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The cost of caring: Emergency department nurses, compassion fatigue, and the need for resilience training

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The Cost of Caring:
Emergency Department Nurses, Compassion Fatigue,
and the Need for Resilience Training
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Dedication

This paper is dedicated to the two most important nurses in my life: Drew, for continuing to show me love that is grounded in roots and wings, and Mom (and Skip!) for giving me the lifelong gift of unconditional love and support. There but for thee go I.

Acknowledgements

This project began first and foremost in conversations with my cohort, and so I want to deeply and wholeheartedly acknowledge my peers, colleagues, and friends for your wisdom, support, insight, humor, and authenticity on this admittedly strange ride. A special thank you to Caroline, Kim, and Angela for being my on-call Women of Substance.

I want to thank Jennifer Cline, who has been something of a lightning rod for me on this journey; I have heard her voice echoing in my mind throughout this Ed.S. project and beyond. I am tremendously lucky to have had Jack, Renee, Lennie, and Debbie guiding (and tolerating) me throughout the last three years, and sadly, there is not enough space to adequately honor what your insights, thoughtfulness, commitment, knowledge, and kindness have meant to me, but thank you, thank you, thank you.

Finally, I would like to acknowledge Eric for being the first person I thought to ask to be my committee chair, in part because I aspire to approach life with the depth and curiosity that he possesses. Thank you, Eric, for teaching us that illumination is not just something that happens when a light switch gets turned on.

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Abstract

Emergency Departments (EDs) are notoriously unpredictable and high stress environments. ED nurses are regularly exposed to stressful events such as sudden death, trauma, death and resuscitation of children, aggression and violence from patients, and systemic environmental stressors. For some ED nurses, prolonged exposure to these stressors leads to the development of compassion fatigue and burnout, but stigma around seeking support for mental health issues can impede a nurse's desire to seek treatment. The counseling profession has seen an increased interest in the role that resilience-building strategies can have in negating the deleterious effects of compassion fatigue and burnout in nurses. Licensed professional counselors (LPCs) might be uniquely positioned to provide counseling support to ED nurses, and develop and implement resilience-based programming in the ED that is rooted in peer support, development of positive emotions, and mindfulness.

Epigraphs

“Thich Nhat Hanh joins other masters who encourage us to be completely present for all things wonderful; if we are going to be present for life’s suffering, we will need all the nourishment and rejuvenation that comes from life’s beauty.”

— *Laura Van Dernoot Lipsky*

*“Ring the bells that still can ring
Forget your perfect offering
There is a crack in everything
That’s how the light gets in.”*

— *Leonard Cohen*

The Cost of Caring: Emergency Department Nurses, Compassion Fatigue, and the Need
for Resilience Training

Introduction

There is an ever-evolving body of work that uses a biopsychosocial lens to examine the lasting impact of trauma on those who encounter it. But what about the professionals who are being exposed to the stories and experiences of the survivors? The field of mental health has long tackled the issue of caring for its practitioners as they immerse themselves in the worlds of their clients, but the medical field is only recently beginning to explore the impact of secondary trauma exposure on its nurses and doctors. Additionally, the long-held stigma associated with seeking mental health support continues to be a barrier to medical practitioners feeling secure enough within the expectations of their chosen professions to seek out support for any symptoms of secondary traumatic stress that they might experience as a result of their work in the Emergency Department (ED).

In reviewing the literature, a convincing body of work is already making the case that ED nurses are at risk for developing compassion fatigue and burnout, but there is less information about what, specifically, might be done to negate the deleterious physical and psychological effects of working in the ED. The goal of this paper is to join the conversation about the need for the integration of mental health practitioners as counselors, consultants, and psychoeducators into the environment of the ED. This integration will not only support the individual nurses providing essential care, but also potentially impact the patient care experience and the career longevity of nurses in the ED.

The purpose of this paper is to first identify and examine the phenomena of compassion fatigue and burnout in Emergency Department (ED) nurses as a direct result of encountering trauma in a hospital environment that might not be systemically set up to provide support for processing the effect of secondary trauma exposure. Although both compassion fatigue and burnout are well documented in the literature, there continues to be a dearth of nurses seeking mental health support, in part because of lingering stigma associated with seeking mental health care as a medical practitioner.

Next, the paper identifies the phenomenon of resilience and examines how resilience training might be best integrated into ED environments to help ED nurses process traumatic exposure. The interventions discussed are rooted in the exploration of peer support, positive emotions, and mindfulness-based interventions. Finally, the paper concludes with recommendations for the ways that Licensed Professional Counselors might be integrated into the ED system to provide direct support to nurses.

The field of counseling is rife with insights about interventions to build resilience in the face of inevitable suffering, and counselors are uniquely trained to be able to work directly with nursing staff to build this skillset. Counselors are also uniquely qualified to build bridges between counseling education and systems assessments. As such, counselors are qualified to consult with administration to build resilience-based programming into the life of the ED. As consultants, counselors can advise on team-building assessments and interventions for administrative staff to help navigate some of the cultural and organizational obstacles that contribute to burnout and compassion fatigue.

Literature Review Part I: Crisis in the Emergency Department

Imagine arriving at work and being confronted with people asking for help who are bleeding, experiencing symptoms of a heart attack, in the throes of processing a recent physical trauma, or begging for help for their injured child. These are just a few of the obstacles that a nurse in an emergency department (ED) might face during any given shift, and there is little doubt that these challenges may take a toll on the physical and mental health of a nurse. As one author put it, the ED “represents a microcosm of all the things that can wrong in the health care setting” (Rosenstein, 2009). Although these events are common occurrences in the ED, the staff do not necessarily develop immunity to the intense stress that exposure to the trauma of others can cause (Healy & Tyrell, 2011). The demands of the nursing field come with high levels of stress, which can have a disruptive impact on the health of the nurse and can also impact nurses’ ability to perform job functions and provide appropriate patient care (Sharma et al., 2014). It stands to reason, then, that nurses in the ED are susceptible to experiencing compassion fatigue and burnout.

Compassion Fatigue

Following the inclusion of diagnostic criteria for Posttraumatic Stress Disorder in the third edition of the Diagnostic and Statistical Manual of Mental Disorders in 1980 (American Psychiatric Association, 2000), counselors have studied the effects of direct exposure to trauma. However, assessment of the effects of indirect exposure to trauma in various helping professions is lacking (Duffy, Avalos, & Dowling, 2015). As a result, curiosity about whether or not people become indirectly affected by having close contact with trauma survivors emerged (Beck, 2011). Initially described as secondary traumatic

stress (STS), in recent years, the broader umbrella term of compassion fatigue has been thought to be more professionally palatable and inclusive for all professions that might interact with traumatized patients (Ludick & Figley, 2017).

Compassion fatigue is defined as a reduction in one's empathic capacity or interest in a patient as a result of experiencing emotional and behavioral reactions to being exposed to the traumatizing experiences of others (Cieslak et al., 2014). Figley (1995) posited that secondary traumatic stress can be conceptualized as an occupational hazard for people who provide direct patient care to traumatized individuals, describing trauma exposure as something that can appear at first only in the traumatized survivor and eventually spread to the whole system. More specifically, the potential exists for the helper to acquire symptoms that are much like the traumatized person the helper is trying to help. Unlike vicarious trauma, which describes the state of psychological and emotional health in which a person exists over time, compassion fatigue focuses on the current experience of an individual who is working with a traumatized patient (Huggard & Dixon, 2011).

Figley (as cited in (Beck, 2011) outlined four reasons why helping professionals caring for trauma survivors might be at risk for developing compassion fatigue (1995).

1. "Empathy is a major resource for trauma workers to help the traumatized (p. 20)
2. Many trauma workers have experienced some type of traumatic event in their lives (p. 21).
3. Unresolved trauma of the worker will be activated by reports of similar trauma in [patients] (p. 21)

4. Children's traumas are also provocative for caregivers" (p. 21).

Sabo (2011) suggested that the very characteristics that contribute to successful nursing—empathy, engagement, and compassion—also play a role in the onset of stress. In essence, the more that a nurse might care for a patient, the greater the likelihood that the nurse will experience compassion fatigue.

Exposure to trauma and the development of compassion fatigue in emergency department nurses can result in physical symptoms of fear or stress, as well as feelings of depression, sadness, fear, shock, anhedonia, and feelings of a reduction in self-worth and self-efficacy (Van der Wath, van Wyk, & Janse van Rensburg, 2013). Additionally, Healy and Tyrell (2011) conducted a descriptive survey of ED nurses and doctors (n=103) and found that the most ubiquitous causes of organizational stress associated with the ED environment related to inter-staff conflict, over-crowding, staff shortages, workload, working in shifts, and frequent rotations of doctors. Other stressors identified included aggression or violence from patients, the death or resuscitation of a child, care management and concerns for critically ill patients, traumatic death, or being confronted with what they described as major incidents.

Luftman et al. (2017) conducted a web-based survey of four Trauma Advisory Council hospital systems in Texas using the Primary Care PTSD (PC-PTSD) screen. The questionnaire had four screening questions, and respondents were considered "positive" to be at risk for PTSD if they answered yes to three of the four questions. The questions were,

"In your experience as a civilian provider, have you ever had an emergency related experience that was frightening, horrible, or upsetting that you:

1. Have had nightmares about it and thought about it when you not want to?
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
3. Were constantly on guard, watchful or easily startled?
4. Felt numb or detached from others, activities, or your surroundings?"

Twenty one percent of in-hospital providers answered yes to three or more of the above questions, meaning that they screened positively to being at risk for PTSD. As part of their discussion, Luftman et. al. concluded that the more intimate the health care providers were with a patient or circumstance, the more likely they were to screen positive.

To return to the initial example of arriving for a nursing shift and being confronted with others' suffering, now add to that the organizational issues unique to the ED, and the potential for developing symptoms synonymous with PTSD. Given this, it is not surprising that some ED nurses experience burnout.

Burnout

First coined in 1974 by Herbert Freudenberger after observing changes in the behavior of free clinic volunteers, burnout refers to a state of emotional, physical, and mental exhaustion caused by long-term engagement in emotionally demanding environments or situations (Freudenberger, 2013). Unlike compassion fatigue, which is more tied to exposure to suffering or trauma of a specific patient, burnout develops gradually.

Maslach and Jackson (1981) expanded on Freudenberger's work and described burnout as a psychological state that results from prolonged experiences of emotional or

psychological stress at work. They went on to say that burnout has three definable dimensions. The first dimension is emotional exhaustion. With emotional reserves exhausted, the practitioner's sense of providing good quality work is impacted, which can cause extreme energy loss and feelings of emotional and physical exhaustion. The second dimension, depersonalization, describes the development of negative attitudes that develop in thinking and behavior towards the self, co-workers, and patients. This can lead to derision, prejudices, and decreases in quality of care. The third element, lack of personal accomplishment, is defined as a reduction or absence of feelings about personal competence and a sense of being unable to achieve goals.

A research team conducted a systemic review of the research on burnout over the past 25 years in ED nurses. They focused on the prevalence of nurses working in ED settings, and on identifying determinants such demographic characteristics, personality factors, coping strategies and job attitudes, as well as factors related to the work environment such as exposure to traumatic events, organizational factors, and characteristics of job demands that might contribute to burnout. After analyzing the results of 17 empirical studies published between 1987 and 2012, they determined that 26% of all respondents exceeded the cut off for emotional exhaustion, 35% exceeded the cut off for depersonalization, and 27% exceeded it for lack of personal accomplishment (Adriaenssens, De Gucht, & Maes, 2015a). Although the optimists in the field might point to the majority that is not experiencing burnout symptoms, the numbers presented by this systemic review are alarming at best.

Compassion fatigue may create fertile ground for burnout, or the two syndromes may exacerbate symptomatology in one another. It follows then, that if medical

professionals are not able to mitigate the deleterious effects of working in an ED, they are more susceptible to burnout and compassion fatigue (Galek, Flannelly, Greene, & Kudler, 2011). When combined, compassion fatigue and burnout can contribute to an overall reduction in empathic capacity due to exposure to traumatic events, and a sense of hopelessness due to prolonged experiences of stress within the workplace. These phenomena can lead to a spectrum of challenges for ED nurses, and they are clearly well identified in the literature. Given that, why do so many nurses and organizational structures avoid seeking mental health help?

Stigma

One of the primary reasons that nurses might not seek mental health support for the secondary challenges they encounter professionally is stigma, or negative attitudes about any mental health challenges they might experience. (Schulze, 2007) identified three observations that healthcare professionals have assumed with regards to mental health stigmatization. First, they have been observed as ‘stigmatizers’ of patients with mental illness whom they care for. Second, they have been observed as being ‘stigmatized’ for any admission of mental health issues they might personally face as healthcare professionals. Third, they are identified as ‘de-stigmatizers,’ or mental health advocates on behalf of the patients with whom they work.

Ross and Goldner (2009) built on Schulze’s three themes with a comprehensive review of the literature relating specifically to nurses’ attitudes and beliefs about mental health. As a result of the literature review, they identified two primary findings. The first is that nurses were identified as playing an unmistakable role in perpetuating stigmatization of patients with mental illness, and the second was that nurses themselves

are often recipients of extraprofessional stigma from colleagues about any personal experience a nurse might have with mental illness. Within their discussion about these findings, Ross and Goldner suggested that increasing exposure to mental health skills and practice during clinical training combined with ongoing continuing education, and an increase in institutional resources to address negative attitudes about patients with mental health issues might have a broad effect of increasing compassion about mental health issues that arise within the field of nursing.

The most recent data reported by the America College of Emergency Physicians stated that there are 180,000 emergency nurses and 42,000 emergency physicians working in approximately 3,390 emergency departments in the United States (ACEP, 2018). Despite there being four times as many ED nurses as physicians, the literature is alarmingly sparse regarding rates of nurse suicide when compared to the literature reporting on physician suicide. When discussing stigmatization of medical professionals disclosing mental illness or seeking help, the literature focuses on physicians.

After noting that the number of physicians who complete suicide annually is tracked nationally, a group of researchers conducted a comprehensive search of the literature and discovered only five dated and descriptive studies regarding incidence of nurse suicide in the United States, noting with dismay that this lack of reporting is indicative of the lack of awareness of the mental health plight of some nurses (Davidson, Mendis, Stuck, DeMichele, & Zisook, 2018). However, it is not an overstep to examine the physician experience to make inferences about the overall culture of mental health seeking behavior and mentalities from the top down in the ED.

A particularly unique barrier to successful diagnosis and treatment of mental health issues and illness for physicians and nurses alike is the requirement that the doctors report any diagnosis or treatment on their application to the state licensing board (Gold, Shih, Goldman, & Schwenk, 2017). The question content varies by state, as do the possible repercussions for the physician if mental illness is disclosed (Worley, 2008).

Possible repercussions range from submitting a letter of fitness from a physician treating the applicant to a mandated appearance before state examiners, enrolling in a Physician Health program, agreeing to inpatient or outpatient services, delayed licensing, or restricted services for a determined amount of time (Gold et al., 2016). Although some mental health related questions may occur in the medical history sections of the application, many of them are located in nonmedical portions of the form. Placing the questions in nonmedical sections alongside sections relating to prior discipline, loss of practicing privileges, malpractice, or criminal history, contextualizes physicians' experience with mental illness in a punitive manner (Schroeder et al., 2009).

Title II of the Americans with Disabilities Act prohibits discrimination by public entities on the basis of disability, stating, "a public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disability to discrimination on the basis of disability." Nor can a public entity, such as a licensure board, "impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability...unless criteria can be shown to be necessary for the provision of service, program, or activity being offered" (Act, 2008).

Nurses also have to submit to a state licensing examination and voluntarily disclose information about mental health history and treatment (American Nurses

Association, 2001). While it might seem that any repercussions that might result from these disclosures by nurse or physician alike is in direct conflict with Title II of the Americans with Disabilities Act, the boards are able to continue to ask these questions and mandate follow up actions because the information is provided in the form of a confidential self-disclosure (Appelbaum, 2015). So, while these questions exist to determine if a physician or nurse is fit for practice, the medical practitioners can choose to omit answers to avoid possible professional repercussions, thus defeating the purpose of including these types of questions in the first place. This fallacy may additionally amplify the stigmatization of mental illness.

Stigmatization of mental illness is an enduring and complicated issue. The findings here suggest that providing more training for nurses who encounter patients with mental illness might help to build compassion for nurses who are themselves dealing with mental health issues. Additionally, addressing the professional culture of disclosure of mental health history as a requirement for licensure of both physicians and nurses might have a de-stigmatizing impact on health care professionals seeking mental health resources.

Literature Review Part II: Fostering Resilience

It is now well established that some nurses experience decreased levels of optimal wellness as a result of job-related stressors, and that maintaining a healthy workforce is an essential need for healthcare. Resilience is an attribute that can help ED nurses successfully adapt to the emotional, physical, and mental demands of the ED (Epstein & Krasner, 2013).

Resilience refers to people's ability to "bounce back" from adversity and continue on with their lives (Dyer & McGuinness, 1996). Resilience has also been described as one's ability to maintain a positive outlook and successfully adapt despite encountering challenging or traumatizing situations (Fletcher & Sarkar, 2013). More recently, the definition of resilience has expanded to include an exploration of the motivation within an individual that supports the individual's desire to make meaning of adversity (Turner, 2014). Resilience is not stagnant, it is dynamic, and although there are some personality traits that lend themselves to a more resilient disposition, resiliency can be fostered and strengthened (Tusaie & Dyer, 2004). The dynamic nature of resilience is an important point when thinking about how to integrate resiliency programming into the environment of the ED.

In a phenomenological study of a small group of female nurses in Australia, Cameron and Brownie (2010) consolidated responses provided by the nurses from one hundred and fifteen phrases relating to nursing and resilience and produced the following:

1. Resilience is the result of experience, complex skills and knowledge required to manage time and crisis situations and prioritize tasks and staff.
2. Resilience is fostered by the degree of satisfaction achieved in being able to provide holistic skillful care.
3. Resilience in the workplace is enhanced by having a positive attitude, making a difference, or a having a sense of faith.
4. Resilience is reinforced by the notion of making a difference, and the close intimate relationships and sharing of experiences with [patients].

5. Resilience is promoted at work using strategies such as debriefing, validating, and self-reflection.
6. Resilience is promoted by support from colleagues, mentors, and [peer support].
7. Resilience is experienced when individuals have insight into their ability to recognize stressors and put strategies in place such as humor to minimize the effects.
8. Resilience is enhanced by ensuring exercise, rest, social support and interest are maintained to maximize work-life balance.

The traits listed above broadly identify that adaptability, a sense of purpose in holistic care, a prosocial attitude, and a strong work-life balance are all critical components of resilience. In the simplest of terms, the points identified above sound like a recipe for happiness, but it is not enough to just demand a happy disposition from nurses; instead, it is important to look at the intentional cultivation of positive emotions.

The Broaden-and-Build Theory

The broaden-and-build theory of positive emotions offers an overarching theory of happiness by linking the cumulative experience of momentary positive emotions to the cultivation of enduring, long term resources for success and wellbeing. Fredrickson (2001) developed the broaden-and-build theory to propose that emotions, or more specifically, emotional responses, are evolved adaptations that function to build lasting resources for the individual. She further posited that the experience of positive emotions opens up human cognition, which further encourages individuals to think more creatively, thoughtfully, and expressively in their efforts to adapt to challenging

situations or experiences. Additional evidence suggests that positive mental health and self-compassion developed through positive emotions moderates the association between negative affect and psychopathology (Trompetter, de Kleine, & Bohlmeijer, 2017).

Gloria and Steinhardt (2016) conducted a study to investigate if positive emotions were associated with greater resilience, if coping strategies reinforced the relationship between positive emotions and resilience, and whether or not resilience tempered the influence of stress on trait anxiety and symptoms of depression. They surveyed two hundred post-doctoral students, and their results supported the suggestion that positive emotions may have the ability to directly support resilience-building while also providing indirect support by facilitating adaptive coping and reducing maladaptive coping strategies. Based on their findings, they concluded that the likelihood of the students developing depressive symptoms or anxiety could be reduced through the implementation of programs specifically designed to increase positive emotions, resilience, and prosocial adaptive coping strategies.

Peer Support

Throughout the literature, peer support was identified as key component of building resilience, although there is a paucity of literature specifically devoted to the concept, development, and implementation of peer support in the ED. Despite that, it was such a frequently mentioned concept that it is important to give it space in this paper in preparation for identifying strategies that EDs can incorporate to promote and build resilience.

Loss of a patient is always a possibility for an ED nurse, and these losses can contribute to the development of compassion fatigue. In a study by Houck (2014), nurses

were asked if they preferred to grieve alone, or if they preferred to participate in group support. Seven of the fourteen nurses identified said that they had a preference for group support, with the majority identifying that sharing with a friend or close colleague was preferable to a larger group. The purpose of the assessment was to identify what assistance, if any, that nurses preferred to effectively design a grief support program.

In seeking to study social network integration (SNI), researchers conducted a study of resilience factors among Taiwanese nurses who experienced violence in the workplace and found that a higher degree of extraversion and peer support was associated with a greater degree of resilience. They concluded that among all the forms of SNI they investigated, only peer support was shown to demonstrably improve resilience (Hsieh, Hung, Wang, Ma, & Chang, 2016).

In a review of the literature about the development of compassion fatigue in nurses from 2005 to 2015, Sorenson, Bolick, Wright, and Hamilton (2016) concluded that nurse managers should promote teamwork and a positive work environment because poor inter-professional relationships were found to be a significant contributing factor to compassion fatigue. Inversely stated, strong relationships contribute to a more resilient staff.

In summary, peer support is mentioned frequently in the literature, but there is not much research directly related to the definition and characteristics of effective peer support when specifically developing resilience. Conceptually, peer support should be considered when designing interventions specifically intended to promote resilience in ED nurses.

Mindfulness

Mindfulness training is one possibility for a systematic approach to enhancing emotional regulation and recovery from stressful events, which is critical in thinking about a prophylactic approach to mitigating compassion fatigue for ED nurses (Craigie et al., 2016). Mindfulness broadly refers to a person's ability to develop personal awareness by purposefully paying attention to the present moment without judgement (Hegney, Rees, Eley, Osseiran-Moisson, & Francis, 2015). The lack of judgement towards one's experiences might be particularly relevant in increasing a nurse's locus of control and sense of wellbeing despite the demands of the ED.

In a meta-analysis of review of the effects of mindfulness on nurses, Guillaumie, Boiral, and Champagne (2017) analyzed a total of 32 studies of mindfulness-based interventions and concluded that they may be effective in significantly reducing anxiety and depression in nurses. They further identified the ability of mindfulness-based interventions to potentially increase inner-state calmness, awareness, and enthusiasm and improved professional performance, all of which can support positive emotions.

There is some evidence that developing compassion for the self through mindfulness may increase one's capacity for compassion for another. Wiklund, Gustin and Wagner (2013) examined the "butterfly effect of caring," as a contributing factor to a compassionate stance toward others. They identified the compassionate self as the ability to be sensitive, respectful, and nonjudgmental toward oneself. In a somewhat ironic twist, the implication here is that although compassion fatigue develops out of the nurse's deep compassion for the patient, if the nurse can develop internal compassion for the self, the nurse then may access more internal resources for safely experiencing compassion for others. Coming to terms with the demands of one's job and the inevitable potential for

stress is a prerequisite for compassionate care, as a nurse who struggles to experience nonjudgmental self-compassion may similarly struggle to feel compassion when confronted with the perceived shortcomings or struggles of a patient (Raab, 2014).

Another group surveyed 415 Australian nurses to determine the extent to which mindfulness might mitigate the effects of stress and be conceptualized as a personal resource (Grover, Teo, Pick, & Roche, 2017). The results suggested that mindfulness impacts the effects of stress in a variety of ways. The first is that, as a personal resource, mindfulness helps nurses to reduce the perception of job demands, which tempers the influence of those stressors. Next, they found that mindfulness training reduced stress by helping nurses to stay grounded in their focus on the present moment, thereby reducing attention on peripheral negative cognitions. Finally, they concluded that mindfulness helped the nurses gain a greater sense of control through an increased understanding of cause-and-effect sequences, which helps moderate emotional reactions to stressors. Another useful aspect of mindfulness training is its relative low impact on the professional demands of the ED itself. After initial training, mindfulness is an internalized practice that can be developed at no further cost to the hospital (Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2005).

Resilience Training Models

Given that compassion fatigue and burnout are well-identified phenomena, there is developing interest in ways to address and proactively prevent burnout and compassion fatigue within the ED. Because the sources for compassion fatigue and burnout are varied, taking a varied approach to cultivating resilience is salient. As it relates to resilience, an additional essential component is nurse leadership's willingness to innovate

and try a variety of programming options. A willingness to try and fail with such programming opportunities bolsters resilience and de-stigmatizes mental health care within a professional healthcare setting (Lanz & Bruk-Lee, 2017).

In his Compassion Fatigue Resiliency Program, Gentry (2010) described five interventions as “antibodies” to compassion fatigue. The five interventions are self-regulation, intentionality, self-validation, connection and support, and self-care. Gentry proposed that teaching these skills in a hospital environment will enable nurses to learn the skills needed to regulate fight, flight, or freeze responses, increase an internal locus of control, increase distress tolerance, relinquish outcomes, create community, and tend to the self.

To test Dr. Gentry’s program, Potter, Deshields, and Rodriguez (2013) implemented a five-week feasibility study at the Barnes-Jewish hospital in St. Louis, Missouri, that involved 14 registered nurses who each completed the Pro-Qol R-IV scale, the Maslach Burnout Inventory, the Revised Impact of Events scale, and the Nurse Job Satisfaction Scale at four time points, once before starting the Compassion Fatigue Resiliency program, immediately following completion, and three months and six months after completion. The researchers reported a significant reduction in secondary trauma scores on the ProQol R-IV, significant improvement of the Revised Impact of Events scale at each follow up point, and statistically insignificant changes on the Maslach Burnout Inventory and the Nurse Job Satisfaction scale. The researchers determined that programs designed to address compassion fatigue have the obvious effects of providing education about the effects of compassion fatigue and ways to resolve it, but additionally

neutralize some of the stigma associated with seeking mental health assistance or intervention as a result of compassion fatigue.

Research supports that using mindfulness interventions is effective for reducing stress, anxiety, and symptoms associated with burnout in the clinical nursing population (Baer, 2003). In a meta-analysis of seven studies of mindfulness-based interventions' efficacy to reduce stress in the general population, the reviewers reported a significant reduction in stress when the treatment and control groups were compared (Botha, Gwin, & Purpora, 2015).

Researchers at the University of Virginia examined the longitudinal impact of implementing a continuing education course based on mindfulness practices to specifically study the correlation between mindfulness and a reduction of burnout and stress among healthcare providers. The course was offered in eight-week sessions eleven times over six years, and each session met for 2.5 hours with a one-day seven-hour retreat. Ninety-three healthcare providers participated in the continuing education course and learned about four formal mindfulness practices which included walking and sitting meditation, body scans, mindful movement, and group discussions centered around incorporating mindfulness practices into the work day. Work-related burnout was measured by the Maslach Burnout Inventory, and healthcare providers' scores improved significantly at the end of the course. Based on their findings, the researchers concluded that a continuing education course focusing on mindfulness-based stress reduction was associated with significantly improving burnout scores and mental health for a spectrum of healthcare providers (Goodman & Schorling, 2012).

These studies suggest that incorporating resilience-oriented programming into the ED environment might have a meaningful impact on reducing compassion fatigue and burnout through mindfulness and exposure to self-regulation, intentionality, self-validation, connection and support, and self-care.

Discussion

It is important to recognize that stress is a state, not an illness, and is therefore dynamic and solvable. However, the nature of an ED is stated in its very name: it is a place that exists because of a revolving door of unpredictable emergencies. Over time, this exposure can cause stress reactions in the nurses working in the ED. Given this enduring truth of the ED, proactively training nurses in stress management skills, and reactively providing an environment that is sensitive to the realities of compassion fatigue and burnout is a common-sense approach to managing the realities of ED nursing.

Secondary traumatic stress, or compassion fatigue, is a natural consequence of stress experienced when a nurse helps or desires to help a traumatized person (Cieslak et al., 2014). Compassion fatigue is compounded by prolonged exposure to the suffering of others and a lack of mental health resources, which can lead to burnout (Ahwal & Arora, 2015). By contrast, resilience is fostered when nurses are able to gain agency, make meaning out of their work, experience increased self-efficacy, and self-regulate emotional reactions by building distress tolerance and practicing self-care through mindfulness interventions (Gloria & Steinhardt, 2016).

Despite the demands of the profession, many nurses enjoy long careers in nursing and these nurses are a resource for continuing to understand how to build resilience in the ED nursing profession. Nurses have identified four themes related to career longevity:

leadership, interprofessional relationships, job fit, and practice environment. Additional themes included feeling valued, acknowledgement of competency and skills, and a sense of being respected (Van Osch, Scarborough, Crowe, Wolff, & Reimer-Kirkham, 2017). These themes are essential insights into offsetting the impacts of working in a negative environment. The ongoing nursing shortage working in EDs is a critical issue impacting hospitals. Additionally, it is time consuming and expensive to onboard and train new nurses, and mentally and emotionally taxing for the nurses themselves to change professions. Not only do nurses stand to benefit from resilience-based interventions in the ED, but the hospital can then enjoy the benefit of staff retention and continuity of care (Adriaenssens, De Gucht, & Maes, 2015b).

Although compassion fatigue and burnout are possible outcomes for nurses working in the ED, nurses have also been shown to intuitively use a variety of positive coping strategies such as problem-focused coping, taking a time out when needed, and offering and seeking out support from co-workers (McCann et al., 2013). Contextualizing these strengths within the working environment is a way to build resilience in nurses. Additionally, focusing on top-down leadership models of work-life balance, hope, control, support, and cultivation of professional identity and professional boundaries can further anchor a resilience-based mentality into the nursing experience. Mindfulness-based models of resilience intervention offer efficient resolution opportunities for stress management and prevention. Additionally, mindfulness-based practices as presented in the research have the added benefit of incorporating group discussions to foster peer support and negate the consequences of stigma (Goodman & Schorling, 2012).

Based on the research presented in this paper, interventions could further focus on promoting appropriate professional autonomy amongst nursing staff, cultivation of team spirit and support programming within the ED, peer mentorship programs between senior nursing staff, nurse leaders, and new nurses, reduction of repetitive exposure to traumatic events, application of time-out facilities specific for nursing staff, provision of on-site counseling for ED staff, and training programs designed to foster coping skills (Adriaenssens et al., 2015). Each aspect of these interventions directly addresses the cultural realities that exist in the ED and point to ways that basic environmental and programming changes could have a lasting impact on preventing or resolving compassion fatigue and burnout.

Nurses in the ED are at risk for experiencing compassion fatigue and burnout, and stigmatization about seeking mental health support as a medical practitioner might prevent some nurses from seeking support. It is important for nurse leadership to closely examine ways that mental health care practices such as mindfulness interventions and psychoeducational opportunities can be integrated into the culture of the ED to foster practitioner resilience. Further, licensed professional counselors (LPCs) are trained in cultivating dimensions of wellness through connectedness to self and others and possess skills to help nurses process primary or secondary trauma exposure through counseling and skills interventions (Pinquart, 2009).

Implications for Counseling

Counselors are trained to leverage the interpersonal process to respond to the client's problems through the counseling relationship and work with the client to provide a corrective emotional experience (Teyber & Teyber, 2010). Additionally, LPCs have

specialized training in crisis intervention, group therapy, couples and family therapy, trauma-informed practices, and various treatment modalities such as Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Motivational Interviewing (MI), and the use of the interpersonal process to facilitate change. Despite this, there is little discussion in the literature about how licensed professional counselors could be embedded in the ED to provide support to ED nurses experiencing mental health troubles directly or indirectly related to their work. Where social workers have long worked with the systemic inner workings of the hospital as patient advocates and counselors, there is little indication that the medical profession recognizes the value of integrating on-site LPCs into the ED to provide counseling to the staff.

In a 2017 study, Adams (2017) reviewed the outcomes of embedding a counselor in a dental school for students to access freely during the first three semesters of the program. At the end of the three semesters, 55 students attended a total of 251 counseling sessions, and the newly minted counseling office offered 18 psychoeducational outreach programs that reached 212 students. The conclusion of the study indicated a significant reduction in reports of depression and anxiety by the students and suggested that the school consider integrating the counselors into its full-time curricula. These findings suggest that future research could include embedding counselors in the ED to provide psychoeducational training, co-created compassion fatigue prevention programming, risk assessment and prevention programming, mindfulness training, and individual and group counseling to assess for reduction in symptoms associated with burnout and compassion fatigue.

A potential added benefit of incorporating LPCs into the staffing configuration of an ED might be a reduction in stigma associated with mental healthcare. In addressing the need for a cultural change in medicine, Ward and Outram (2016) wrote,

“As a trainee, I witness a professional culture that places undue stress on its medical practitioners. It expects excellence of practice, praises perfectionism, encourages relentless standards, and promotes the prioritization of work, study and learning over other important areas of life. This culture seems to judge unkindly those who prioritize having a work-life balance, take sick or other personal leave, seek to work part time or job share, and who display vulnerability needing extra support and guidance” (p.113).

This points to the double bind that many medical professionals might find themselves in. The culture of the ED demands extra-human efforts, and yet, these demands are the very source of the resulting compassion fatigue and burnout that some nurses face. As advocates of mental health and wellness, LPCs could play an important role in mitigating the confusing demands of the culture of nursing.

The American Counselors’ Association (ACA) code of ethics, section A.6.a. states, “When appropriate, counselors advocate at individual, group, institutional, and societal levels to examine potential barriers and obstacles that inhibit access and/or growth and development of clients” (ACA, 2014). With this in mind, it seems appropriate to suggest that the counseling profession advocate to expand aspects of its professional identity to include working with medical professionals in individual hospital units. According to the 2016 National Healthcare Retention and RN Staffing Report (Solutions, 2014), the average cost of individual nurse turnover ranges from \$37,700 to \$58,400 and

hospitals are losing \$5.2 million to \$8.1 million dollars annually as a result of this expense. Practically speaking, research dedicated to the potential for the economic benefits of paying to incorporate an LPC into a hospital unit could have positive future implications. This would provide a tangible measurement for what reduction in revenue losses, if any, might be eliminated as a result of greater nurse job satisfaction and resiliency as a result of increased mental health care benefits.

Although many ED nurses find great satisfaction in their work, the research supports that a significant number of nurses will experience compassion fatigue and/or burnout over the course of their career. Pervasive culture change requires the involvement of all parties in the system, and in the case of preventing compassion fatigue and burnout in the ED, the change might not only need to involve those who are already working within the system, but all the counselors who are being left out. As Russell and Fosha (2008) claimed, "Relieving suffering through transforming the negative effects associated with it is essential but not sufficient. To maximize effectiveness, the therapeutic enterprise must also deal, with equal rigor, with the positive effects associated with experiences of transformation, growth, and connection" (p 168). Given this, counselors are uniquely situated to capitalize on helping nurses to make making meaning out of their meaningful work.

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