Concept Development of "Compassion Fatigue" in Clinical Nurses: Application of Schwartz-Barcott and Kim's Hybrid Model

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Abstract

Compassion fatigue is not a new concept in nursing; yet, it is not well known and there is no fixed clear definition of the term. The ambiguity surrounding how to define compassion fatigue has challenged its measurement and evaluation. Thus, any attempt to determine attributes of this underdeveloped concept and studying it in a new socio-cultural context requires concept development. The purpose of this study is to clarify the concept of compassion fatigue through concept development and to produce a vivid and tentative definition of this concept in clinical practice.

Concept development was conducted using a three-step hybrid concept analysis including theoretical, field-work, and final analysis phases according to Schwartz-Barcott and Kim's method. We reviewed and analyzed 48 articles that met the inclusion criteria. Following, the first author conducted 13 interviews with clinical nurses followed by an inductive content analysis. Finally, a comprehensive definition of compassion fatigue in nurses was attained.

Compassion fatigue in nurses can be explained as a cumulative and progressive process of absorption of the patient's pain and suffering formed from the sympathetic and caring interactions with the patients and their families. The physical, emotional, intellectual, spiritual, social, and organizational consequences of compassion fatigue are so extensive that they threaten the existential integrity of the nurse. Context-based variables (culture, family, and community) such as personality features like devotion behaviors and commitment towards the patient, exposure to multiple stressors, organizational challenges, and lack of self-care are factors associated with an increased risk of compassion fatigue. Concept development of compassion fatigue is the first step in the protection of nurses against the destructive consequences of compassion fatigue and to improve quality of care.

Continual exposure to traumatic and stressful situations such as losing a patient, observing their pain, suffering, and agony and working in a challenging crowded climate imposes physical, emotional, and spiritual deficiencies on nurses (Flarity, Nash, Jones, & Steinbruner, 2016). The nature of this phenomenon is so incapacitating that it leads to increased work leave in the nursing profession, increased job dissatisfaction, and reduced productivity, ultimately resulting in decreased quality of care, diminished satisfaction, and reduced patient safety (Owen & Wanzer, 2014). This phenomenon was first identified by Joinson (1992) and coined compassion fatigue (CF).

A review of the literature showed that there is no commonly acceptable definition of CF (Coetzee & Klopper, 2010; Owen & Wanzer, 2014) and there is a deficiency in concept clarity (Beck, 2011). The ambiguity surrounding how to define CF has challenged its measurement and evaluation. Moreover, the semantic overlap between this concept and the interchangeably

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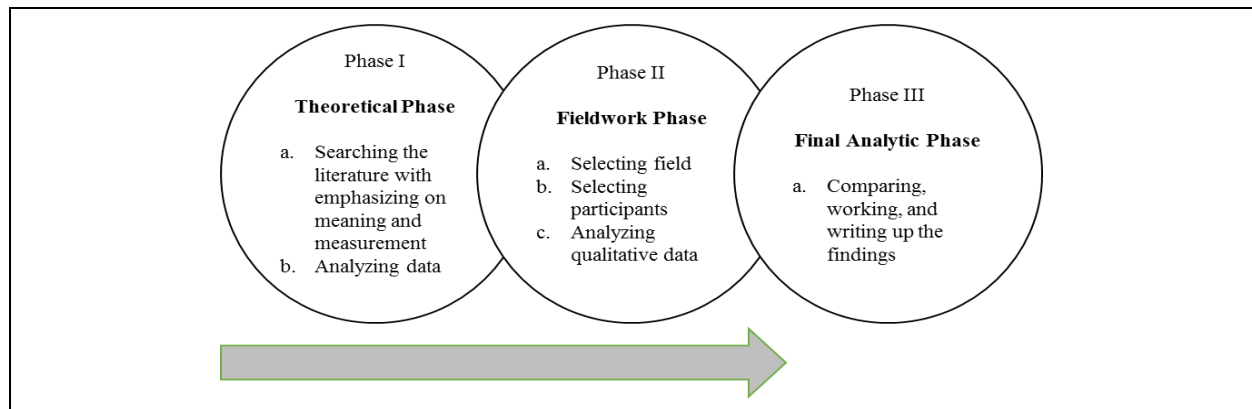[c]*Behavioral Sciences Research Center, Nursing Faculty of Baqiyatallah University of Medical sciences, Tehran, Iran*

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Figure 1. Main components of the study design based on a hybrid concept development.

used alternatives such as secondary traumatic stress (STS), occupational burnout, and vicarious traumatization in various studies has, fostered the ambiguity, ambivalence, and confusion about the nature of this phenomenon (Chung, 2015; Ledoux, 2015; Najjar, Davis, Beck-Coon, & Carney Doebbeling, 2009).

Although CF is not a new concept in nursing (Branch & Klinkenberg, 2015), the absence of a clear definition, the existence of confusing definitions, and a lack of awareness of nurses indicate that its importance has been overlooked (Chung, 2015). Determining the CF phenomenon and providing a vivid and clear definition of CF increases nurses' understanding of the phenomenon and predisposes them to the promotion of their physical and psychological well-being and improved quality of patient care. Also, it is the required basic step in determining effective interventions for preventing and managing CF to protect nurses against its destructive consequences (Owen & Wanzer, 2014). Kelly, Runge, and Spencer (2015) further introduced the recognition of this phenomenon as the prerequisite for the efficacy and efficiency of all the strategies.

Figley (2002) tried to elucidate CF by providing a model. In Figley's model, CF was defined as a combination of burnout and STS. However, Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, and Smith-Macdonald (2017) believed that this conceptual model cannot be generalized to nursing or other professions as it is based on the experiences of therapists and counselors. Hence, more studies are required to provide the theoretical foundations of CF and reinforce the present conceptualizations of the phenomenon or even its comprehensive reconceptualization (Ananda-Stout, 2015).

In clinical practice, the first author has observed CF symptoms among clinical nurses and managers, including nurses' ignorance towards it due to their unawareness of the phenomenon and the effects of social, political, economic, and cultural factors on

CF (Craigie et al., 2016; Sabo, 2008). From these observations and the fact that there are few studies on this topic conducted in Iran, an investigation of this issue in the sociocultural context of Iran is mandatory. The Iranian context is different from the Western culture because Iranian people value spirituality and religion greatly and they see patient care as a way of approaching God. Considering that Schwartz-Barcott and Kim's (2000) approach covers the deficiencies in this field and provide rich data in the new context, the present researchers embarked on conducting a hybrid concept analysis of CF.

Method

Design

This study used a three-step hybrid concept analysis. This included theoretical, fieldwork, and final analysis phases according to Schwartz-Barcott and Kim's method as an appropriate approach to concept development (Figure 1).

Ethical Considerations

The research proposal was approved by the Committee of Research at the School of Nursing and Midwifery at Shahid Beheshti University of Medical Sciences (#SBMU2.REC.1394.46, dated October 2015). Informed written consent was obtained from each participant prior to study commencement. The principles of confidentiality and anonymity were explained to each participant.

Literature Search

The Theoretical Phase (Phase I) included a comprehensive review of the literature using the Center for Reviews and Dissemination's guidance (Tacconelli, 2010). We performed a literature search
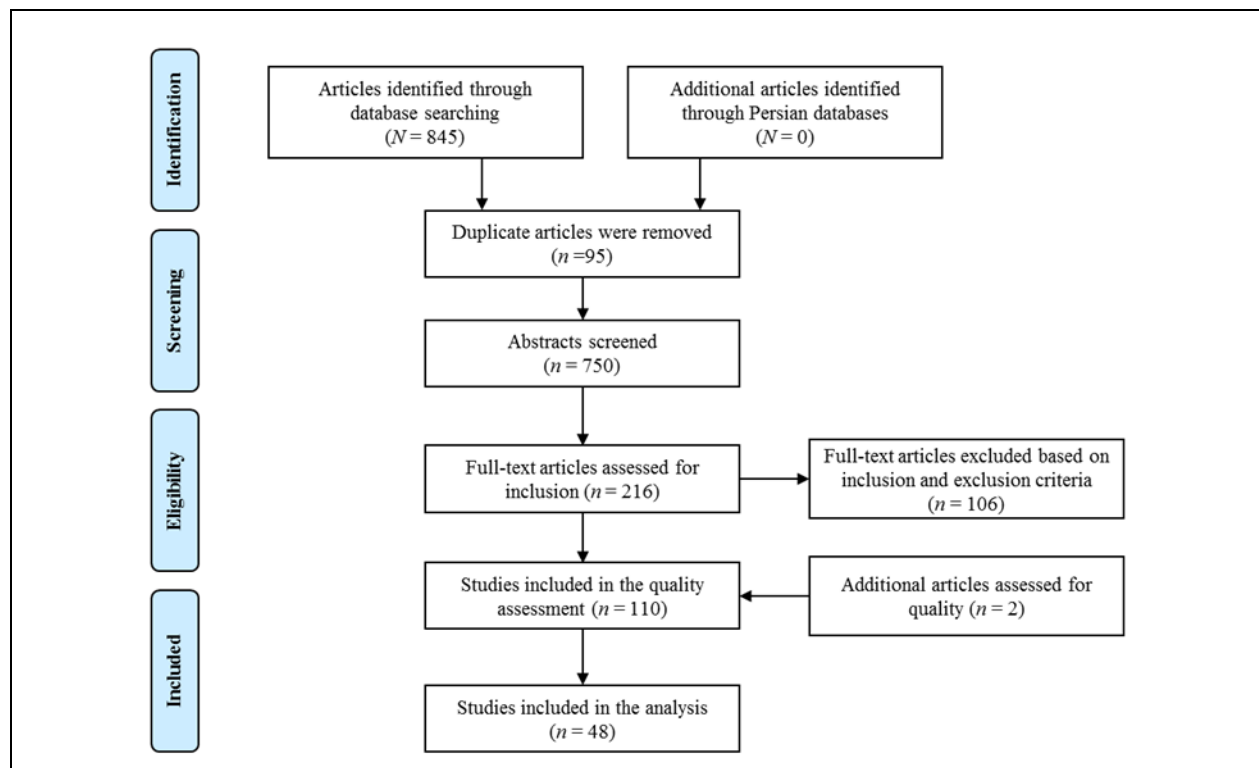
Figure 2. Summary of the theoretical phase based on the PRISMA flowchart (selection, critical appraisal, and data extraction of studies). TREND = Transparent Reporting of Evaluations with Nonrandomized Designs checklist; COREQ = Consolidated Criteria for Reporting Qualitative Research checklist.

using PubMed, CINAHL, Medline, and ScienceDirect databases with keywords *compassion fatigue*, *secondary traumatic stress*, *vicarious traumatization*, *professional burnout*, and *nursing*. The search was limited to articles published between January 1, 1990 and July 31, 2015 and nursing papers in the English language. Original articles related to CF including quantitative studies, qualitative studies, meta-analyses, mixed methods synthesis, and instrument development were included. We aimed to answer two questions when selecting articles: (1) How is compassion fatigue in nurses described? (2) How can compassion fatigue in nurses be measured? The initial search yielded 845 articles. After review of the titles and abstracts, omiting duplicate articles, and performing quality assessment of articles using the Transparent Reporting of Evaluations with Non-randomized Designs checklist (Caetano, 2004) and the Consolidated Criteria for Reporting Qualitative research (Booth et al., 2014), 48 articles were included in this review (Figure 2).

Data Collection

The Fieldwork Phase (Phase II) was conducted to elucidate and explore the concept of CF.

Qualitative data were collected using semi-structured interviews with Iranian clinical nurses to acquire the attitudes of clinical nurses regarding their experience of CF. The first author performed 13 interviews with clinical nurses (10 nurses, two clinical supervisors, and one head nurse; Table 1) employed in the teaching hospitals of Shahid Beheshti University of Medical Sciences in Tehran and Kashan University of Medical Sciences (the researcher's hometown and workplace). The purposive sampling technique was used to identify participants. The inclusion criteria were (a) must have a Bachelor of Science in Nursing, (b) have at least two years of experience working as a nurse, and (c) inclination for participation in the study. Along with the interviews, field notes including theoretical, methodological, and observational notes were taken using Schwartz-Barcott & Kim's approach. The interview began with a question on the participant's routine daily work shift and then gradually shifted towards CF. Additional interview questions included (1) Does the patient's care cause an unpleasant feeling or mental exhaustion in you? (2) Does the patient's unfavorable condition affect you? (3) What aggravates or improves this state? Each interview lasted 35-60 minutes. Data were collected during a 4-month period from November 2015 to February 2016. Data saturation was

Table 1. *Demographic Information of the Participants*

Participant	Gender/Age	Marital status	Town	Ward	Work experience/ Previous wards	Education Level
1	Female/37	Single	Kashan	Obstetric surgery	13 years' work experience/internal ward and surgical ward	BS
2	Female/29	Single	Tehran	ICU surgery	5 years' work experience/internal ward	BS
3	Female/31	Single	Kashan	Kidney transplant	8 years' work experience/transplantation ward	MSc
4	Female/42	Married	Kashan	Obstetric in-patient	13 years' work experience/surgical ward	BS
5	Female/32	Married	Kashan	NICU	7 years' work experience, ICU ward	BS
6	Female/33	Married	Tehran	Oncology	10 years' work experience/ ICU ward	BS
7	Male/41	Married	Tehran	Cardiac ICU	14 years' work experience/internal and surgical wards	BS
8	Female/35	Married	Kashan	Neurology surgery	6 years' work experience/neurology surgery ward and gynecology in-patient ward	BS
9	Female/40	Married	Kashan	Surgery emergency	15 years' work experience/internal ward and ER	BS
10	Male/27	Single	Kashan	Internal emergency	7 years' work experience/ ER	MSc

Note. BS = Bachelor of Science; ER = Emergency room; ICU = Intensive care unit; MSc = Master of Science; NICU = Neonatal intensive care unit

achieved following the 11th interview. The remaining two interviews were performed, but no new characteristics or categories were observed in the data. Soon after completing the interviews and importing the audio files to the computer, they were transcribed verbatim and typed to maintain data integrity and reduce researcher bias.

In the Final Analytical Phase (Phase III), data from the theoretical and fieldwork phases were compared to provide a refined definition to be supported by both the literature and participants' attitudes (Rogers & Knafl, 2000). All of the previous findings were contemplated on the basis of what was discovered. Next, all of the data culled in the theoretical and fieldwork phases were analyzed, the concepts and main themes were extracted, and the concept of CF was defined from the obtained attributes and indicators that were supported by both the theoretical and empirical data.

Data Analysis

Given the qualitative analysis approach, the comparative process continued during data analysis to aid in increasing the recognition of and insight towards the nature of the CF (Rogers & Knafl, 2000). To organize the data, in Phase I and II, the full text of the articles identified in the literature review and interview transcriptions were imported to MAXQDA10 (Udo Kuckartz, Berlin, Germany) after repeated and careful study of the data. Inductive content analysis was conducted based on Graneheim and Lundman (2004). The meaning units were extracted on the basis of research goals; and the codes, categories, and subcategories were formed and ultimately classified into attributes, antecedents, and consequences. Similar codes were grouped into subcategories, which in turn formed the main categories (Graneheim & Lundman, 2004). Additionally, the instruments and methods used for measuring CF in nurses were investigated. At the end, the points of agreement and disagreement were determined considering the opinions of the team.

Trustworthiness

To secure data accuracy, Lincoln and Guba's (1985) criteria were considered. To increase the credibility, sufficient time was devoted to immersion in the study, data, and interaction with the participants. The data obtained from interviews were reviewed and revised by the research team after transcription and coding. To remove data ambiguity and to complete them more clearly and comprehensively, the data were member-checked. Subsequently, two experts and two nursing doctoral students were asked to peer-check the interviews, codes, and the extracted themes. To promote confirmability, all the research stages, methodology, and the decisions made at various phases were explained in detail so that other researchers may follow up the research (Elo & Kyngäs, 2008).

Results

Theoretical Phase

Characteristics and Definition of CF

The findings demonstrated that despite the attempt to define and clarify, various definitions and perceptions of CF have induced ambiguity in its nature (Ledoux, 2015). When Joinson (1992) was exploring the nature of burnout in emergency ward nurses, she noticed that they had lost the nurturing ability. She introduced this phenomenon as a unique form of burnout and called it CF. Nonetheless, Joinson never formally coined this concept (Joinson, 1992).

The findings revealed that CF is a multidimensional concept with multilateral definitions. This concept is defined in the British Dictionary as the "inability to respond to a crisis or disaster due to excessive exposure to crises or natural disasters, etc." Etymologically, this is an American term described in the Oxford English Online Dictionary as the indifference about the aches and pains of others or to humanistic causes which act on their behalf, usually assigned to frequent requests for help, specifically donations. So, it is a retreating public response to frequent kind demands. Medical dictionaries have related this term to caregivers dating back to 1980. Other dictionaries such as the Penguin English Dictionary, Brewers Dictionary, and Dictionary of Media Studies have provided the same definition (Lynch & Lobo, 2012).

Figley (1995) formally determined CF as a reaction to STS as a result of helping or the inclination for helping a hurt or sick person. He renders CF as the cost paid by caregivers for helping patients and called it "cost of caring." He even used it as a synonym term for STS so that from then on, scholars would use these two terms synonymously and interchangeably (Coetzee & Klopper, 2010; Figley, 1995; Melvin, 2012; Sabo, 2011).

Lynch and Lobo (2012) postulated that CF is a state of extreme fatigue and biological, psychological, and social disturbance due to compassion stress and like any other type of fatigue, reduces the capacity and inclination for tolerating the suffering of others. In Wentzel and Brysiewicz (2014), CF was considered an occupational hazard and the final outcome of continual and progressive exposure to patients with severe disease and caring for patients who experienced stressful life events. van Mol, Kompanje, Benoit, Bakker, and Nijkamp (2015) defined CF as the physical or mental distress in caregivers, which occurs as a consequence of a continual and cumulative process in an exhaustive relation with the needful person.

Attributes

In the literature review, three categories of attributes were extracted:

- **Cumulative and progressive process:** Repeated in the literature through assertions such as daily exposure ($n = 11$), daily observation of various types of trauma and damage to patients ($n = 13$), long-term continual exposure to patients ($n = 18$), gradually increased CF due to continuous stress ($n = 10$), cumulative exposure over months and years ($n = 9$), creation over time ($n = 8$), and progressive state ($n = 12$). As Coetzee and Klopper (2010) stated, CF is the result of an advanced process due to long-term continuous exposure to patients, the use of one's power, and exposure to stress.

- **Sympathetic caring-relational interaction:** Frequently mentioned in the literature as compassionate interaction ($n = 8$), sympathetic relation with clients ($n = 12$), and caring for painful patients, caring for suffering patients, and caring for the damaged individuals ($n = 13$); and sympathetic and repetitious responses to others' aches and pains ($n = 11$).

- **Inclination for helping others and contributing to the patients' relief of suffering:** Referred to in the literature as motivation for helping others ($n = 10$), commitment and inclination for helping others ($n = 7$), mental and emotional needs for helping others ($n = 8$), inclination for relieving the pains of others ($n = 7$), and nurses' compassionate contribution to the patient's suffering ($n = 9$).

Antecedents

The antecedents of CF in the related literature fit into four categories: (a) personality features (devotion behaviors and commitment; $n = 11$), (b) stress ($n = 13$), (c) organizational challenges ($n = 14$), and (d) lack of self-care ($n = 14$):

- **Personality features:** Cited in the literature as the use of self, preferring others' needs over one's needs, self-sacrifice behaviors, and overlooking oneself and one's expectations (Branch & Klinkenberg, 2015; Sabo, 2011).

- **Stress:** Noted as the most important antecedent of CF by researchers. Stress has been stated as continual anxiety about satisfying the patients' needs, multiple stressors, and working in stressful situations (Flarity, Gentry, & Mesnikoff, 2013; Sabo, 2011).

- **Organizational challenges:** Problems relating to resources and facilities in hospitals (inadequate resources and staff) and workplace problems (confusing policies and procedures, influences from the surrounding environment, hard and challenging work, and heavy workload) in the literature (Boyle, 2015; Drury, Craigie, Francis, Aoun, & Hegney, 2014; Flarity et al., 2013).

- **Lack of self-care:** An important factor that puts nurses at risk of CF (Boyle, 2011; Lombardo & Eyre, 2011; Melvin, 2012; Sabo, 2011; Yoder, 2010).

Consequences

Six categories of CF consequences emerged:

- Physical problems (increased physical complaints, low energy, low power, lost tolerance, fatigue sense, exhaustion, etc.; $n = 16$).
- Exciting-emotional problems (anger, apathy, cynicism, flashbacks, irritability, lessened enthusiasm; $n = 14$).
- Intellectual problems (boredom, impaired concentration and attention; $n = 14$).
- Spiritual problems (lack of spiritual awareness, decrease in discernment; $n = 6$).
- Social problems (indifference, estrangement, withdrawal from family and friends; $n = 10$).
- Organizational problems such as absenteeism, medication errors, decreased performance ability ($n = 15$; Boyle, 2015; Chung, 2015; Coetzee & Klopper, 2010; Romano, Trotta, & Rich, 2013).

Fieldwork Phase

Attributes

Three categories for attributes of CF were identified during the interviews:

- **Cumulative and progressive process:** Participants stated that daily repeated exposure to patients induces CF, which progressed over the course of time: "…it bothers me to see all the time the aches and pains of the patients."
- **Sympathetic caring-relational interaction:** Participants referred to this as one of the most important attributes of CF, which distinguishes this concept from similar terms, especially occupational burnout. In this regard, one of the nurses employed at a transplantation ward with eight years of work experience asserted, "Our patients in the transplantation ward go back and forth very frequently and make emotional rapport with us; we get accustomed to them just like our family members. If something bad happens to them, it affects our spirituality negatively."
- **Self-absorption:** Exposure to the patients' aches and pains and related suffering were main attributes from the participants' viewpoints called *self-absorption* or *absorption of patients' suffering*. One participant, an intensive care unit nurse, said:

    > It bothers me greatly to see a patient's suffering and torment. It makes me feel bad. There are some painful procedures performed on patients which make me ill. That's why I like to arrange the conditions in a way that they do not suffer much.

Antecedents

A concept analysis of CF in interviews with the nurses generally depicted the findings of the theoreti-

cal phase and confirmed the results of the literature review. However, based on interviews with the nurses, three new categories of antecedents were extracted:

- **Context-based variables:** It appears that nurses' attitudes, beliefs, and values, which originate from the social, religious, and cultural context of Iran, specific to the Iranian community, affects this concept among the Iranian nurses. From the participants' viewpoints, factors such as culture, religion, family, and community were the most important factors related to CF, which consisted of two main subcategories:

  1. **Organizational culture:** The participants enumerated the following as causes of CF: the dominant bureaucratic culture of the organization's greater attention was on instrumental care versus compassionate care, documentation, and vain bureaucratic cycles, which removes the nurses from the patients' clinic and effective care. They also stated lack of organizational support as another cause of CF. One participant said:

      > All this bureaucracy, which the hospital mangers emphasize, just removes us from the patient's bedside. I waste my time documenting the procedures and this prevents me from patient care; otherwise, I will be reproached. In that case, I can't make rapport with the patient as I want it. All these affect my mentality.

  2. **Socio-religious culture:** There are some limitations in the compassion between the patient and the medical staff in Iran due to socio-religious features which affect the professional relationship. One of the nurses with 13 years of work experience in the postpartum ward stated:

      > My husband does not like me to work in a ward where I have to deal with men, take the patients' blood pressure, take IV line, etc. So, I prefer to work in the women's wards. If the conditions are not right for my working in that ward, this makes me mentally and psychologically fatigued.

- **Inability to help the patient or provide sufficient care:** Generally, the nurses were inclined to provide effective and nurturing care for their patients. So, if they could not provide such care, they would experience CF. Most of the participants declared that patient-care by itself does not cause CF in them. On the contrary, caring for the patient who is recovering and healing induces work satisfaction in them. However, when they were unable to relieve the patients' pain and suffering or could not aid in improving the patient's

Table 2. *Comparison of CF Findings between the Theoretical and Fieldwork Phases*

Theoretical Phase	Fieldwork Phase	
Attributes		
Cumulative and progressive process	Cumulative and progressive process	
Sympathetic caring-relational interactions	Sympathetic caring-relational interactions	
Inclination to help others and contribute to the patients' relief of suffering	Self-absorption	
Antecedents		
Personality features	Context-based variables:	Organizational culture
Stress		Socio-religious culture
Organizational challenges	Inability to help the patient or provide sufficient care	
Lack of self-care	Multiple stressors	
Consequences		
Physical problems	Integrity threat	
Exciting-emotional problems		
Intellectual problems		
Spiritual problems		
Social problems		
Organizational problems		

condition, they sustained psychological consequences. One participant, an emergency nurse, said:

> If I work for the patient from early morning till night and do useful measures for them that improve their condition, all these do not exhaust me; it even enhances my love of nursing. If I get tired, I feel better after a short rest. Yet, when I can't do anything to help the patient, it makes me emotionally and physically exhausted.

- **Multiple stressors:** Another antecedent of this concept was the presence of multiple stressors, which were also found in the theoretical phase. The participants frequently referred to various sources of stress as important antecedents of CF. This highly important category consisted of the subcategories of resources and facilities, interactions and conflicts with colleagues, and weak and unsupportive management. A neonatal care unit nurse said, "Our work stress is very high, patient stress, patient's family stress, ward stress, equipment shortage stress, personnel shortage stress, numerous work shifts stress, physician, colleagues, and managers stress, and stress of critically ill patients all of which worry me."

Consequences

The findings of the fieldwork phase were highly similar to those of the theoretical phase (Table 2). The results demonstrated that CF consequences are so widespread that they involve all aspects of nursing inducing physical, exciting-emotional, intellectual, and socio-spiritual problems for nurses. These problems progress to a degree that has disabled nurses not only

in meeting their personal and professional management but also in providing compassionate care forever. These conditions enhanced the organizational problems (i.e., incidence of work errors, occupational dissatisfaction, and job leave), which finally fell into a comprehensive and extensive category called *integrity threat*. An emergency nurse stated that "When I am highly exhausted, whether physically or mentally, I can't concentrate. Maybe I check an order wrongly or I can't care of my patient properly." Another participant, an oncology nurse, explained the signs of integrity threat:

> My family tell me: you were very gay previously, you were very energetic with high spirits; now, your spirit is very sensitive; you've got a low irritability threshold level; your adaptability has decreased. You can't come up with problems; you succumb very easily. You have a low self-confidence. You are not energetic and happy as previously.

The Final Definition

A comprehensive definition of CF in nurses was obtained by integrating the findings of the theoretical and fieldwork phases. We defined CF as a cumulative and progressive process of absorption of the patient's suffering formed from the sympathetic and caring interactions with patients and their family. The physical, emotional, intellectual, spiritual, social, and organizational consequences of CF are so extensive that they threaten the existential integrity of the nurse. Context-based variables (culture, family, and community), personality features like devotion behaviors and commitment towards the patient, exposure to multiple

stressors, organizational challenges, and lack of self-care are associated with an increased risk of CF. This relatively comprehensive definition of CF was distilled from the literature review (Western and Eastern) and from qualitative interviews with Iranian nurses (Iran as one part of the geographical zone of Asian/Pacific Islanders) using the hybrid model. It corresponds to the Western and Eastern cultures, covering both.

Discussion

In this study, the concept of CF in clinical nurses was investigated using the hybrid concept analysis approach by integrating the findings of the theoretical and fieldwork phases. The results show that CF is a multi-dimensional, complex, and relatively unknown phenomenon with weak and conflicting underlying theories (Sinclair et al., 2017). The inconstant and present contradictions make it difficult to provide a clear and standard definition of CF. Because of this, a number of scholars have rendered the reconceptualization of the phenomenon as mandatory (Ledoux, 2015; Sinclair et al., 2017).

The findings from the theoretical phase and the fieldwork phase found that sympathetic caring-relational interactions emerged as an important attribute of CF. Nurses provide safe quality care for patients through establishing sympathetic interactions with the patient, leading to increased work satisfaction, and staying in the profession. Sinclair et al. (2017) believed that compassion begins during the time when the nurse interacts with the patient experiencing pain and suffering, which culminates into sympathetic feelings, and triggers some measures for relieving the patient's aches and pains.

Figley's model (2002) is based on the assumption that individuals with high empathy who manifest a sympathetic and compassionate response to patients' suffering are highly vulnerable to experiencing CF themselves (Figley, 2002). Most scholars agree with this model and render CF as the cost of caring for patients who are in pain and suffering in nurses (Figley 1995, 2002; Lombardo & Eyre, 2011; Melvin, 2012; Owen & Wanzer, 2014; Potter, 2010; Sabo, 2006).

van Mol (2015) asserted that when nurses continually sympathize with pain patients, they are affected with CF. This is a two-edged sword. On one hand, this leads to the provision of quality care and effective treatment for the patients, but on the other hand, leads to the vulnerability of CF in nurses (Perry, Toffner, Merrick, & Dalton, 2011). Klimecki, Leiberg, Ricard, and Singer (2014) investigated the effect of sympathy and compassion training on cerebral functioning flexibility and concluded that sympathy training increases adverse sympathetic and emotional responses. This means that sympathy training not only leads to a stronger induction of painful and distressful experiences but also increases vulnerability to negative emotional feelings in response to daily life situations. Klimecki et al. believed that compassion training reverses these effects by reinforcing positive emotions. Compassion training is a coping strategy for overcoming sympathetic distress and fostering resilience, leading to the strengthening of personal resources, and overcoming the effects related to sympathetic distress. Hence, the method of establishing effective therapeutic interactions ought to be investigated again in nurse-patient relationships. This allows nurses to exercise sympathy and compassion with patients while avoiding the risk of exposing themselves to hazards. Through this, both patients and nurses benefit from effective treatment interactions.

Self-absorption is another category identified in the fieldwork phase. This finding is consistent with Bush (2009), that when health care personnel have a close interpersonal relationship with the patient and remove the emotional boundaries, nurses unconsciously absorb the patients 'suffering and distress, which can manifest into CF.

Another finding from the fieldwork phase is the effect of context-based variables on the incidence of CF, which was implied in Ariapooran's (2014) study. The participants frequently referred to the physician-oriented and non-supporting culture of the organization, and the policy of prioritizing treatment over care provision as the causes of low social status of nurses and even their disrespectfulness. All of these predispose nurses to CF. Sabo's (2008) study presented similar results that factors such as organizational culture, socio-political factors, and lack of social support correlate with an increased risk of CF. Consequently, organizations and nurse managers should design and implement policies and procedures to support the nurses and to balance their values between treatment and care provision. Furthermore, the physician-oriented micro-culture governing the hospitals may be modified by promoting inter-professional collaboration between physicians and nurses to promote a supportive and progressive environment. Improving the organizational culture may lead to the improvement of the community culture, which will increase the value and status of nurses in society.

An important finding from the fieldwork phase is the inability to help the patient and to provide sufficient care. The nurses announced that if they are put in a position where they cannot help or support the patients or if their interventions are not effective for the patients, they will be both physically and emotionally fatigued. Our finding is consistent with Figley (1995), which asserted that when nurses observe the agony and suffering of their patients and cannot help them, they are affected negatively themselves. Valent (2002) stated that in threatening traumatic situations when the victims may not be saved, rescued, or properly cared for, compassion stress reaches damaging levels and CF occurs.

A number of participants explained that care and compassion, if accompanied by positive outcomes of healing, do not exhaust them and it increases their satisfaction. Compassion satisfaction is the emotional reward of patient care so that nurses are provoked to provide more care when they see the recovery of their patients. Compassion satisfaction protects individuals against the effects of occupational distress and serves as an effective protector against CF (Stamm, 2010). Austin, Goble, Leier, and Byrne (2009) believed that the observation of a patient's healing, compassion satisfaction, the presence of a protective team, and sufficient resources are the protective factors in the prevention of CF. Hence, organizations should take appropriate measures to promote nurses' compassion satisfaction levels.

Stress is a significant finding of CF, which was observed in both the theoretical and fieldwork phases. Today, the hospital settings are exposed to challenges, even under the best conditions, creating stressors for nurses (e.g., professional-organizational and emotional stressors). Professional-organizational stressors include personnel shortage, budget deficit, long working hours, intensive workload, lack of support (Boyle, 2015), management stress (Drury et al., 2014), constrained workplace, heavy workload, excessive noises or silence, high technology, invasive and violent alternative treatments, lack of rank promotion and positions, or secondary opportunities (Ariapooran, 2013). Emotional stressors included repeated exposure to patients' and families pain, suffering, and distress; futile efforts to relieve painful deaths, ethical distress as a result of paradigmatic conflicts between treatment and care, and conflicts with physicians, colleagues, and supervisors (Ariapooran, 2013; Sabo, 2008).

Stress diminishes the intrinsic resources leading to ineffective coping strategies. When multiple emotional and professional stressors and context-based variables are combined, nurses gradually lose their feelings of competency, efficiency, and success (Ariapooran, 2013; Lombardo & Eyre, 2011). They are affected by various physical, emotional, intellectual, and social disorders, which serve as a threat to their existential integrity. This destructive consequence may affect the nurses themselves, patients, organization, and community, and even lead to a condition in which the nurses lose their ability to provide compassionate care. Thus, it is necessary for managers to designate educational programs such as stress management, crisis management, and coping and self-care strategies in highly stressful situations. The instruction of these skills should also be included in the nursing curriculum at the Bachelor of Science level and continued at the higher levels.

Limitations

The theoretical phase in this study was based on an international literature analysis (Western and Eastern), but the empirical data with the qualitative approach were restricted to Iran. Therefore, the results of the qualitative phase cannot be generalized to all sets. In the hybrid concept development, the aim of the fieldwork phase is to empirically elucidate and explore the concept and not the empirical generalization. Additionally, the results of the theoretical phase were generally consistent with the result of the fieldwork phase, which shows the validity of the concept analysis in other places.

Conclusions

The findings of the present study can be helpful in developing or revising the models, theories, and instruments for investigating CF because concepts are the building blocks of any theory. Concept development of CF is the first step in protecting nurses against its consequences and improving quality of care. Considering the effects of contextual factors that predispose nurses to CF, the relative sociocultural and religious similarities between Iran and other Asian countries, and the numerous sociocultural and religious differences between the Iranian and the Western culture, it seems necessary to explore the various aspects of organizational and social culture to take effective steps in identifying, preventing, and managing CF in nurses.

Declaration of Conflicting Interests

The authors have no financial interest or potentially conflicting interests that could have any influence on the study.

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