware of the need for counseling, participants find it hard to discuss the frustrations and annoyances of leadership in the administrative setting. Finally, while it was necessary to have a schedule for the counseling sessions, clinical staff participants did not feel the weight of their job on a schedule. Signs and symptoms of compassion fatigue and burnout would manifest between visits or at the end of the day when the participants were nowhere near the office. Some of the participants traveled as much as seventy-five minutes for a visit. To visit a counselor during a workday with that type of travel was challenging to say the least.

While clinical staff are always able to attend counseling even outside the workplace, the likelihood of that occurring when free resources inside the workplace are not utilized is slim.
Staff can talk to counselors at ACH during work hours and yet they are rarely used. Because of the pressure to complete the caseload and the taboo of focusing on mental health, staff feel pressured to not focus on themselves during the work hours. Then, after work, life and personal responsibilities require focus. Essentially the need to speak to a professional counselor is ignored because the ability to engage in the resource is so small.

The calming room also faced challenges during the study. Though the care center staff had marked the room as closed, families of patients used the room as their personal area while their loved ones were present. The care center staff made no attempts to address the protocol violations during these times; therefore, the participants could not always utilize the calming room. While this only occurred on two instances, they both lasted a week, leaving two weeks of not being able to employ the usage of the room. The fact that the families utilized a room that was first marked off for COVID-19 precautions and then agreed upon for the study by administration and the study implementor reinforced a previously mentioned issue. The leadership and administration are not taking steps to assist with the mental health of the clinical staff. A positive way for the care center staff to quickly decompress and return to work was provided, and yet, the usage of the room could not be relied on because leadership would not enforce their own rules. The room was designed so that it would not interfere with the care of patients and families, using a room that was not being used for any other purpose. Families had various other locations to employ for their care, but they were not redirected to those areas. This reinforces that the mental health of clinical staff is not as important as making the families happy. What this fails to accomplish, however, is that patients and families will receive less than adequate care if their mental and emotional health is continually pushed to the backburner.
Another issue with the calming room was the location. Even though the study provided a room located at the hospice care center, the homecare staff found this difficult to employ. As mentioned before, many participants drive long distances to visit patients. Due to time constraints with visits, the participants could not drive even the shorter lengths of twenty or thirty minutes to decompress in the room. If they did, the participants were not even guaranteed the usage of the room, due to the family utilization. Because of this, clinical staff participants who worked in homecare, which was more than half, were unable to use the calming room as intended.

However, the care center staff participants involved in the study found comfort in the calming room when they were able to utilize it. The feedback of those able to use the room was overly positive. While this is rewarding and serves as a basis for those who can be present in the calming room, a disconnect is still present for homecare staff members. A need to enforce the importance of mental and emotional health among the leadership in the hospice care setting is strongly evident.

**Taking the Research Further**

The project provided a foundation for those wishing to explore further ways to combat compassion fatigue and burnout in hospice clinical staff. The foundation provides wisdom on helpful resources and those that are not. More than that, the study showed the necessity of education for clinical staff to understand what compassion fatigue and burnout are and how to recognize them in their own lives. However, many setbacks and further questions arose during the study requiring further research or studies to combat the compassion fatigue and burnout that hospice clinical staff face in their work field.
What can be done from this point to ensure success? First, education needs to be provided continually to hospice clinical staff. While there is a definite need to educate at the beginning of one's work in that setting, the ability to reflect on personal experiences and apply them to one's own journey is missing. The administration should provide ongoing education to hospice clinical staff about recognizing and combatting compassion fatigue and burnout in themselves and their colleagues. The administration themselves need education on how to help clinical staff in times of emotional distress. If leadership would take an active role in helping their teams combat the symptoms of compassion fatigue and burnout, they would see a great difference in the morale, work ethic, and employee retention. Employees who feel appreciated and supported are more willing and able to take on difficult workloads.

Second, resources need to be continually explored to find what works for each location. In a hospital, nursing home, or hospice care center setting, the calming room can provide an ideal resource for staff to decompress and reset as needed. The room would have to be set aside, and enforced, as an employee calming room, and allow clinical staff to not have hinderances in the utilization of the resource. Calming rooms are a valuable way for staff present at facilities to decompress in the moment it is needed and return to work with little to no interruption. This allows for better care of patients and families altogether. However, other resources should be explored for homecare staff and those continually working on the road or alone. Calming rooms are pointless for those who are nowhere near the facilities, because it is impossible to know when emotional turmoil will hit. A person can be an hour away when the need to decompress arises. Resources such as relaxation listening resources for the car in the form of CDs or playlists, as well as travel diffusers can help those unable to utilize the calming room. Also, having someone to talk to about issues while on the road is imperative as well. However, as seen in this study,
clinical staff members need someone they can trust to not divulge information to others. This could be leadership if they would provide the support needed, but more often than not, clinical staff will turn to peers who understand what they are facing.

Third, just as mentioned before, there needs to be an emphasis on the importance of peer communication and decompression. This study showed strong support among peers. Peers could communicate freely with one another without fear of retribution in their workplace. Peers could also vent about frustrations, knowing that their peers understood the perspective from which they were coming. The ability to have someone to relate to and open up to provides a perfect resource for the majority of the study participants. The effect that communication with peers on an emotional and personal level cannot be ignored. While having a professional to talk to can be helpful, having someone in the same situation, the same position, to discuss the emotional toll one is facing can be healing in a way no counselor can.

Compassion fatigue and burnout are evident and compounding problems facing hospice clinical staff. Having no outlet and no way to decompress can push that problem further. Compassion fatigue and burnout can lead to staff shortages, the disillusionment of present staff, and a lack of compassionate patient care. The issues can also cause depression, anxiety, exhaustion, and a myriad of other emotional and physical symptoms of the clinical staff. Research must continue until there is a way to combat compassion fatigue and lessen the effects on the hospice clinical staff.
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Appendix A

Consent for Executive Director of Ashland Community Hospice, Inc.

By initialing and signing below, I ________________________ hereby agree to the following elements for the doctoral thesis project implemented by (Betsy) Ruth Cole, spiritual counselor:

(Please initial by every statement that state you read and agree.)

_____ Mrs. Cole has permission to conduct thesis project in Ashland Community Hospice, Inc.

_____ Mrs. Cole has permission to provide an education session for clinical staff on compassion fatigue and burnout.

_____ Mrs. Cole has permission to provide a training session for participating employees on the project.

_____ Bereavement counselors will be available for agreed upon times.

_____ A calming can be implemented and maintained during the six-week period and available to participants at 15-minute increments.

_____ Employees will be encouraged, but not required, to participate in project through its entirety.

_____ Employee participants will be allowed to participate without hinderance to their employment.

__________________________
(Print Name)

__________________________
(Signature)

__________________________
(Date)
Appendix B

Consent

Title of the Project: Compassion Fatigue and Burnout: When Caring Becomes Too Much
Principal Investigator: (Betsy) Ruth Cole, D.Min candidate, Liberty University

---

**Invitation to be Part of a Project Study**

You are invited to participate in a project study. In order to participate, you must be a doctor, nurse, social worker, or chaplain for Ashland Community Hospice, Inc. Taking part in this project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this study project.

---

**What is the study about and why is it being done?**

The purpose of the study is to determine the presence of compassion fatigue and burnout among hospice clinical staff, as well as determine the effectiveness of interventions including counseling sessions, peer conversations, and a calming room in lessening or stopping the onset of compassion fatigue and burnout.

---

**What will happen if you take part in this study?**

If you agree to be in this study, I will ask you to do the following things:

1. You will need to be available for an education session on October 26 at 9:00 a.m.
2. You will fill out surveys and questionnaires at various intervals throughout the six-week period of the study evaluation your personal level of compassion fatigue and burnout.
3. You will need to participate in a final session, involving focus group discussion, about the validity, helpfulness, and further suggestions to the project.

---

**How could you or others benefit from this study?**

The direct benefits participants should expect to receive from taking part in this study are direct feedback about personal compassionate fatigue and burnout concerns and the ability to engage in activities designed to lessen compassion fatigue and burnout.

Benefits to society include providing direct feedback on helpful techniques for lessening compassion fatigue and burnout to hospice clinical staff and developing a strong program for future use.

---

**What risks might you experience from being in this study?**

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

---

**How will personal information be protected?**
The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Project records will be stored securely, and only the study implementor will have access to the records.

All data will be maintained through assigned numbers to each participant to protect the responses and confidentiality. Information stored will be on a password locked computer and erased three years after the conclusion of the study. Counseling sessions and peer conversations will be held in private areas. Confidentiality cannot be guaranteed in focus group settings. While discouraged, other members of the focus group may share what was discussed with persons outside of the group.

<table>
<thead>
<tr>
<th>Is study participation voluntary?</th>
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<tbody>
<tr>
<td>Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University or Ashland Community Hospice, Inc. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.</td>
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<tr>
<th>What should you do if you decide to withdraw from the study?</th>
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<tr>
<td>If you choose to withdraw from the study, please contact the study implementor at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you, apart from focus group data, will be destroyed immediately and will not be included in this study. Focus group data will not be destroyed, but your contributions to the focus group will not be included in the study if you choose to withdraw.</td>
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<tr>
<th>Whom do you contact if you have questions or concerns about the study?</th>
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<tr>
<td>The study implementor conducting this study is (Betsy) Ruth Cole. You may ask any questions you have now. If you have questions later, you are encouraged to contact her at [redacted] or <a href="mailto:betsycole13@gmail.com">betsycole13@gmail.com</a>.</td>
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<th>Whom do you contact if you have questions about your rights as a study participant?</th>
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<tr>
<td>If you have any questions or concerns regarding this study and would like to talk to someone other than the study implementor, you are encouraged to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at <a href="mailto:irb@liberty.edu">irb@liberty.edu</a></td>
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<th>Your Consent</th>
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| By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The implementor will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above. 

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.
| Printed Subject Name | Signature & Date |
Appendix C

Schedule for Project

Tuesday, October 26, 9:00 a.m.-10:00 a.m.
Informational Session on Project
Education and Consent Session for Participants

Tuesday, November 9, 9:00 a.m.-10:00 a.m.
Secondary Check-in Session

Tuesday, December 7, 9:00 a.m.-10:00 a.m.
Final Check-in and Wrap-up Session for Project
Appendix D

PowerPoint Presentation for Educational Session

WHEN EVERYTHING BECOMES TOO MUCH

COMPASSION FATIGUE AND BURNOUT

PREPARED AND PRESENT BY: BETSY COLE, M.DIV., DOCTORAL CANDIDATE, SPIRITUAL COUNSELOR FOR ASHLAND COMMUNITY HOSPICE, INC.

LET’S BEGIN WITH A SURVEY

• ANSWER THESE QUESTIONS...
  • ARE YOU TIRED?
  • DO YOU FEEL OVERWHELMED?
  • DO YOU FEEL UNDERAPPRECIATED AT WORK?
  • DO YOU STRUGGLE CARING FOR YOUR PATIENTS?
  • DO YOU FEEL LIKE SHUTTING OFF YOUR EMOTIONS SO YOU DON’T HAVE TO DEAL WITH YOUR FEELINGS?
NORMAL VERSUS
COMPASSION FATIGUE AND BURNOUT

• MANY OF US CAN ANSWER YES TO ALL OF THESE QUESTIONS AT ONE POINT OR ANOTHER. THE ISSUE ARISES WHEN WE RELATE TO ALL OF THEM.

• AS WE TELL CHILDREN, IT IS NOT THAT WE HAVE EMOTIONS, IT’S HOW WE EXPRESS THEM.

• WHAT, THEN, IS COMPASSION FATIGUE AND BURNOUT?

BURNOUT

• “A GENERAL CONSTRUCT DESCRIBING A REACTION TO WORK-RELATED STRESS.”

• LACK OF WORK ETHIC

• NO LONGER CARING ABOUT WORK RESPONSIBILITIES

• NON-COMPASSIONATE CARE

• ANGER

COMPASSION FATIGUE

• COMPASSION FATIGUE IS DEFINED AS “NEGATIVE COGNITIVE AND EMOTIONAL CONSEQUENCES FOR THE EMPATHIZER OF FEELING EMPATHY”

• PHYSICAL EXHAUSTION

• HEADACHES

• INDIFFERENCE

• EMOTIONAL FATIGUE

• SELF-MEDICATING

RESOURCES TO COMBAT COMPASSION FATIGUE AND BURNOUT

• THERE WILL BE THREE RESOURCES PROVIDED TO COMBAT THE ONSET AND SEVERITY OF COMPASSION FATIGUE AND BURNOUT.
  • COUNSELING SESSIONS
  • PEER CONVERSATIONS
  • CALMING ROOM

COUNSELING SESSIONS

• COUNSELING SESSIONS WILL BE PROVIDED TO ALL PARTICIPANTS ON AGREED UPON DATES IN THE BEREAVEMENT DEPARTMENT.

• THESE SESSIONS ARE AVAILABLE ON FIRST-COME FIRST-SERVE BASIS AND ARE LIMITED TO 30-MINUTE SESSIONS.

• THE BEREAVEMENT COUNSELORS WILL PROVIDE ONE-ON-ONE COUNSELING SESSIONS SPECIFICALLY GEARED TOWARDS FACTORS CAUSING COMPASSION FATIGUE AND BURNOUT IN THE HOSPICE WORKPLACE.

• ALL INFORMATION PROVIDED IN THESE SESSIONS WILL BE CONFIDENTIAL.
PEER CONVERSATIONS

• Peer conversations will be available on a more flexible schedule, though they will be limited to 30-minute sessions as well.
• The peers available for conversation will be chaplains and social workers. They will also specifically address issues related to compassion fatigue and burnout in the hospice workplace.
• All information provided in these sessions will be confidential.

CALMING ROOM

• The calming room will be available at 15-minute increments.
• This room is also first come-first service basis and will be available at all times.
• The calming room will provide resources to self-calm, including coloring therapy, music therapy, and aroma therapy.
FURTHER STEPS

- SURVEYS AND QUESTIONNAIRES
- FOLLOW-UP MEETINGS
- FINAL MEETING
- CONTACT INFORMATION:
  - BETSY COLE
HELPERS NEEDED!

Have you noticed that your co-workers are drained and in need of someone they can confide? Have you wondered how you can help? Well, wonder no more! Help your co-workers and Community Hospice by participating in the compassion fatigue and burnout study conducted by Chaplain Betsy Cole!

Come to the informational meeting on Tuesday, November 9, 2021 from 9:00 a.m.-10:00 a.m. to learn about the project and how you can help!

For questions, contact Betsy Cole at betsycole13@gmail.com or (606) 922-0704.
Appendix F

Sample Questions for Counselors in Counseling Sessions

7. What feelings have you experienced related to your work?

8. What events in your work have caused these feelings?

9. Are there outside factors contributing to these feelings?

10. How is this all affecting your work?

11. What are ways you can work through these feelings?

12. What have you tried? What has been helpful? What hasn’t?
Appendix G

Initial Questionnaire

Please rate each statement on a scale of 1 to 5, 1 being “definitely not” and 5 being “definitely so”.

1. I enjoy my work.
   1  2  3  4  5

2. I feel tired when I arrive at work.
   1  2  3  4  5

3. I feel appreciated at work.
   1  2  3  4  5

4. I can maintain my composure at work when I am mad or sad.
   1  2  3  4  5

5. I have a hard time separating my personal life and my work life.
   1  2  3  4  5

6. I am able to manage my workload.
   1  2  3  4  5

7. I feel supported by the leadership in my workplace.
   1  2  3  4  5

8. I make a difference at my work.
   1  2  3  4  5

   1  2  3  4  5

10. I know how to calm my emotions when work becomes too difficult.
    1  2  3  4  5
Appendix H

Initial Survey

Please answer the following questions honestly and to the best of your ability.

1. In the past month, work has made me feel:

2. In the past month, I have had the following concerns with my emotions in relation to work:

3. In the past month, my workload has been:

4. In the past month, when I struggled with my workload or my emotions, I:

5. Please describe what physical (sleeplessness, overeating, no appetite, etc.), emotional (crying, anger, no emotions, etc.), or spiritual (disconnected from God, anger with God, etc.) issues you have encountered, if any, in the past month, due to your role as a hospice clinical staff member (use back of sheet if necessary).
Appendix I

Confidentiality Agreement

I, ________________________________, will not repeat any information provided to me in counseling or peer conversations in relation to the study, unless it discloses harm to oneself or another. I will uphold all confidentiality.

___________________________
Print Name

___________________________
Signature

____________________________
Date
Appendix J

Secondary Survey

Please answer the following questions honestly and to the best of your ability.

1. In the three weeks, work has made me feel:

2. In the past three weeks, I have had the following concerns with my emotions in relation to work:

3. In the past three weeks, my workload has been:

4. In the past three weeks, when I struggled with my workload or my emotions, I:

5. Please describe what physical (sleeplessness, overeating, no appetite, etc.), emotional (crying, anger, no emotions, etc.), or spiritual (disconnected from God, anger with God, etc.) issues you have encountered, if any, in the past three weeks, due to your role as a hospice clinical staff member (use back of sheet if necessary).
6. Have you used the counseling sessions, peer conversations, or calming room provided in this study? If so, what was useful and what would you improve upon? If not, what has prevented you from using the resources?
Appendix K
Final Survey

Please answer the following questions honestly and to the best of your ability.

1. In the past three weeks, work has made me feel:

2. In the past three weeks, I have had the following concerns with my emotions in relation to work:

3. In the past three weeks, my workload has been:

4. In the past three weeks, when I struggled with my workload or my emotions, I:

5. Please describe what physical (sleeplessness, overeating, no appetite, etc.), emotional (crying, anger, no emotions, etc.), or spiritual (disconnected from God, anger with God, etc.) issues you have encountered, if any, in the past three weeks, due to your role as a hospice clinical staff member (use back of sheet if necessary).
6. Have you used the counseling sessions, peer conversations, or calming room provided in this study? If so, what was useful and what would you improve upon? If not, what has prevented you from using the resources?
Appendix L

Schedule of Availability for Counseling Sessions

November 10, 2021  8:30 a.m. to 9:30 a.m.
November 18, 2021  2:00 p.m. to 4:00 p.m.
November 26, 2021  8:00 a.m. to 10:00 a.m.
November 30, 2021  8:00 a.m. to 10:00 a.m.
December 7, 2021  8:00 a.m. to 10:00 a.m.
December 14, 2021  8:00 a.m. to 10:00 a.m.
September 24, 2021

Ruth Cole  
Brent Kelly  

Re: IRB Application - IRB-FY21-22-271 Compassion Fatigue and Burnout: When Caring Becomes Too Much

Dear Ruth Cole and Brent Kelly,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study does not classify as human subjects research. This means you may begin your project with the data safeguarding methods mentioned in your IRB application.

Decision: No Human Subjects Research

Explanation: Your study is not considered human subjects research for the following reason:

(2) Your project will consist of quality improvement activities, which are not "designed to develop or contribute to generalizable knowledge" according to 45 CFR 46.102(l).

Please note that this decision only applies to your current application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued non-human subjects research status. You may report these changes by completing a modification submission through your Cayuse IRB account.

Also, although you are welcome to use our recruitment and consent templates, you are not required to do so. If you choose to use our documents, please replace the word research with the word project throughout both documents.

If you have any questions about this determination or need assistance in determining whether possible modifications to your protocol would change your application’s status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, MA, CIP  
Administrative Chair of Institutional Research  
Research Ethics Office