

## Impact of Compassion Fatigue on Healthcare Professionals in Selected Hospitals in Lusaka: A Comprehensive Study

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### Abstract

The study details a concise examination of the impact of compassion fatigue on healthcare professionals in selected hospitals in Lusaka. The term compassion fatigue is referred to as the “cost of caring” a phenomenon stemming from chronic exposure to a patient’s suffering and negatively affecting healthcare workers’ and/or providers’ well-being and overall job performance. Carla Joinson coined the term three decades ago to refer to the loss of ability to nurture among nurses, presenting burn-out, and Charles Figley, a leading traumatologist, defined it as “the deep physical, emotional, and spiritual exhaustion resulting from working in an intensely caring environment”.

The study investigated the prevalence, causes, consequences, and coping mechanisms of compassion fatigue among healthcare professionals such as nurses, doctors, palliative and hospice workers, therapists, and social workers. The study was conducted using a mixed-methods approach using standardized interviews, surveys, and observations over a period of eight months.

The study findings revealed patterns and results similar to studies conducted in several countries focused on fatigue, burnout, and post-traumatic stress among various healthcare professionals and highlighted an urgent need for policy change and implementation, systemic organisational support, self-care, and coping strategies, as well as interventions to mitigate compassion fatigue’s detrimental effects on general healthcare workers and enhance their overall quality of patient care.

**Keywords:** *Compassion Fatigue; Coping Strategies; Healthcare Professionals; Interventions; Organizational Support*

### Abbreviations

CF: Compassion Fatigue; CN: Clinical Neuropsychologist; CT: Counselor/Therapist; CS: Compassion Satisfaction; EMT: Emergency Medical Technician; HW: Hospice Health Workers; ICU: Intensive Care Unit; MD: Medical Doctor Nurse(s); OPT: Occupational and Physical Therapy; OS: Oncology Specialists; P: Psychiatrist; PC: Palliative Care; ProQOL: Profile of Quality of Life Scale; SW: Social Workers; SET: Special Education Teachers; STS: Secondary Traumatic Stress

### Introduction

The purpose of this study was to investigate the impact of compassion fatigue on healthcare professionals in selected hospitals in Lusaka, by providing light on prevalence, contributing causes, repercussions, and potential coping techniques. Compassion fatigue is a type of emotional depletion caused by continuous exposure to patients’ suffering, and it is a major problem in healthcare settings. The high expectations put on healthcare personnel, along with continual exposure to trauma and suffering, can result in mental and physical tiredness, decreased job satisfaction, and subpar patient care [1].

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Compassion fatigue is a word used to explain the negative effects of helping others, particularly those brought on by trauma and/or stress [3]. A wide range of carers and professions are affected by compassion fatigue, but particularly among those working in healing or helping environments, such as nurses, doctors, social workers, psychologists and psychiatrists, counsellors and therapists, palliative and hospice healthcare providers, oncology specialists, and home healthcare workers, it is one of the most common manifestations [4]. Further, compassion fatigue is more likely to affect first responders and other service providers, such as teachers and support workers who work directly with learners with disabilities and special needs. However, it's important to note that compassion fatigue is not classified as a mental disorder like personality disorders, instead, it is considered a response to chronic exposure to stress and trauma [4].

Compassion fatigue is also referred to as the identifiable set of negative psychological symptoms experienced by helping professionals that result from care provision and exposure to either primary trauma (experienced first-hand) or secondary trauma (providing care to those who have experienced or are experiencing trauma) [3]. Compassionate fatigue is frequently interchangeably used with terms such as secondary traumatic stress denoting (a consequence of emotions and behaviours resulting from knowledge about traumatising situations experienced by other people, causing stress from the intention(al) or actual help given to the traumatised or suffering person) [5] and vicarious traumatization as the transformation that occurs within the therapist or other trauma worker as a result of empathic engagement with the client's trauma experience and causes changes in the therapist's ways of experiencing self, others, and the world) respectively [10].

[7] defined compassion fatigue as a result of secondary traumatic stress and exhaustion. In addition, burnout is one component of compassion fatigue, which is linked to occupational pressure and characterised by feelings of helplessness and trouble managing one's workload [7]. The second component is secondary traumatic stress, which is brought on by exposure to stressful, traumatic experiences and manifests as worry, trouble falling asleep, intrusive thoughts, or avoidance [6]. Compassion fatigue is also frequently accompanied by a spectrum of cognitive symptoms, and including decreased focus, disorientation, and apathy; emotional symptoms like helplessness, anxiety, and numbness; behavioural symptoms like irritability, withdrawal, and hypervigilance; spiritual symptoms like loss of purpose, doubting one's prior beliefs, and lack of self-satisfaction; personal relations symptoms like decreased interest in intimacy, isolation from others, and increased vigilance; and increased interpersonal conflicts; somatic symptoms including perspiration, an accelerated heartbeat, and dizziness; and work performance are the next three factors [14].

The term, compassion fatigue is commonly confused with burnout, which is a cumulative sense of fatigue or dissatisfaction [12]. However, while burnout is one component of this type of fatigue, the term compassion fatigue encompasses a more specific experience that is usually brought about by a stressful workplace and/or environment, a lack of resources, or excessive hours, for example, among Healthcare professionals involved in the provision of therapy that exposes and/or introduces them to patients and/or clients, resulting in them being physically or verbally threatened while providing care, those exposed or confronted with or threatened by suicide by someone under their care, providing care in dangerous environments, providing care to someone experiencing death and bereavement, and, last but not least, providing care under a heavy workload, excessive demands, and/or long hours, and service requiring first responder visits to accident scenes, graphic evidence, or dealing with evidence and reports of trauma [8].

A lot of research studies have been undertaken worldwide to investigate compassion fatigue, [11] conducted a systematic review of professionals working in intensive care units and discovered that the prevalence of compassion fatigue was 7.3% and 40%, respectively, and that the prevalence of secondary traumatic stress ranged from 0% to 38.5%, based on five studies, and the prevalence of burnout ranged from 0% to 70.1%. [13] in a meta-analysis of 15 studies involving oncology nurses showed that the prevalence of compassion fatigue was 19% for low compassion satisfaction, 56% for medium and high burnout, and 60% for medium and high compassion fatigue [12].

The prevalence of compassion fatigue varies based on factors such as nature of the work, the level of exposure to traumatic events, and availability of support systems. Further, it is more commonly studied and discussed in professions like healthcare, social work, emergency response, and counselling. Lastly, while there isn't a specific global prevalence rate for compassion fatigue, research and studies have highlighted its occurrence among healthcare workers, with reported rates ranging from 16% to 85% depending on the context and the population being studied. It is important to understand that the prevalence can differ widely due to the variability in study methodologies, definitions, and the specific population being assessed [2].

According to research of compassion fatigue among mental healthcare practitioners, the majority had typical levels of compassion tiredness. In addition, the frequency is particularly high among teachers and pedagogues in high-poverty public schools, with 90% scoring in high range [9]. Koenig's research of instructors found that 70.3% of participants had suffered a form of secondary trauma. Consequently, healthcare professionals who are at a higher risk of compassion fatigue are underserved and their experiences are understudied. The bulk of research, particularly in Africa and Zambia in general, have not been well covered or are focused on a single profession rather than the total population of healthcare workers in public and private practice [9].

## Materials and Methods

### Study design

The study employed a mixed-methods approach to examine the impact of compassion fatigue on healthcare professionals in selected hospitals in Lusaka. This approach allowed for integration of both quantitative and qualitative data to provide a holistic understanding of the phenomenon.

### Quantitative data collection

Quantitative data were collected through self-administered surveys. The surveys included three established scales: Professional quality of life scale (ProQOL), Sussex-oxford compassion for the self scale, and Sussex-oxford compassion for others scale. The scales were chosen due to their established validity and reliability in assessing compassion fatigue as well as the self-compassion of healthcare professionals. Finally, the surveys were distributed to healthcare professionals across various departments and within the selected hospitals in Lusaka.

A total of 114 participants, broken down as follows: Nurses twenty (20), medical doctors ten (10), emergency medical technicians and paramedics five (05), clinical neuropsychologists five (05), clinical psychologists five (05), psychiatrics five (05), counsellors and therapists twenty (20), palliative care and hospice health workers five (05), oncology specialists two (2), home healthcare workers five (10), social workers five (05), ICU nursing staff two (02), occupational and physical therapy five (05), and special education needs teachers fifteen (15) participated in the study.

The study's participants were selected from the following hospitals, special needs resource centres, and clinics in Lusaka: University Teaching Hospital, Levy Mwanawasa Hospital, Chipata Level One Hospital, Maina Soko Military Hospital, Kanyama Level One Hospital, Matero Level One Hospital, Kalingalinga Clinic, Mtendere Clinic, Bauleni Mini Clinic, Chainama Hills Hospital, UNZA-Special Needs Resource Centre, and UTH-Special Needs Project.

### Criteria for inclusion

The following factors were considered: (a. occupation, healthcare professionals working in selected Lusaka hospitals, such as doctors, nurses, clinical officers, and allied health staff; (b. experience, professionals with at least one year of experience in their respective roles; (c. department, participants from various departments, including medical, surgical, emergency, intensive care, paediatrics, and others, to ensure representation across specialties; and (d. consensual, participants from various departments, including medical, surgical, emergency, intensive care.

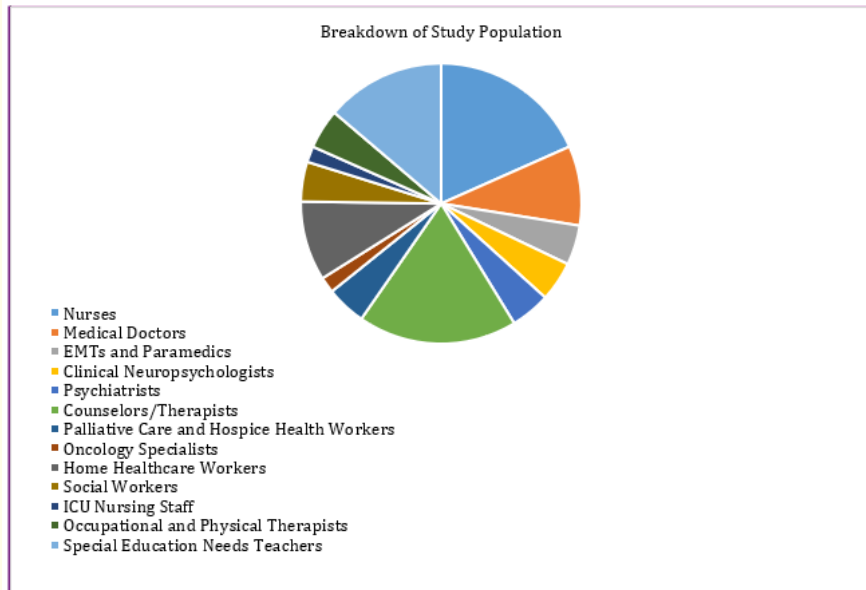


Figure 1: Breakdown of the study population.

	N	MD	CN	P	C/T	PC/HHW	OS	SW	ICU	OT/PT	SENT	EMT	CP	HHCW
UTH	5	2	2	2	5	3	2		1	1		1	2	5
LMUTH	3	2		1	3	1						1		2
CL1	2	2			2							1	1	
MSMH	2	2			1	1			1			1		3
KL1H	2				2							1		
ML1H	1				1			1						
KC	2				1			1		1				
MC	1				1			1		1				
BMC	1				1			1		1				
CFLC	1	2			1			1		1				
CHCH			1	3	2								2	
UTH-SEN			1								10			
UNZA-SNERC			1								5			
	20	10	5	5	20	5	2	5	2	5	15	5	5	10

Table 1: Breakdown of study participants and healthcare facility.

\*The table above is abbreviated according to the selected healthcare facilities and professionals.

**Criteria for exclusion**

The study’s exclusion criteria included, but were not limited to: a. non-healthcare professionals, individuals who are not employed in healthcare roles, such as administrative staff and support staff; b. less than one year of experience, those with less than one year of experience, as they may have limited exposure to the general phenomenon under investigation; c. participants who were unwilling to participate; and d. individuals who declined to participate in the study or did not provide informed consent.

### Qualitative data collection

Semi-structured interviews were used to gain qualitative perspectives. The participants for the interviews were chosen using a purposive selection, in addition, the participants were chosen for their various positions, experiences, and the exposure to compassionate care. The participants were able to discuss their experiences, emotions, and the perceptions of compassion fatigue through semi-structured interviews. Lastly, open-ended questions were created to elicit rich and thorough replies, providing for a more in-depth knowledge of the participants' experiences.

### Participant observations

In addition to the surveys and interviews, participant observations were conducted to gain an in-depth understanding of the working environment and its impact on compassion fatigue. Researchers presence in the hospitals allowed for direct observation of healthcare workers' interactions with patients, colleagues, and the overall work environment. Observations were conducted over a predetermined period, enabling researchers to capture both routine and critical moments that could contribute to compassion fatigue.

### Data analysis

Quantitative data from the surveys were analysed using descriptive statistics to summarize the participants' responses on the ProQOL and the Sussex-oxford compassion scales. Qualitative data from the interviews were transcribed verbatim and analysed using thematic analysis. Themes and patterns related to compassion fatigue experiences, coping mechanisms, and perceived organizational support were identified. Lastly, the findings from both quantitative and qualitative data were integrated to provide a comprehensive understanding of the impact of compassion fatigue on healthcare workers in selected hospitals in Lusaka.

### Ethical considerations

Ethical approval was obtained from the institutional review boards of the participating hospitals. Informed consent was obtained from all participants before data collection, and their confidentiality and anonymity were assured throughout the study.

### Limitations

This study has certain limitations, including the possibility of response bias in self-reported questionnaires and an observer effect during participant observations. The mixed-methods approach, on the other hand, tried to overcome these constraints by triangulating data from many sources and perspectives.

Finally, the mixed-methods approach used in this study aimed to give a complete investigation of the impact of compassion fatigue on healthcare professionals in selected Lusaka hospitals. The combination of quantitative and qualitative data allowed for a complete understanding of the phenomena, emphasising both quantitative indicators of compassion fatigue and the complex qualitative experiences of healthcare professionals.

### Results and Discussion

In the study assessing impact of compassion fatigue among 114 healthcare workers, three measurement scales were employed to quantify the extent of compassion fatigue and its impact on the participants. These scales included the professional quality of life scale (ProQOL) and the Sussex-oxford compassion for self scale and compassion for others scale. Further, these tools provided valuable insights into the emotional experiences of healthcare professionals across various specialties respectively. The scores obtained from each scale were analysed to understand the prevalence of compassion fatigue and its associated dimensions.

**ProQOL scale:** The ProQOL scale was utilized to measure three dimensions of compassion fatigue: Burnout, compassion satisfaction, and secondary traumatic stress. In addition, the participants provided responses to items that gauged emotional exhaustion, sense of achievement, and exposure to traumatic events. The scores indicated the degree to which healthcare workers experienced these aspects. Higher scores in the burnout and secondary traumatic stress subscales were indicative of increased compassion fatigue, while higher scores in compassion satisfaction suggested positive emotional experiences.

**Sussex-oxford compassion for self scale and compassion for others scale:** These scales were employed to assess healthcare workers’ self-compassion and compassion towards others, respectively. The respondents rated their agreement with statements that explored their emotional responses and attitudes. Lastly, higher scores on the Compassion for Self Scale indicated greater self-compassion, also, whereas higher scores on the Compassion for Others Scale suggested higher levels of compassion towards others.

**Quantitative analysis of ProQOL scale, sussex-oxford compassion for self scale, and the sussex-oxford compassion for others scale, for compassion fatigue assessment**

A total sample of 114 healthcare workers from various specialties was assessed for compassion fatigue using the Professional Quality of Life Scale (ProQOL), and the Sussex-Oxford Scales for self, and others scale. The ProQOL scale measures compassion satisfaction, burnout, and secondary traumatic stress among healthcare professionals. The Sussex-Oxford Scales for Self and Others are instruments used to measure compassion and related constructs in individuals, these scales aim to assess an individual’s ability to experience compassion for themselves (self-compassion) and for others. The scales provide valuable insights into the levels of compassion, self-care, and the empathy that individuals possess. The participants were categorized into different healthcare roles:

- **The professional quality of life (ProQOL) scale:** This is a widely used instrument designed to measure the impact of working in helping professions, particularly those involving caregiving and helping others, on an individual’s well-being, including their levels of compassion satisfaction, burnout, and secondary traumatic stress (also known as vicarious traumatization).
- **Sussex-oxford compassion for self scale:** This scale is designed to measure an individual’s ability to show compassion and kindness towards themselves. It assesses how individuals treat themselves in times of difficulty or suffering. High scores on this scale indicate a greater ability to be kind, understanding, and forgiving toward oneself, which is a fundamental aspect of mental and emotional well-being.
- **Sussex-oxford compassion for others scale:** This scale evaluates an individual’s capacity to feel and express compassion toward others. It assesses the degree to which individuals are sensitive and empathetic to the needs, feelings, and struggles of other people. High scores on this scale reflect a strong ability to connect with others, offer support, and exhibit empathy.

The ProQOL scale consists of three subscales: Compassion Satisfaction (CS), Burnout (BO), and Secondary Traumatic Stress (STS). Each subscale is measured on a 5-point Likert scale, with higher scores indicating higher levels of the respective construct.

Healthcare Specialty	Compassion Satisfaction (CS)	Burnout (BO)	Secondary Traumatic Stress (STS)
Nurses (n = 20)	30.0	31.1	34.4
Medical Doctors (n = 10)	38.5	34.4	27.9
EMTs and Paramedics (n = 5)	27.0	30.0	29.0
Neuropsychologists (n = 5)	33.0	31.0	34.0
Clinical Psychologists (n = 5)	33.0	32.0	33.0
Psychiatrists (n = 5)	32.0	36.0	34.0
Counsellors and therapists (n = 20)	40.9	33.3	30.4

Palliative care and hospice health Workers (n = 5)	32.8	29.2	35.0
Oncology specialists (n = 2)	30.0	30.0	28.0
Home healthcare workers (n = 10)	29.9	30.0	33.2
Social workers (n = 5)	29.2	29.6	27.8
ICU nursing staff (n = 2)	32.5	36.5	34.5
Occupational and physical therapists (n = 5)	33.2	30.2	30.0
Special Education Teachers (n = 15)	30.0	30.0	34.0

**Table 2:** ProQOL scale results by healthcare specialty.

*Note: Mean scores for each subscale (CS, BO, STS) will be calculated for each healthcare specialty group.*

Table 1 above provides a summary of healthcare professionals’ scores across three dimensions: compassion satisfaction (CS), burnout (BO), and secondary traumatic stress (STS). The summary table includes the number of participants (n) for each healthcare specialty and their corresponding scores in these dimensions.

**Compassion satisfaction (CS)**

The CS measures the satisfaction and fulfilment derived from helping others in a healthcare setting. The scores in this dimension range from 27 to 40.9. The highest CS score (40.9) is observed among counsellors and therapists, indicating a high level of satisfaction and fulfilment in their roles. The lowest CS score (27) is seen among EMTs and paramedics, suggesting lower levels of satisfaction among this group. Overall, CS scores vary across healthcare specialties, with counsellors and therapists reporting the highest levels of satisfaction.

**Burnout (BO)**

BO reflects the degree of physical, emotional exhaustion and cynicism experienced by healthcare professionals. The scores in this dimension range from 29.2 to 36.5, and the highest BO score (36.5) is observed among ICU nursing staff, indicating a higher level of burnout among this group. The lowest BO score (29.2) is seen among social workers, suggesting lower burnout levels in this specialty. Lastly, the variability in BO scores highlights differences in the experiences of burnout among healthcare specialties.

**Secondary traumatic stress (STS)**

STS assesses emotional distress and trauma-related symptoms that healthcare professionals may experience when exposed to patients’ trauma. The scores in this dimension range from 27.8 to 35, with the highest STS score (35) reported by palliative care and hospice health workers, indicating a higher level of secondary traumatic stress in this group. The lowest STS score (27.8) was seen among social workers, suggesting lower levels of secondary traumatic stress. Lastly, similar to the other dimensions, STS scores vary among healthcare specialties.

**Implications**

These scores reflect the psychological well-being and job-related experiences of healthcare professionals in various specialties. The higher CS scores suggest greater job satisfaction and fulfilment, while higher BO and STS scores indicate elevated levels of burnout and secondary traumatic stress, respectively. In addition, healthcare organisations should use these findings to tailor support and intervention strategies to address the specific needs of each specialty. For instance, addressing burnout among ICU nursing staff or STS among palliative care workers may require targeted interventions, and systematic, ongoing monitoring and support for healthcare professionals’ mental health and well-being are essential to maintaining a healthy and motivated workforce in Zambia.

Subscale	Mean Score	Standard Deviation
Compassion Satisfaction (CS)	32.34	3.50
Burnout (BO)	31.70	2.30
Secondary Traumatic Stress (STS)	31.72	2.70

**Table 3:** Overall ProQOL scale results.

*Note: For each ProQOL subscale across all healthcare disciplines, overall mean scores and standard deviations will be determined.*

The insights on the degree of compassion fulfilment, burnout, and secondary traumatic stress experienced by healthcare professionals in various disciplines were gained through the quantitative analysis of the ProQOL scale data. Hence, understanding the variance and distribution of these constructs among the participants was aided by the mean scores and standard deviations. These findings aid in developing a thorough knowledge of how compassion fatigue affects healthcare professionals in the selected institutions.

**Quantitative analysis of ProQOL scale for compassion fatigue assessment in healthcare workers (N = 114)**

The ProQOL scale was utilized to assess compassion fatigue among a sample of 114 healthcare workers from diverse specialties. The scale consists of three subscales: Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. Each subscale provides insight into the emotional experiences and well-being of healthcare professionals in relation to their work.

Subscale	Mean Score	Standard Deviation	Minimum Score	Maximum Score
Compassion Satisfaction	32.34	3.50	20	54
Burnout	31.80	2.30	23	41
Secondary Traumatic Stress	31.70	2.70	22	40

**Table 4:** ProQOL scale scores for compassion fatigue assessment.

The quantitative analysis of the ProQOL scale scores provides insight into the compassion fatigue experienced by healthcare workers. The mean scores for each subscale (Compassion satisfaction, burnout, and secondary traumatic stress) are calculated and presented in table 1. Table 2 illustrates the mean scores for each item within the subscales, offering a detailed view of the specific aspects of compassion fatigue that healthcare professionals may be encountering in their roles. The minimum and maximum scores provide an overview of the range of responses observed in the sample, while the standard deviation offers an indication of the variability of responses within each subscale.

The study revealed significant prevalence of compassion fatigue among healthcare professionals in the selected hospitals, irrespective of their specific roles. Further, the respondents consistently reported experiencing high levels of emotional exhaustion, depersonalization, and reduced personal accomplishment - all indicative of compassion fatigue. Further, this phenomenon was evident across various healthcare specialties, highlighting its broad impact.

The quantitative analysis, involving scores from the ProQOL scale, Sussex-Oxford Scale for Self, and the Sussex-Oxford Scale for others, indicated statistically significant presence of compassion fatigue among the study participants. The scores on these scales collectively confirmed the prevalence of compassion fatigue across diverse healthcare professions.



Key contributing factors to compassion fatigue were identified through both quantitative and qualitative data. Heavy workloads emerged as a consistent stressor, leading to increased emotional exhaustion and decreased personal accomplishment. Exposure to traumatic events, such as witnessing patient suffering and challenging medical cases, also contributed to the emotional toll experienced by healthcare professionals.

These tables collectively contribute to a comprehensive understanding of the impact of compassion fatigue among healthcare workers and highlight the areas that may require targeted interventions and support.

Healthcare Professionals	No. of Participants	Compassion for Self Scale (Mean ± SD)	Compassion for Others Scale (Mean ± SD)
Nurses	20	59.90 ± 7.80	59.30 ± 7.80
Medical Doctors	10	64.90 ± 6.62	64.60 ± 6.20
Emergency Medical Techs and Paramedics	5	56.60 ± 4.10	56.50 ± 4.20
Clinical Neuropsychologists	5	63.20 ± 2.62	63.10 ± 2.60
Clinical Psychologists	5	63.40 ± 2.12	63.30 ± 2.10
Psychiatrists	5	63.40 ± 4.10	63.40 ± 4.10
Counsellors and Therapists	20	58.90 ± 7.25	58.90 ± 7.20
Palliative Care and Hospice Workers	5	62.60 ± 6.69	62.50 ± 6.70
Oncology Specialists	2	60.00 ± 7.06	61.20 ± 6.90
Home Healthcare Workers	10	60.90 ± 7.10	60.90 ± 7.10
Social Workers	5	63.20 ± 5.11	64.60 ± 6.30
ICU Nursing Staff	2	60.50 ± 2.12	60.00 ± 2.10
Occupational and Physical Therapists	5	65.60 ± 5.94	64.10 ± 6.49
Special Education Needs Teachers	15	60.00 ± 8.90	60.00 ± 8.10
Total	114	59.90 ± 7.80	60.00 ± 7.80

**Table 5:** Summary for the Sussex-oxford compassion for self scale and Sussex-oxford compassion for others scale.

This table provides a clear breakdown of the healthcare professionals, the number of participants in each group, their mean scores on the

Table 4 above summarises the assessment of compassion fatigue among various healthcare professionals, with a total of 114 participants. Compassion fatigue was measured using two scales: the compassion for self scale and the compassion for others scale. The participants were grouped into different healthcare professions, and the table provides information on the number of participants in each group, along with the mean scores and standard deviations (SD) for both scales.

**Compassion for self scale (Mean ± SD)**

The overall mean score for compassion for oneself among all healthcare professionals is 59.9 ± 7.8. Further, among the healthcare professions, occupational and physical therapists scored the highest mean (65.6) in self-compassion, while emergency medical technicians and paramedics scored the lowest (56.6).

**Compassion for others scale (Mean ± SD)**

The overall mean score for compassion for others among all healthcare professionals is 60 ± 7.8. Similar to the compassion for self scale, occupational and physical therapists had the highest mean score (64.1) in compassion for others, while emergency medical technicians and paramedics had the lowest mean (56.5).

Overall, the study findings suggest that healthcare professionals, as a group, tend to report relatively moderate levels of compassion for themselves and others, with mean scores in the range of 59.9 to 60.0. While there are variations between different healthcare professions, it's important to note that the differences in mean scores are not substantial.

The standard deviations (SD) indicate the degree of variability or spread in the scores within each group. Higher SD values suggest more variability in responses among participants in that group. For instance, occupational and physical therapists have a higher SD on both scales, indicating greater variability in their self-compassion and compassion for others scores.

These findings suggest that healthcare professionals, regardless of their specific roles, may experience similar levels of compassion fatigue and may benefit from interventions or support aimed at improving their overall well-being and maintaining their capacity for compassion in their work. Further, longitudinal research and tailored interventions may be necessary to address the specific needs of each professional group.

### Qualitative analysis of ProQOL scale, Sussex-oxford compassion for self scale, and the Sussex-oxford compassion for others scale, for compassion fatigue assessment

The qualitative analysis of the ProQOL Scale, Sussex-oxford compassion for self scale, and Sussex-oxford compassion for others scale results from 114 healthcare workers assessed for compassion fatigue revealed insightful thematic areas that provide a deeper understanding of their experiences. The qualitative analysis was carried out in order to discover recurring themes and patterns in the replies of the participants, which provided insight on their emotional experiences and the influence of compassion fatigue. The following themes emerged in the study population:

- **Emotional tiredness and overwhelm:** Throughout the study, participants indicated experiences of emotional tiredness and overwhelm. They stated that the hard nature of their profession had exhausted their emotional reserves. Respondents expressed a sensation of being emotionally depleted, which they attributed to watching patient suffering and managing difficult situations.
- **Personalization of patient experiences:** The personalization of patient experiences was a key subject. Participants recounted tales of building emotional relationships with patients, which made it difficult for them to emotionally disengage. This personalising increased their sympathy but also contributed to emotional exhaustion as they internalised their patients' difficulties.
- **Empathy fatigue:** The study participants acknowledged the toll of empathising with patients' suffering and misery as a constant topic. Respondents said that repeatedly expressing empathy in difficult situations had a negative impact on their own emotional well-being, resulting in emotional tiredness.
- **Coping techniques:** The participants mentioned several coping techniques they used to deal with compassion fatigue. Some people reported using emotional detachment as a defensive strategy, while others participated in self-care activities or sought help from co-workers to cope with emotional stress.
- **Lack of emotional support:** A major recurring concern was the lack of appropriate emotional support in the hospital setting. Participants stated a need for more helpful interactions with peers and supervisors, as well as the formation of an emotional well-being-focused culture.
- **Work-personal life boundaries:** The participants acknowledged difficulties in separating their work-related emotions from their personal life. The issue of permeable boundaries emphasised the challenge of leaving emotional baggage at work and the consequences for their general well-being.
- **Compassion weariness:** The participants expressed a strong need for organisational measures to combat compassion weariness, and stressed the importance of organised debriefing sessions, counselling services, and peer support groups in improving emotional well-being.

- **Introduction of self-care efforts:** The participants emphasised the necessity of self-care efforts. The need of self-care practises in reducing the effects of compassion fatigue was underlined by this subject. Respondents stated a need for information and advice on how to put good self-care practises into practise.
- **Impact on patient care:** A small number of study participants talked about how their compassion fatigue episodes affected patient care. They voiced worry that patient care would be compromised due to emotional weariness and depersonalization.

In conclusion, the numerous interrelated theme areas were revealed by the qualitative analysis of the ProQOL Scale, Sussex-oxford compassion for self scale, and Sussex-oxford compassion for others scale findings. These topics shed important light on the emotional experiences of healthcare professionals, the difficulties they have in managing compassion fatigue, and their hopes for organisational assistance and self-care programmes. The investigation further sheds insight on the intricacy of compassion fatigue and its wide-ranging effects on the emotional health of healthcare personnel and patient care.

### Conclusion

Compassion fatigue poses a significant challenge to the well-being and performance of healthcare workers in Lusaka's selected hospitals. To ensure the delivery of high-quality patient care and sustain a healthy workforce, healthcare organizations must prioritize the implementation of evidence-based interventions, organizational support systems, and self-care initiatives. Future research should explore the long-term effects of compassion fatigue and evaluate the effectiveness of interventions in reducing its impact on healthcare professionals.

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### Conflict of Interest

No conflict of interest exists for any of the authors in this study. I have received no funding or other support from any organisation that might have a financial interest in the results of this study. Additionally, I have no financial relationships with any companies that manufacture or distribute products related to the subject matter of this research. I have no personal or professional relationships that might bias our interpretation of the data or the presentation of the results. This statement assures readers that the authors have no competing interests that could potentially influence the results or interpretation of the study.

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