COMPASSION FATIGUE WITHIN THE NURSING PROFESSION: A CONCEPT ANALYSIS

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Siedine Knobloch

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"The love of Christ compels us to do what we never thought we could do and go to heights we never thought we could reach."

~Max Lucado~

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SUMMARY

Nurse practitioners have a duty to compassionately care for the sick, wounded, traumatised and weak patients in their charge, which personally exposes them to the patients' pain, trauma and suffering on a daily basis. In addition to this, nurse practitioners work in demanding and dire circumstances, which influences not only their well-being, but also their ability to provide compassionate care. The result is a nursing workforce that is experiencing compassion fatigue.

The aim of this study was to define compassion fatigue within the context of the nursing profession, through achieving three objectives which were guided by a philosophical inquiry design, used along with qualitative, exploratory, descriptive and contextual research strategies.

The first objective was to conduct a concept analysis of compassion fatigue in order to construct a connotative (theoretical) definition. Using the concept analysis method of Walker and Avant (2005) which is based on the original method of Wilson (1987), the characteristics of compassion and fatigue were listed, ordered and reduced to identify the defining characteristics (connotations) and categories of compassion fatigue. These defining characteristics (connotations) and categories were used to clarify the meaning of compassion fatigue through the construction of a connotative (theoretical) definition. A model case, borderline case and contrary case were described to confirm the defining characteristics (connotations) of the concept. The categories and defining characteristics (connotations) of compassion fatigue were further established through a literature control that grounded the findings of the concept analysis.

The second objective was to identify and describe the empirical indicators of compassion fatigue in order to construct a denotative (operational) definition. The empirical indicators were identified from the characteristics (connotations) of compassion fatigue and the literature control. These listed empirical indicators were then ordered and divided, so as to permit the synthesis of a denotative (operational) definition of compassion fatigue.

The third objective was to describe a conceptual framework through an integrative literature review. The main constructs embedded in compassion fatigue, namely the environment, the nursing practice, and the nurse practitioner, were described in detail and the relationship between these factors and compassion fatigue explicated, with their interconnectedness being graphically presented in a conceptual map

The findings reveal that there is an urgent need to make a concerted effort to deal with compassion fatigue, which is calamitous for the nursing profession. The recommendations for practice, education and research crystallize out of these findings.

OPSOMMING

Verpleegpraktisyns het 'n plig om met medelyde sorg om te gee vir die siek, gewonde, getraumatiseerde en swak pasiënte onder hulle sorg, wat hulle persoonlik blootstel aan die pasiënte se pyn, trauma en leiding op 'n daaglikse basis. Bykomend, werk verpleegpraktisyns in veeleisende en uiterste werksomstandighede, wat nie net hulle welsyn beïnvloed nie, maar ook hulle vermoë om medelyde sorg te voorsien. Die gevolg is verpleegkunde werkkragte wat medelyemoegheid beleef.

Die doel van hierdie studie was om medelyemoegheid te definieer, binne die konteks van die verpleegkunde professie, deur drie doelwitte te bereik wat deur 'n filosofiese ondersoek ontwerp en kwalitatiewe, verkennende, beskrywende en kontekstuele navorsing strategieë gerig is

Die eerste doelwit was om 'n konsep analise van medelyemoegheid te onderneem om 'n konnotatiewe (teoretiese) definisie te konstrueer. Deur die metode van Walker en Avant (2005), wat gebasseer is op die oorspronklike metode van Wilson (1987), te gebruik, is al die eienskappe van medelyde en moegheid gelys, georden en gereduseer om die definiërende eienskappe (konnotasies) en kategorieë van medelyemoegheid te identifiseer. Hierdie definiërende eienskappe (konnotasies) en kategorieë is gebruik om die betekenis van medelyemoegheid uit te klaar deur die konstruksie van 'n konnotatiewe (teoretiese) definisie. 'n Modelgeval, grensgeval en kontrasterende geval is daarna beskryf om die definiërende eienskappe (konnotasies) en kategorieë van die konsep te bevestig. Die definiërende eienskappe (konnotasies) en kategorieë van medelyemoegheid is verder vasgestel deur 'n literatuurkontrole wat die bevindinge van die konsep analise begrond het.

Die tweede doelwit was om die empiriese indikatore van medelyemoegheid te identifiseer en beskryf om 'n denotatiewe (operasionele) definisie te konstrueer. Die empiriese indikatore is geïdentifiseer vanuit die definiërende eienskappe (konnotasies) van medelyemoegheid en die literatuurkontrole. Hierdie lys van empiriese indikatore is daarna georden en verdeel om die sintese van 'n denotatiewe (operasionele) definisie van medelyemoegheid te verkry.

Die derde doelwit was om 'n konseptuele raamwerk deur 'n integrerende literatuuroorsig te beskryf. Die hoof konstrukte waarbinne medelyemoegheid ingebed is naamlik, die omgewing, die verpleegpraktyk en die verpleegpraktisyn is omvattend bespreek en die verhouding tussen hierdie konstrukte en medelyemoegheid is verduidelik, met die onderlinge verband grafies voorgestel in 'n konseptuele diagram.

Die bevindinge dui daarop dat daar 'n dringende behoefte is aan 'n gesamentlike poging om medelyemoegheid, wat rampspoedig is vir die verpleegprofessie, te hanteer. Die aanbevelings vir die praktyk, onderrig en navorsing kristalliseer uit hierdie bevindinge.

CHAPTER ONE

OVERVIEW OF THE RESEARCH STUDY

1.1 INTRODUCTION

An overview of the research study is provided in this chapter. The chapter commences with the background and problem statement that inspired this study of compassion fatigue, followed by the identification of the aims and objectives of the study, and a discussion of the meta-theoretical, theoretical and methodological assumptions. A brief description of the research design and research method is then given and the chapter concludes with the research study outline.

1.2 BACKGROUND AND RATIONALE FOR THE STUDY

When focusing on the emotional well-being of South African nurses, one has to take into consideration the nature of the South African health care system and the effect it has on the practicing nurse. In the last five to ten years, there has been a shift from a fragmented, mainly curative, hospital-based service to an integrated, primary health care, community-based service (ANC, 1994a:19-20; Geyer *et al.*, 2002:11). The health care system consists of both a private and a public sector. The private sector is a profitable sector, as clients have a medical insurance which pays for services rendered by the health care providers, while the public sector is a state system, that is publicly funded and is free to all unemployed citizens or at a small fee to those who are able to pay (Geyer *et al.*, 2002:11; Van Rensburg & Pelser, 2004:298). The public health sector is divided into three tiers consisting of a national system, a provincial system and a district system, where professional nurses are involved in all three levels of the health care system, but are the

predominant health care providers in the provincial and district levels (Dennill *et al.,* 2002:45-46; Geyer *et al.*, 2002:11).

These changes in the structure of the South African health care system have far reaching effects on health care professionals, as larger sections of the population are now able to access the health care system for free services (Van Rensburg & Pelser, 2004:164). This resultant increase in health care utilization has placed a great burden on nurse practitioners, as there has been an increase in workload, a shortage of equipment and supplies, and limited communication and consultation between the nurse practitioner and the patient in professional practice (Walker & Gilson, 2004). Further implications of a free health care system include factors such as overcrowding in clinics, poor working conditions, poor staff morale, excessive use of services, deterioration in the quality of care and abuse of scarce resources (Van Rensburg & Pelser, 2004:164).

Pelser *et al.* (2004:298) claims that approximately 80% of the population is currently making use of the public health sector, and the demands for health care services will continue to increase, exceeding 5% a year from 2004 and rising to 11% a year from 2010 onwards, as a direct result of HIV and AIDS. At the end of 2005 there was an estimated 5 500 000 adults and children living with HIV and AIDS in South Africa with an accompanied 320 000 deaths in that same year, that is more than 800 deaths every day (UNAIDS, 2006). From these statistics it is clear that the HIV and AIDS epidemic places a great burden on nurse practitioners, as they not only deliver the greatest percentage of patient care, providing both physical and emotional support for people living with HIV and AIDS, and their families, but they also care for those who are dying (Evian, 2003:313; Oulton, 2006:34). Furthermore, these statistics affect them directly, with 15.6% of health care workers being HIV positive, resulting in the fact that the individuals are often ill and absent from work, which forces their co-workers to shoulder an even greater workload and responsibility in their absence (Shisana *et al.*, 2004:849-850).

Nurse practitioners in South Africa face another emotionally taxing aspect concerning the HIV and AIDS epidemic and that is accidental exposure to the HI virus. Aiken *et al.* (1997:106) estimates that on average, a nurse practitioner will sustain 0.7 or 0.8 sharp object injuries a year, or 3-4 injuries over 5 years. Contracting HIV is a frightening concern for nurse practitioners who deal with the fatality of the disease on a daily basis and are constantly at high risk of exposure (Clarke *et al.,* 2002:211; Olivier & Dykeman, 2003:653; Smit, 2004:25). From December 1981 through December 2001, 57 confirmed cases and 138 suspected cases of occupationally acquired HIV infection has been reported to the Centers for Disease Control and Prevention (CDC) in the United States of America, of which nursing practitioners account for the largest percentage (Do *et al.*, 2003:88). It is an obvious conclusion that the higher the HIV and AIDS prevalence in a country, the greater the chances are of accidentally being infected by the virus, especially in Sub-Saharan Africa which carries 71.5% of the world's HIV and AIDS infections (Ehlers, 2006; UNAIDS, 2006). Further complicating the situation, is the policy of most African countries, including South Africa, which states that it is the patients' right to withhold their HIV and AIDS status. The result is that the HIV status of most patients remains unknown to the nurse practitioners, forcing them to treat every patient as being HIV positive, increasing not only their workload, but also the use of scarce resources and supplies (Ehlers, 2006).

With nurse practitioners at the very core of health care provision it is alarming to realise that South Africa faces a critical nurse shortage. According to the South African Nursing Council a total of 47 390 800 patients were served by 101 295 registered nurses in 2006, with a ratio of 468 patients to one registered nurse (SANC, 2006). Furthermore, Goering (2006) reports that about half the nursing positions at public health clinics in South Africa are currently vacant, while Oulton (2006:35) states that there is currently a nurse shortage of 32 000 in South Africa alone. According to Bateman (2005:906) this shortage of nursing staff can be attributed, in part, to nursing emigration, as over 23 000 South African born nurses were employed in the United States of America, Britain, Canada and Australasia by the end of 2001. The reasons

for emigration are varied and include: low wages, heavy workloads, poor working and living conditions, lack of resources, limited career opportunities, the impact of HIV and AIDS, poor management of health services, general decline of public services in South Africa, unstable work environments and economic instability (Buchan, 2006:21; Ehlers *et al.*, 2003:31). According to Buchan (2006:22) the nurse practitioners who remain behind suffer from a high workload and low morale which has lead to a compromise in the quality of care provided.

Many literature sources support the opinion that a high workload directly influences patient outcomes and decreases the quality of care (Blegen & Vaughn, 1998:202; Yang, 2003:156; Rafferty *et al.,* 2006:179; Aiken *et al.* 2001:260; Mitchell 2003:221). Studies have shown that a high workload results in an increase of nosocomial infections, patient falls, pressure ulcers, patient/family complaints, higher medication administration errors and cardiopulmonary arrests (Blegen & Vaughn, 1998:202; Yang, 2003:156), while Rafferty *et al.* (2006:179) revealed that significantly higher surgical mortality and failure to resuscitate rates were evident in hospital wards where nurse practitioners had high workloads. Aiken *et al.* (2001:260) further discovered that between 40-50% of nursing care activities such as patient education, oral hygiene, skin care and therapeutic communication with patients are not performed in hospitals due to high workloads.

Mitchell (2003:221) showed that with adequate staffing, the quality of care is very good, nurse-patient activities happen as expected and patients are satisfied with the care they receive. In these circumstances nurse practitioners feel the workload is manageable, their work has meaning to them, their morale is high, they are able to give individualised care and they can partake in various other nursing activities. However, with just five nursing personnel less the results are disastrous. The quality of care and patient safety are severely compromised, vital nursing procedures are difficult to complete, emergency incidents increase, there is discontinuous care, individual concerns of the patients are overlooked, contact and

communication with patients and their families are minimal, and patients' complaints increase. In these circumstances the nursing personnel tries only to survive as they work under high stress levels and unbearable work loads.

South African nurse practitioners find themselves in this stressful working environment everyday and it not only affects their physical health, but also their emotional well-being (Van den Berg *et al.,* 2006:13; Levert *et al.*, 2000:37). Many literature sources mention that nurse practitioners feel emotionally overloaded, stressed, fatigued, helpless, hopeless, angry, shocked, grieved, irritated, fearful, unsettled, frustrated, experience job dissatisfaction, moral distress, have a sense of depersonalisation and lack a feeling of personal accomplishment (Smit, 2004:25-26; Van den Berg *et al.*, 2006:11; Sandgren *et al.*, 2006:82; Billeter-Koponen & Fredèn, 2005:26; Shisana *et al.,* 2004:850; Aiken *et al.*, 2001:261; Clarke & Aiken, 2003:107; Bester *et al.* 2006:47). In the field of psychology, terms such as vicarious traumatisation, traumatic counter-transference, secondary traumatic stress, burnout and compassion fatigue have emerged to explain these adverse emotional effects within caring professions (Salston & Figley, 2003:167-170; Collins & Long, 2003b:417; Figley, 2002a:1434).

The term burnout appeared as early as 1961 in fictional literature, until Freudenberger researched and coined the term in 1974 (Maslach *et al.,* 2001:398; Coetzer, 2004:202). The term has since been described as a gradual response to job strain and interpersonal stressors that leads to emotional exhaustion, depersonalisation and reduced personal accomplishment (Maslach & Goldberg, 1998:64). Other terms that have come about since then include the term traumatic counter-transference which was studied by Danieli in 1988 (Sexton, 1999:396) and described in 1991 by Corey (*in* Collins & Long, 2003b:420), as the therapist's over-involvement or self-identification with the client's traumatic experience, or the desire of the therapist to fulfil his own needs through the client. Later, the term vicarious traumatisation was coined by McCann and Pearlman (1990) and can be portrayed as the change a therapist experiences in his personal views and

thoughts of himself and others, while empathetically listening to a client's traumatic experience. Finally, the term secondary traumatic stress was introduced into the field of psychology by Figley, and can be depicted as the emotions and behaviours that result from knowing about and wanting to help someone who is suffering or experiencing trauma (Figley, 2002a:1435).

Most recently the term compassion fatigue has come to the forefront. The term was coined by Joinson in 1992 while she was investigating the nature of burnout in nurses in an emergency unit (Collins & Long, 2003b:421; Joinson 1992:119). This term was then researched and adopted in the field of psychology as a more "*user friendly term*" for Secondary Traumatic Stress Disorder (STSD) which Figley defined as "*a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders or persistent arousal associated with the patient*" (2002a:1435). This definition is however specifically focused on the psychology field and is far removed from Joinson's original impression that compassion fatigue is a loss of the nurse practitioners "*ability to nurture*" (Joinson, 1992:119).

1.3 PROBLEM STATEMENT

Compassion is defined as *"a feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause"* (The Random House Dictionary of the English Language, 1967:299). In the researcher's opinion, this definition describes the very crux of the nursing profession. Nurse practitioners enter the profession because they have a deep rooted desire and calling to compassionately care for the sick, wounded, traumatised and weak. This very aspect makes them excellent caregivers, but being surrounded by pain, trauma and suffering on a daily basis, eventually takes its emotional toll. Added to this, is the fact that nurse practitioners in South Africa are further challenged by factors such as staff shortages, unbearable workloads, poor working conditions, lack of resources and the impact of HIV and AIDS which

further adds to their emotional burden. The result is a nursing workforce that is experiencing compassion fatigue. Compassion fatigue has, however, never been specifically defined within the context of the nursing profession before, and in order to truly comprehend the effect it is having in the nursing practice, the concept, compassion fatigue, has to be defined. Prompted by this problem statement the following research questions can be asked:

1. What is compassion fatigue within the context of the nursing profession?
2. What are the empirical indicators of compassion fatigue?
3. What are the constructs of the conceptual framework?

1.4 RESEARCH OBJECTIVES

The overall aim of this study is to define compassion fatigue within the nursing profession. To attain this aim the following objectives are set:

1. To conduct a concept analysis of compassion fatigue in order to construct a connotative (theoretical) definition.
2. To identify and describe the empirical indicators of compassion fatigue in order to construct a denotative (operational) definition.
3. To describe a conceptual framework through a literature review.

1.5 PARADIGMATIC PERSPECTIVES

The paradigmatic perspectives are the researcher's assumptions. These perspectives are divided into the meta-theoretical, theoretical and methodological statements which serve as a framework in which the research was conducted (Botes, 1995:9).

1.5.1 Meta-theoretical statements

The researcher supports the Judeo-Christian philosophy which is centred on the Bible as source of truth. The Bible states that the earth was created by God in five days, and on the sixth day man was created in the very image of God with the command to have dominion over and populate the earth, while fulfilling his primary purpose of living in an intimate relationship with God.

Man was created with a free will, and after being tempted by Satan, man chose to rebel against God, and sin formed a chasm in their relationship. God, however, in His love for mankind, set in motion a divine plan to redeem and restore the relationship between Him and man, by sending his Son, Jesus Christ, the Second Person of the Trinity, to earth through a virgin birth.

Jesus Christ walked this earth, performed miracles, proclaimed the Word of the Lord and taught people how to live a life of virtue, being clothed in compassion, kindness, humility, gentleness, patience and above all else, love (Colossians 3:10). His ultimate purpose on earth was fulfilled, according to the Old Testament prophecies, when Jesus Christ took our sins and punishment upon Himself, and died upon the cross as the ultimate sacrifice, having known no sin. Three days later, Jesus Christ was resurrected from the dead, having overcome sin and death, and reconciling us to God. It is through the acceptance of Jesus Christ as our Lord and Saviour that we can receive forgiveness from our sins and be called the children of God, having an inheritance and eternal life with God in heaven (Bible, 1995).

Forty days after Jesus Christ was resurrected from the dead, He ascended to heaven to be seated at the right hand of God the Father, and seven weeks later, at Pentecost, God sent the Third Person of the Trinity, the Holy Spirit, to earth as our Helper. The Holy Spirit indwells every believer of Christ, convicting us of sin, comforting us and empowering us with spiritual gifts to serve mankind and spread the Gospel of Salvation. God requires of each individual to live a life of excellence, holiness and obedience to Him, and to grow daily in the character of Christ, displaying love, joy, peace, patience, kindness, gentleness and self-control in all our thoughts and actions towards all people (Galatians 5:22-23), until the day we die and are brought to wholeness in Christ. Jesus Christ is seen as the embodiment of compassion and caring, and the standard to which every person must live. Within this framework the researcher will define the meta-theoretical statements of man, health, environment and nursing (Bible, 1995).

1.5.1.1 Man

For the purpose of this study, man refers to the nurse practitioner, who is a God-created, unique, multi-dimensional being that is called by God to love his/her fellow man as much as he/she loves himself and to love God with all his/her heart, mind, soul and strength. The nurse practitioner therefore has a duty in his/her profession to deliver compassionate care to the sick, weak, traumatised and wounded patients in his/her care, so as to act as an instrument of service and demonstrate the loving, compassionate heart of God towards his/her fellow man.

1.5.1.2 Health

For the purpose of this study, health is compassion and caring, and refers to the nurse practitioner's ability to compassionately care for the sick, wounded, traumatised and weak patients in his/her professional care, while compassion fatigue is the nurse practitioner's inability to show compassion to the sick, wounded, traumatised and weak patients in his/her professional care, and is depicted as the absence of health or disease.

1.5.1.3 Environment

The environment refers to the nurse practitioner's workplace. In this environment the nurse practitioner works in dire circumstances with staff shortages, unbearable workloads, poor working conditions, inadequate management support, a lack of resources, low wages, limited career opportunities, the impact of HIV and AIDS and poor management of health services (Buchan, 2006:21; Ehlers *et al.*, 2003:31), all while caring for the sick, wounded, traumatised and weak patients in his/her professional care that personally exposes the nurse practitioner to the patients' pain, trauma and suffering on a daily basis.

1.5.1.4 Nursing

For the purpose of this study nursing is the art and science of compassionately caring for the individual, family and community to promote, maintain and restore health, as well as care for the dying. Promotion of health includes all the activities the nurse practitioner performs to assist the patient in

attaining a higher level of health. Maintenance of health is all the activities the nurse practitioner performs to prevent illness and preserve health, while restoration of health includes all the nursing activities the nurse practitioner performs to reinstate the individual, family or community's previous level of functioning or health. The nursing activities that are provided by the nurse practitioner are adaptive and holistic in nature, catering to the individual, family and community's physical, psychological, social, intellectual and spiritual needs (Kozier *et al.*, 2000:8-9).

1.5.2 Theoretical statements

The theoretical statements that are used in this research include the central theoretical argument as well as the conceptual definitions.

1.5.2.1 Central theoretical argument

The analysis of the concept, compassion fatigue, provides a connotative (theoretical) definition, and further allows the identification and description of empirical indicators, which permits the synthesis of a denotative (operational) definition. The description of the conceptual framework portrays the context and related constructs which are embedded in compassion fatigue.

1.5.2.2 Conceptual definitions

The following concepts are central in the research and are defined as follows:

Concept Analysis

This term refers to the use of language in a prescribed method to examine and describe the structure and function of a concept (Walker & Avant, 2005:63). In this formal process, the concept is broken down into its most basic elements, so that its unique defining characteristics (connotations) can be identified. The exact meaning of the concept is then clarified, resulting in connotative (theoretical) and denotative (operational) definitions of the concept which promotes understanding of the concept (Walker & Avant, 2005:63-64; Burns & Grove, 2005:122).

Nurse Practitioner

This term refers to all persons who practice the profession of nursing and includes registered nurses, enrolled nurses, enrolled nursing auxiliaries and nursing students who are registered at the South African Nursing Council in these categories respectively.

Nursing Profession

This term refers to the context of nursing, which is inclusive of the environment of nursing, the practice of nursing and the nurse practitioner, as it relates to the concept, compassion fatigue. It further includes aspects of the health care sectors, nurse practitioner staffing, health status of the South African population, the philosophical framework of nursing in South Africa, theories of care, the legal-ethical framework of the nursing practice and the well-being of the nurse practitioner.

1.5.3 Methodological statements

The methodological statements of this research are based on the Botes research model (1995:6). This model was specifically developed for nursing research and has a functional reasoning and open methodological approach (Botes, 1995:13-14). The Botes research model is divided into three interconnected levels of nursing activities which function in a specific relationship with each other (Botes, 1995:14).

The first level represents the nursing practice, which focuses on the nurse practitioner's interaction with the patient and the activities of nursing performed to promote, maintain and restore the health of patients. The nursing practice forms the research domain for nursing, as it is in this level where pre-scientific knowledge is identified, questioned and analysed, to find solutions (Botes, 1995:6).

The second level includes nursing research and theory development. On this level the researcher executes the research process on the identified problem

by making research decisions within the framework of research determinants, which include the researcher's assumptions, the research problem, the research objectives, the research context and the attributes of the research field. The results of the research are then incorporated in the scientific knowledge content of nursing and directly applied to the nursing practice (Botes, 1995:6). This research analysed the concept, compassion fatigue, within the nursing profession. The concept analysis process allowed the construction of a connotative (theoretical) definition, identification and description of the empirical indicators, and a resultant denotative (operational) definition of compassion fatigue, while the description of the conceptual framework portrayed the context and related constructs which are embedded in compassion fatigue.

On the third level, the researcher's paradigmatic perspective of nursing is represented. The paradigmatic perspective includes the meta-theoretical, theoretical and methodological assumptions of the researcher, which directly influence the nursing practice, the research methodology and interpretation of the data (Botes, 1995:7). The meta-theoretical statements of this study were kept within the framework of the Judeo-Christian philosophy.

1.6 RESEARCH DESIGN

The research design of this study is a philosophical inquiry that was used along with qualitative, exploratory, descriptive and contextual research strategies, so as to achieve the objectives of this study. A philosophical inquiry is defined by Burns and Grove (2005:745) as *"using intellectual analysis to clarify meanings, make values manifested, identify ethics, and study the nature of knowledge".*

Qualitative research is described as delving into the depths of a phenomenon so as to discover the complexity and meaning of the phenomenon (Burns & Grove, 2005:52). Qualitative research allowed the researcher to holistically study the phenomenon of compassion fatigue within the context of the South African nursing profession using a precise, systematic process to gather and

analyse information concerning this specific concept. The purpose of its exploration and description was to gain a greater understanding of the concepts' characteristics (connotations), which resulted in a connotative (theoretical) definition, identification and description of the empirical indicators and the synthesis of a denotative (operational) definition of compassion fatigue. Finally, the conceptual framework described the context and related constructs which are embedded in compassion fatigue (Burns & Grove, 2005:52).

1.7 RESEARCH METHOD

The research method includes the population and sample, data collection, ensuring rigour and data analysis (Klopper, 2006:15).

1.7.1 Population and sample

The population was selected from the North-West University library resources and included the following databases: Nexus, South African journal database or SAePublications, international journal databases (EBSCOhost and ScienceDirect), books, journals, dictionaries, thesauri, theses and dissertations from the North-West University library and inter-library loans, as well as the World Wide Web, in which the word compassion fatigue emerged. Purposive sampling was applied in the selection of data, as the researcher consciously selected the databases, so as to gain rich data and a comprehensive understanding of the concept from various sources and professional disciplines (Burns & Grove, 2005:352). The number of literature sources sampled was determined by the depth of information needed to describe the concept compassion fatigue and to achieve saturation of information (see 3.2.3.1) (Burns & Grove, 2005:358).

1.7.2 Data collection

The data collection techniques used in this study will be briefly described and explained below, so as to clarify the different methods' contribution to the understanding of the concept, compassion fatigue.

1.7.2.1 Concept analysis (Objective 1)

A concept analysis of compassion fatigue was performed using the method of Walker and Avant (2005) which is based on the original method of Wilson (1987) and includes the following steps:

- Selecting a concept (see 2.5.2.1 and 3.2.1)
- Determining the aims or purpose of analysis (see 2.5.2.1 and 3.2.2)
- Identifying all uses of the concept (see 2.5.2.1 and 3.2.3)
- Determining defining characteristics (see 2.5.2.1 and 3.2.4)
- Identifying a model case (see 2.5.2.1 and 3.2.6)
- Identifying additional cases – borderline and contrary case (see 2.5.2.1 and 3.2.7)
- Identifying antecedents and consequences (see 2.5.2.1 and 3.2.4)

1.7.2.2 Empirical indicators (Objective 2)

The empirical indicators of compassion fatigue were identified and described from the results of the concept analysis and the integrative literature control (see 2.5.2.2 and 3.3), which allowed the synthesis of a denotative (operational) definition of compassion fatigue (see 3.3.1).

1.7.2.2 Conceptual framework (Objective 3)

A conceptual framework is described as the development of an outline that specifically enhances the understanding of a particular phenomenon through the selection and definition of concepts, the proposition of relationships between those concepts, the expression of statements in hierarchical fashion and the development of a conceptual map that expresses the framework (Burns & Grove, 2005:136; Brink, 2006:24). A conceptual framework was developed to describe the underlying meanings, relationships and interconnectedness between the constructs of environment, nursing practice and nurse practitioner, in which compassion fatigue is embedded (see 2.5.2.3 and 4.1 to 4.4)

1.7.3 Data analysis

Data analysis is described as different reasoning approaches to systematize, condense and synthesize findings that culminate in the production of theoretical explanations (Burns & Grove, 2005:565). The data collected were sifted for relevant information and incorporated into the study if it answered the proposed research questions (see 3.2.3.2) (Burns & Grove, 2005:565). These identified sources were then examined and analysed using the process of content analysis (see Table 3.4) to identify the defining characteristics (connotations) of compassion fatigue which resulted in a connotative (theoretical) definition (see 3.2.5), identification and description of empirical indicators (see 3.3) and a denotative (operational) definition (see 3.3.1), as well as the description of a conceptual framework (see 4.1-4.4) that presented the context and related constructs which are embedded in compassion fatigue (Walker & Avant, 2005:63-64; Burns & Grove, 2005:122).

1.8. RESEARCH REPORT OUTLINE

CHAPTER 1: Overview of the study
CHAPTER 2: Scientific justification of the research design and method
CHAPTER 3: Concept analysis of compassion fatigue
CHAPTER 4: Conceptual framework
CHAPTER 5: Evaluation of the study and recommendations for practice, education and research

1.9 CONCLUSION

In this chapter, an overview of the research study was provided. The background and problem statement that roused interest in the dilemma of compassion fatigue was explored and the meta-theoretical, theoretical and methodological assumptions which directed the study were discussed. The chapter then concluded with a brief description of the research design, research methods and an outline of the study.

CHAPTER TWO

SCIENTIFIC JUSTIFICATION OF THE RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

In this chapter the research methodology used in the study is discussed in greater detail. According to Botes (1995:7) research methodology refers to the research decisions that are made and justified within the framework of research determinants. These determinants include the researcher's assumptions, the research problem, the research context, the research objectives and the attributes of the field of research, all of which were discussed in Chapter 1. The research decisions that are made are described as initiation, formulation, conceptualising, research design and implementation, where the research design includes the following: the research strategy, the methods and techniques for data collection and data analysis, the target population, the sampling method and the method to ensure rigour of the study. A research design is further described by Mouton and Marais (1996:33) and Burns and Grove (2005:231) as a plan or framework that is developed from the research objectives or the purpose of the study, with the aim of clearly stating the conditions under which the collection and analysis of the data will be done, so as to achieve greater control of and validity in examining the research problem.

2.2 AIM AND OBJECTIVES OF THE STUDY

To orientate the reader, the aim and the objectives of the study are repeated.

The overall aim of this study was to define compassion fatigue within the nursing profession. To attain this aim the following objectives were set:

1. To conduct a concept analysis of compassion fatigue in order to construct a connotative (theoretical) definition.
2. To identify and describe the empirical indicators of compassion fatigue in order to construct a denotative (operational) definition.
3. To describe a conceptual framework through a literature review.

The research design is discussed in accordance with the aim and objectives of the study, and aspects such as data collection, the population, the sampling method and data analysis are described. The rigour of the study is discussed, and the chapter concludes with a portrayal of the ethical considerations of the study.

2.3 RESEARCH DESIGN

The research design of this study is a philosophical inquiry and it is used along with qualitative, exploratory, descriptive and contextual research strategies, so as to achieve the objectives of this study.

2.3.1 Philosophical inquiry

A philosophical inquiry is described as intellectually examining phenomenon so as to explain meanings, clearly describe values, identify ethics and learn about the very nature of knowledge (Burns & Grove, 2005:27). Ellis (1983:212) maintains that the primary purpose of a philosophical inquiry is to *"expose, clarify, and articulate the perspectives, beliefs, conceptualizations and methods that characterize a field".* In this study, the researcher focused on exploring and clarifying the meaning of the concept, compassion fatigue, within the nursing profession by making use of different branches of existing knowledge that had researched the phenomenon, and further using the boundaries of language to

clearly describe and explain the meaning of compassion fatigue in its entirety (Uygur, 1964:77; Ellis, 1983:212-213).

When explaining the meaning of a concept in philosophical inquiry, the aim is not to explore the concept in itself, but rather to explore what the concept stands for or speaks of – its *"meaning content"* (Uygur, 1964:77). The meaning of a concept is discovered through critically examining the logic of what is said about the phenomenon (Christian, 1959:78-80) and by focusing on the usage of the concept. Philosophical inquiry further aims to understand phenomena and to translate abstract meanings into concrete meanings by *"intellectually dissecting"* or breaking down the concept into its most basic structure, so as to get an *"inside look"* at the nature and working of things, or the *"inner constitution"* of the phenomenon (Moore, 1953:205-206; 216-217; Lazerowitz, 1958:194-200). This process allows the researcher to discover the exact relationship and meaning between concepts, which can then be clearly conveyed to people using *"ordinary language with extraordinary care"* (Christian, 1959:80-81).

Burns and Grove (2005:27) portray a philosophical researcher as one who, *"...considers an idea or issue from all perspectives by extensively exploring the literature, examining conceptual meaning, raising questions, proposing answers, and suggesting the implications of those answers."* This definition can be directly applied to this study, as the concept compassion fatigue was explored and described by constructing specific meanings (connotative and denotative definitions) by the method of concept analysis (*"examining conceptual meaning"*) and a literature study (*"extensively exploring the literature"*). Questions (*"raising questions"*) that were stated are: What is compassion fatigue within the context of the nursing profession? What are the empirical indicators of compassion fatigue? What are the constructs of the conceptual framework? From these answers (*"proposing answers"*) it was possible to construct a connotative (theoretical) definition, identify and describe empirical indicators and synthesize a denotative (operational) definition of compassion fatigue through a concept

analysis, as well as describe a conceptual framework (*"suggesting the implications of those answers".)*

2.4 RESEARCH STRATEGIES

The research strategies used in this study are qualitative, explorative, descriptive and contextual strategies. The word strategy is defined as a *"plan of action"* (Concise Oxford Dictionary, 1999:927) and originates from the Greek word "*strategos*" which means "*General*". It can therefore be said that a research strategy is the "*General*" or "*plan of action*" which gives direction to the study, with respect to the methods and techniques that must be used to realise the aim of the research (Klopper, 1994:37).

2.4.1 Qualitative research

Qualitative research is an expansive description of a method of investigation, which encompasses different approaches based on specific philosophical orientations from the fields of philosophy, sociology and psychology. Despite the contrariety of the different approaches, the main purpose of qualitative research is to delve into the depths of phenomena, so as to discover and understand the complexity and meaning of a specific phenomenon (Burns & Grove, 2005:52).

Qualitative research further holds at its core the following beliefs (Burns & Grove 2005:52):

- There is no single reality. Each person has his own perception of reality and this is apt to change over time.
- The meaning we ascribe to a phenomenon is only fitting within a given situation or context
- The reasoning process involves perceptually putting pieces together to make wholes.
- From this process meaning is produced.

Creswell (1998:15) describes qualitative research as *"... an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem."* Using qualitative research in this study allowed the researcher to holistically investigate the problem of compassion fatigue within the context of the South African nursing profession, with the use of a precise, systematic process to gather and analyse information, which resulted in the researcher gaining a thorough understanding of the exact meaning of this phenomenon.

2.4.2 Explorative research

Explorative research is described as the investigation of the full nature of a relatively unknown phenomenon, including the manner in which it manifests itself and all the factors to which it is related (Polit & Hungler, 1997:20; Mouton & Marais, 1996:43). Explorative research aims to comprehend and gain new insights into phenomena, to explain concepts and constructs, to do preliminary research prior to a more structured study, to determine priorities for future research and to develop new hypothesis. For explorative research to be successful, however, the researcher must be willing to examine new ideas and suggestions from all perspectives and be open to new stimuli (Mouton & Marais, 1996:43).

This study can be described as explorative in nature as the researcher aimed to clarify and theoretically ground the meaning of compassion fatigue through a concept analysis. A connotative (theoretical) definition, empirical indicators and a denotative (operational) definition were constructed from this analysis. These results serve to increase insight and understanding of compassion fatigue, which according to the researcher's knowledge, and an in-depth literature search, has never been defined in the nursing profession before.

2.4.3 Descriptive research

Qualitative descriptive research is portrayed as identifying, observing, understanding, and unfolding the nature and the relationship between phenomena, as it exists in reality, as accurately as possible (Burns & Grove, 2005:3; Polit & Hungler, 1997:20; Mouton & Marais, 1996:44). The primary purpose of descriptive research is to depict that which exists, to discover new information and meaning, to further understanding of situations and to order information, so that it can be used in the nursing practice (Burns & Grove, 2005:3).

This study can be portrayed as descriptive in nature as a systematic, factual and accurate description of compassion fatigue was performed through both a concept analysis and description of a conceptual framework. The concept analysis provided a connotative (theoretical) definition, empirical indicators and a denotative (operational) definition, while a literature review allowed the description of a conceptual framework that portrayed the context and related constructs which are embedded in compassion fatigue.

2.4.4 Contextual research

Contextual research is depicted as describing differences and distinguishing characteristics of phenomenon of intrinsic interest, in its immediate, unique, value and time-space context (Mouton & Marais, 1996:49-50, Botes, 1995:9). Contextual research does not aim to generalise findings of the research, but rather aims to analyse and describe the reality of a particular research setting in such detail, that transferability of the research findings will be possible in a similar context (Botes, 1995:9).

The context of this study is nursing science (the body of knowledge that directs nursing), the nursing practice and specifically the emotional well-being of nurse practitioners in South Africa. According to the researcher, the connotative

(theoretical) and denotative (operational) definitions, the empirical indicators, as well as the conceptual framework developed in this study is applicable to the nursing profession as a whole, and may even be transferable to other human service professions.

In the preceding section of this chapter the research design was explained through the discussion of each research strategy. In the following section the research method is described in relation to the research design.

2.5 RESEARCH METHOD

The research method is discussed in relation to the activities of sampling, data collection and data analysis.

2.5.1 Sampling

Sampling includes the population, the sampling method and the sampling size that was used in this research study.

2.5.1.1 Population

The population was selected from the North-West University library and included: Nexus database, South African journal database or SAePublications, international journal databases (EBSCOhost and ScienceDirect), books, dictionaries, thesauri, journals, theses and dissertations from the North-West University library and inter-library loans, as well as the World Wide Web, in which the word compassion fatigue emerged.

2.5.1.2 Sampling method

Purposive sampling was applied in the selection of data, as the researcher consciously selected information which conformed to the stated inclusion criteria and the proposed research questions. This allowed the researcher to gain rich

data and a comprehensive understanding of the concept from various sources and professional disciplines (see 3.2.3) (Burns & Grove, 2005:352).

Dictionaries, encyclopaedias and thesauri were used in the concept analysis process. These literature sources were searched using the root words of compassion fatigue, namely "compassion" and "fatigue", as compassion fatigue is a relatively new term, with very limited entries in the above mentioned literature sources.

The World Wide Web, books, theses, dissertations and journals were used as an integrative literature control to confirm the findings of the concepts analysis. The World Wide Web, books, theses and dissertations were searched using the keyword "compassion fatigue", while journals were searched using the keywords: "compassion fatigue in AB Abstract or Author-Supplied Abstract, NOT disaster or combat or terroris* or media or journalism in the subject terms".

The articles selected, had to comply with the following criteria:

- The language of the data must be English, Afrikaans or German to allow understanding of the text.
- The articles must be peer-reviewed and published anywhere within the timeframe of January 1992 (when the term compassion fatigue was first coined) to October 2007 (time of data collection).

Strict record was kept of each step of the sampling process and detailed information documented on each source used, so that the researcher's decisions and study results could be trailed, evaluated and replicated, if so desired.

The conceptual framework was described through a literature review of the constructs - environment, nursing practice and nurse practitioner - based on their relevance to the phenomenon of compassion fatigue within the context of the nursing profession.

2.5.1.3 Sampling size

The number of literature sources sampled was determined by the depth of information needed to describe the concept, compassion fatigue, and to achieve saturation (when themes elicited become repetitive and redundant) of information (Burns & Grove, 2005:358) (see 3.2.3.1).

2.5.2 Data collection

The data collection techniques of concept analysis, identification of empirical indicators and the description of a conceptual framework are illustrated and explained in the following section, so as to clarify the different methods' contribution to the understanding of the concept, compassion fatigue.

2.5.2.1 Concept Analysis (Objective 1)

The first objective of this study was to perform an analysis of the concept, compassion fatigue. A concept is described by Chinn and Kramer (2004:61) as a complex mental formulation of experience, where the term 'experience' is conveyed as the perception of the world, including objects, other people, visual images, colour, movement, sounds, behaviour, interaction or the totality of what is perceived.

A concept analysis can therefore be described as the use of language in a prescribed method to examine and describe the structure and function of a concept (Walker & Avant, 2005:63). In this formal process, the concept is broken down into its most basic elements, so that its unique defining characteristics (connotations) can be identified, and the exact meaning of the concept clarified to result in connotative (theoretical) and denotative (operational) definitions of the concept (Walker & Avant, 2005:63-64; Burns & Grove, 2005:122). A connotative (theoretical) definition describes the *"sense"* of a concept, or the meaning and intention we have when we use the concept, while the denotative (operational) definition describes the *"reference"* of a concept or to the *"set of phenomena,*

entities, events, characteristics, behaviours, or processes which exist in reality, and which are included when we use that concept" (Mouton & Marais, 1996:58-59).

A concept analysis of compassion fatigue was performed using the method of Walker and Avant (2005) which is based on the original method of Wilson (1987) and includes the following steps:

STEP 1: Select a concept

The selected concept was of interest to the researcher and fundamental to the area or subject of research (Walker & Avant, 2005:66). On the basis of the problem statement (see 1.3), compassion fatigue was chosen as the central concept (see 3.2.1).

STEP 2: Determine the aims or purpose of analysis

The aim or reason for concept analysis is varied and may include: differentiating between the ordinary everyday usage and scientific usage of a concept, clarifying the meaning of a concept, developing a connotative (theoretical) or denotative (operational) definition of a concept, or adding to the existing theory of a concept (Walker & Avant, 2005:66-67; Van Vuuren & Botes, 1999:27).

In this research, the aim of analysing the concept compassion fatigue was to determine the identifying characteristics (connotations) of the concept (see 3.2.4), so as to clarify its meaning and develop a connotative (theoretical) definition (see 3.2.5), identify and describe the empirical indicators (see 3.3) and construct a denotative (operational) definition (see 3.3.1) of compassion fatigue (Walker & Avant, 2005:66-67) (see 3.2.2).

STEP 3: Identify all uses of the concept

All uses of the concept compassion fatigue within various professional disciplines were considered. Data collection was performed using all resources available at

the North-West University which included: Nexus database, South African journal database or SAePublications, international journal databases (EBSCOhost and ScienceDirect), books, dictionaries, thesauri, journals, theses and dissertations from the North-West University library and inter-library loans, as well as the World Wide Web, in which the word compassion fatigue emerged (see 3.2.3).

STEP 4: Determine the defining characteristics

While identifying all the uses of the concept compassion fatigue, characteristics (connotations) that were most frequently associated with this concept were listed, ordered and reduced to determine the defining characteristics (connotations) of compassion fatigue (see 3.2.4). This cluster of defining characteristics (connotations) allowed the researcher to synthesize a connotative (theoretical) definition of compassion fatigue (see 3.2.5), which served to differentiate it from other similar or related concepts (Walker & Avant, 2005:68) (see 3.2.4).

STEP 5: Identify a model case

A model case demonstrates all the defining characteristics of a concept and can be considered a pure case or exemplar of the concept. A model case provides insight into the internal structure of the concept and allows clarification of its meaning and context. After the characteristics of compassion fatigue had been identified (see 3.2.4) the researcher constructed a model case using a nursing example to demonstrate a true instance of compassion fatigue (see 3.2.6) (Walker & Avant, 2005:69).

STEP 6: Identify additional cases

Additional cases include borderline, related, contrary, invented and illegitimate cases. Identifying these cases allows the researcher to distinguish between concepts that are related, similar, contrary to or overlap with the concept being studied, allowing identification of those defining characteristics (connotations) that most closely represent the concept being studied (Walker & Avant, 2005:70). Below two of the relevant additional cases are discussed:

Borderline Cases:

Borderline cases are concepts that contain many or most of the defining characteristics (connotations) of the concept being studied, but not all of them. Those characteristics (connotations) that are not the same may differ significantly from the concept being studied, which helps to elucidate the defining characteristics (connotations) of the concept being studied. In this study the borderline case of Secondary Traumatic Stress Disorder (STSD) was examined as it is used synonymously with compassion fatigue in literature (see 3.2.7.1) (Walker & Avant, 2005:70).

Contrary Cases

A contrary case is the opposite of a model case and aims to give an example of what the concept is not, ultimately helping the researcher to determine the final set of defining characteristics (connotations) of the concept being studied. In this study, the concept, compassion satisfaction, was described so as to clarify what compassion fatigue is not (see 3.2.7.2) (Walker & Avant, 2005:71-72).

STEP 7: Identify antecedents and consequences

Antecedents and consequences can never be used as defining characteristics of a concept. The identification of consequences and antecedents, however, allows further refinement of the defining characteristics and a better understanding of the social context in which the concept is generally used. An antecedent can be described as a circumstance, event, object, style or phenomenon that precedes the occurrence of the concept, while a consequence is a circumstance, event, object, style or phenomenon that occurs after or as a result of the outcome of the concept (Walker & Avant, 2005:72-73). In this study the antecedents and consequences of compassion fatigue were identified, listed and ordered (see table 3.4) and later confirmed through an integrative literature control (see 3.2.8).

2.5.2.2 Empirical Indicators (Objective 2)

The second objective was to determine the empirical indicators (see 3.3) from the defining characteristics (connotations) of compassion fatigue (see 3.2.4) and the integrative literature control (see 3.2.8), so as to permit the synthesis of a denotative (operational) definition (see 3.3.1). Walker and Avant (2005:73) describe empirical indicators as observable phenomena that clearly demonstrate the existence or reality of the defined concept in the outside world.

The identified empirical indicators will allow the nurse practitioner to identify compassion fatigue within him/herself, as well as in fellow nursing colleagues and will further provide the content and theoretical basis for future instrument development, which will make measurement of compassion fatigue within nurse practitioners possible (Walker & Avant, 2005:73-74).

2.5.2.3 Conceptual Framework (Objective 3)

The third objective of this study was to describe a conceptual framework. A conceptual framework is portrayed as the development of an outline that specifically enhances the understanding of a particular phenomenon through the selection and definition of concepts, the proposition of relationships between those concepts, the expression of statements in hierarchical fashion and finally the development of a conceptual map that expresses the framework (Burns & Grove, 2005:136; Brink, 2006:24).

STEP 1: Select and define concepts

The constructs of environment, nursing practice and nurse practitioner were selected and conceptually defined for the conceptual framework, on the basis of their relevance to the phenomenon of compassion fatigue within the nursing profession (Burns & Grove, 2005:137).

STEP 2: Develop relational statements

Relational statements describe, explain or predict the nature of interactions between concepts. They may be simple in nature relating only two concepts or complex statements that explain the interactions between three or more concepts. When designing relational statements the researcher must pay attention to the substance, direction, strength and quality of the interactions. These relational statements may be descriptive, explanatory or predictive in nature. Descriptive statements demonstrate what the concept is or what its characteristics are, explanatory statements demonstrate the how and why of the concept, while predictive statements demonstrate conditions under which the concept is created or altered (Chinn & Kramer, 2004:112).

In this study, all the selected constructs were studied by method of a literature review, which resulted in a literal and diagrammatic representation of the constructs – environment, nursing practice and nurse practitioner - that clearly stipulated the relationship between them (see 4.2 to 4.4) (Burns & Grove, 2005:138-139).

STEP 3: Construct a conceptual map

A conceptual map is portrayed as a framework that shows the interrelationships of concepts and statements of a study in a diagrammatic layout (Burns & Grove, 2005:731). The conceptual map was compiled of all the concepts necessary to diagrammatically explain and clearly portray the constructs embedded in compassion fatigue (see Figure 4.1) (Burns & Grove, 2005:139).

2.5.3 Data Analysis

Data analysis is described as different reasoning approaches to systematize, condense and synthesize findings that culminate in the production of theoretical explanations (Burns & Grove, 2005:565). The data collected were sifted for relevant information and data that answered the proposed research questions were extracted (Burns & Grove, 2005:565). The data extracted was then listed,

ordered and reduced by summarising and documenting the information in a concise and retrievable way (Rodgers & Knafl, 1993:202). These documented sources were then analysed and classified into categories based on their theoretical importance through the systematic use of content analysis (Burns & Grove, 2005:554). According to Burns and Grove (2005:554) content analysis serves to measure "*...the frequency, order or intensity of occurrence of words, phrases, or sentences.*"

In this study the researcher identified specific characteristics (connotations) of compassion and fatigue within the text of the literature and listed them (see Table 3.3). These characteristics (connotations) were then ordered and divided into units of meaning and construct idea categories, with words that represented each of these categories (see Table 3.4) (Burns & Grove, 2005:555). Furthermore, the researcher made use of inductive reasoning to explore the texts for latent characteristics, attributes, meanings and associations among ideas, reality and language (Burns & Grove, 2005:555), which resulted in the description of a connotative (theoretical) definition (see 3.2.5), empirical indicators (see 3.3) and a denotative (operational) definition (see 3.3.1), as well as the portrayal of a conceptual framework that illustrated the context and related constructs which are embedded in compassion fatigue (see 4.2 to 4.4).

In this section of the chapter the research method which included the activities of sampling, data collection and data analysis were described in relation to the research design. In the following section the rigour of the study is discussed.

2.6 RIGOUR

The rigour of this study is evaluated by using the epistemological standards of truth value, applicability, consistency and neutrality (Lincoln & Guba, 1985:290-300).

2.6.1 Truth value

Truth value is the confidence the researcher has in the believability of the findings and the data of a particular inquiry, with reference to the participants, as well as the context in which the research was undertaken (Lincoln & Guba, 1985:290). Truth value includes the techniques of prolonged engagement, inferential validity, theoretical validity, triangulation, peer examination, negative case analysis and member checking (Klopper, 2006:17; Polit & Hungler, 1997:304-305; Sliep *et al.*, 2001:69). The techniques relevant to this study include theoretical validity and inferential validity.

Theoretical Validity: Theoretical validity refers to the connotative (theoretical) meaning of a concept (Mouton & Marais, 1996:63). The first objective of this research study was to determine the connotative (theoretical) meaning of the concept, compassion fatigue, through a concept analysis. The characteristics (connotations) of the concept were listed, ordered, reduced and classified into specifically identified categories to develop a connotative (theoretical) definition of the concept, compassion fatigue. Mouton and Marais (1996:63) describe a connotative (theoretical) definition as classifying or systemizing the most essential dimensions of meaning of a concept logically.

According to Rossouw (2005:19-20) there are some basic guidelines one must subscribe to when defining concepts:

1) The definition must indicate the unique identifying characteristics (connotations) of the concept.
2) The definition must not be circular or a repetition of the concept that is being defined.
3) The definition must contain all the characteristics (connotations) normally associated with the word and not be too broad, or include too many characteristics (connotations), nor be too narrow, or include too little characteristics (connotations).

4) The definition must not employ figurative language, but should rather be comprehensively and clearly stated using simple language.
5) The definition tells us what we should understand of the concept and should therefore not be formulated negatively.
6) The definition should be free of emotive words, as such words appeal to people's feelings rather than to their reason, thus threatening the rationality of the academic argument.

These guidelines were followed to construct a clear, comprehensive, simple, unambiguous connotative (theoretical) definition of the concept, compassion fatigue.

A further method that was used to ensure theoretical validity was conceptualising. Conceptualising refers to the description of key concepts in the research, as well as the grounding and integration of research within the accepted nursing body of knowledge (Botes, 1995:11-12). Conceptualisation allowed the researcher to describe and organise concepts within a conceptual framework, through a literature review, so that the underlying meanings and relationships between concepts could be clearly described and schematically presented.

Inferential Validity: An inference is portrayed as the logical conclusion that a researcher arrives at from the statements or premises, to a general truth or conclusion. The term inferential validity can thus be described as the evaluation of the legitimacy and relevance of the premises through to the conclusions. Premises should therefore be acceptable, relevant and supportive towards each other, so that they can serve as a credible, reliable and accurate foundation for the conclusion (Mouton & Marais, 1996:106-107).

To fulfil the requirement of logical reasoning, a concept analysis of compassion fatigue was performed so as to determine the connotative (theoretical) definition, the empirical indicators and the denotative (operational) definition of the concept.

The characteristics (connotations) of compassion and fatigue were listed, ordered and reduced through the process of content analysis, so as to clarify the defining characteristics (connotations) and categories of compassion fatigue. Thereafter, a connotative (theoretical) definition of compassion fatigue was inferred and formulated from these defining characteristics (connotations). The empirical indicators of compassion fatigue were determined from the defining characteristics (connotations) of the concept, as well as a literature review. These empirical indicators were used to synthesize a denotative (operational) definition, which clearly demonstrates the existence or reality of compassion fatigue in the nursing profession and the outside world. Furthermore, to ensure the logical course and the coherence of the data, a conceptual framework was described.

2.6.2 Applicability

Applicability is the extent to which research findings of an inquiry can be transferred to other settings or larger populations (Lincoln & Guba, 1985:297). Applicability includes the techniques of thick description, and expert consultation in the selection of sources and focus of the data (Klopper, 2006:17; Polit & Hungler, 1997:307-308; Sliep *et al.*, 2001:69).

In this study, the researcher made use of the study leader's expertise as well as that of a discussion group and a panel of experts in the selection of sources and the focus of the data, so as to ensure that the research was associable in the specific context where the phenomenon occurs, namely the nursing profession. To ensure applicability of the findings to other contexts and professions, a thick description was given of the research methodology, the background and rationale of the study, as well as the goal and objectives of the study. The research design, including data collection, analysis and interpretation of the data were also comprehensively documented and linked to each objective of the study (Polit & Hungler, 1997:308).

2.6.3 Consistency

Consistency is the ability to reproduce the study with the same population in a similar context and yield the same or comparable results (Sliep *et al.*, 2001:69). According to Klopper (2006:17-18) consistency includes both indirect and direct techniques. Indirect techniques include the measures of truth value, which consist of prolonged engagement, inferential validity, theoretical validity, triangulation, peer examination, negative case analysis and member checking, as well as direct techniques which include stepwise replication, an inquiry audit and triangulation. The researcher applied the techniques of theoretical and inferential validity which have been discussed in 2.6.1.

2.6.4 Neutrality

Neutrality is described as the application of partiality in the collection, analysis and interpretation of data that is based singularly on the selected population and is absent of personal biases, interests or perspectives of the researcher (Sliep *et al.*, 2001:70; Lincoln & Guba, 1985:300). According to Klopper (2006:18) neutrality is ensured through the techniques of a confirmability audit and triangulation.

In this study, the researcher ensured that the raw data, the analysis products, the process notes, the materials relating to the intention and dispositions of the researcher and the data reconstruction products were available, so that the researcher's decisions and study results could be trailed, evaluated and replicated if so desired (Polit & Hungler, 1997:307). Table 2.1 provides a summary of the standards and techniques used to ensure rigour in this study.

Table 2.1 Summary of the standards and techniques used to ensure rigour of the study

EPISTEMOLOGICAL STANDARD	TECHNIQUES APPLIED IN THIS STUDY
Truth value	• **Theoretical Validity** • **Inferential Validity**
Applicability	• **Expert consultation in the selection of sources and focus of the data** • **Thick description**
Consistency	• **Theoretical Validity** • **Inferential Validity**
Neutrality	• **Confirmability audit**

In this section of the chapter the epistemological standards of truth value, applicability, consistency and neutrality, and the techniques applied to ensure rigour of the study were described. In the next section the ethical considerations of the study are discussed

2.7 ETHICAL CONSIDERATIONS

The ethical aspects of this study are discussed in accordance to the guiding ethical principles of the Department of Health (2004:3), which state that all research conducted must be of a high standard which protects the wellbeing and rights of research participants, while ensuring that the ethical values of beneficence, justice and respect for persons are fulfilled. Principles that were crucial to the objectives of this study included the relevance and scientific integrity of the study, as well as investigator competence.

Research conducted in South Africa should be relevant to the national and individual needs of those who endure suffering and should culminate in the production of results that can be used to improve the health of individuals. The research is further required to be of a high standard using sound methodology that will answer the posed research questions, in addition to being grounded in

literature and open to peer review (Department of Health, 2004:3). This research focused on analysing the concept, compassion fatigue, within the nursing profession and the knowledge acquired from this concept analysis and the conceptual framework can be applied to the nursing practice, so as to promote emotional well-being amongst nurse practitioners. The planning, implementation and reporting of this research was grounded in literature and conducted in the highest standard possible, with every step of the research process being documented in detail so that peer review of the entire process is possible.

Scientific honesty of the study was ensured through competently, accurately and honestly conducting research and reporting research findings. The North-West University's Manual for Postgraduate Studies (2007) was used as a guiding framework to ensure the credibility, relevance and integrity of this research with specific reference to the procedures and composition of a dissertation, the code of conduct regarding plagiarism and guidelines to ethical research.

The investigator competence is determined by technical and research competence that is made available through provision of an appropriate clinical and research environment, as well as high-quality research mentoring (Department of Health, 2004:3). In this study, the research design was within the study leaders' area of expertise and the resources needed to conduct the study were available at the North-West University library and inter-library loans. The research study was approved by the Research Committee and Faculty Board of the Faculty of Health Sciences, at the North-West University.

2.8 CONCLUSION

In this chapter, the methodology of the study was described. The design and population were depicted, data collection and analysis were discussed, and methods to ensure rigour described, with a portrayal of the ethical considerations concluding the chapter.

CHAPTER THREE

CONCEPT ANALYSIS OF COMPASSION FATIGUE

3.1 INTRODUCTION

In this chapter a detailed concept analysis of compassion fatigue was performed, so that a connotative (theoretical) definition, empirical indicators and a denotative (operational) definition specific to the nursing profession could be identified, synthesized and described. The concept analysis process that was followed has been discussed comprehensively in Chapter 2 (see 2.5.2.1). However, the process is used to provide structure to this chapter.

3.2 CONCEPT ANALYSIS PROCESS

The concept analysis process was performed using the method of Walker and Avant (2005) which is based on the original method of Wilson (1987) and includes the selection of a concept, determination of the aims or purpose of analysis, identification of all the uses of a concept, determination of the defining characteristics of a concept, identification of a model case and additional cases, identification of antecedents and consequences (Walker & Avant, 2005:65).

3.2.1 Select a concept

The concept, compassion fatigue, was selected based on the fact that it was of interest to the researcher and fundamental to understanding the phenomenon, which has never been defined in the nursing profession before. Based on the problem statement, the importance of defining compassion fatigue was stressed, as this will allow identification and understanding of compassion fatigue amongst

nurse practitioners, and so combat and curtail the compassionless culture that seems to be evolving in the nursing practice (see 1.3).

3.2.2 Determine the aims or purpose of analysis

The aim of analysing the concept, compassion fatigue, was to determine the identifying characteristics (connotations) of the concept, so as to clarify its meaning and develop a connotative (theoretical) definition, identify and describe empirical indicators and synthesize a denotative (operational) definition (Walker & Avant, 2005:66-67).

3.2.3 Identify all the uses of the concept

Compassion fatigue is a relatively new term, appearing only in the latest dictionaries, resulting in the fact that definitions of the concept were few and very repetitive in nature. The researcher decided to combat this occurrence by splitting the word "compassion fatigue", into its two root words, namely "compassion" and "fatigue". The common uses of the words "compassion" (see 3.2.3.2.1) and "fatigue" (see 3.2.3.2.2) were then explored using dictionary definitions, thesauri, subject specific dictionary definitions and encyclopaedic descriptions. The common characteristics (connotations) in these definitions were then identified and listed.

The list of identified characteristics (connotations) of "compassion" and "fatigue" were merged (see table 3.3), ordered and reduced (see table 3.4), to identify the defining characteristics (connotations) and categories of compassion fatigue (see 3.2.4). These defining characteristics and categories were used to generate a connotative (theoretical) definition of compassion fatigue (see 3.2.5). A model case (see 3.2.6) and additional cases (see 3.2.7), namely a borderline (see 3.2.7.1) and contrary case (see 3.2.7.2), were constructed using nursing examples. These cases allowed identification and verification of the defining characteristics (connotations) of compassion fatigue, as well as insight into the

internal structure of compassion fatigue that allowed clarification of its meaning and context according the requirement of a philosophical inquiry.

The defining characteristics (connotations) and categories of compassion fatigue were then theoretically grounded through an integrative literature control (see 3.2.8) where uses of the term "compassion fatigue" were investigated in different literature sources. This was inclusive of the following human service professions:

- compassion fatigue in nurse practitioners
- compassion fatigue in physicians
- compassion fatigue in psychologists/counsellors
- compassion fatigue in police officials
- compassion fatigue in emergency care workers
- compassion fatigue in religious workers
- compassion fatigue in hospice caregivers
- compassion fatigue in social workers
- compassion fatigue in occupational therapists

} Human service professions

Finally, the defining characteristics (connotations) of compassion fatigue were ordered and refined to identify and describe the empirical indicators of compassion fatigue (see 3.3), from which a denotative (operational) definition was synthesized (see 3.3.1).

3.2.3.1 Realisation of the population

The study population consisted of dictionaries, thesauri, journals, books, theses, dissertations and the World Wide Web in which the word, compassion fatigue, emerged. In the next section, each division of the study population and the sampling criteria applied to it are discussed in more detail.

- **Dictionaries**

The dictionaries that were used included English language dictionaries, as well as nursing, medical and psychology subject specific dictionaries. The library catalogue was used to identify the above mentioned dictionaries and a list was printed, so that each dictionary could be manually traced. Each type of dictionary was sampled and where more than one edition was available, only the latest edition was included in the study. Dictionary.com was used as an internet dictionary reference source, which concurrently gave direct access to WordNet and Wikipedia Encyclopaedia internet sources that were included in the study. Table 3.1 provides a summary of the number of dictionaries used.

Table 3.1 Summary of the number of relevant dictionaries used

DICTIONARY	Original Number Retrieved	Latest editions	No definition available	Number used
English Dictionaries	**55**	**18**	**3**	**15**
Nursing Dictionaries	**6**	**5**	**2**	**3**
Medical Dictionaries	**23**	**11**	**5**	**6**
Psychology Dictionaries	**21**	**16**	**9**	**7**
Total number of dictionaries used				**31**

- **Thesauri**

The library had only one thesaurus listed in the library catalogue. This thesaurus was used in conjunction with the internet resource, Thesaurus.com.

- **Journals**

The journal databases used in this study include the South African Journal Database System, or SAePublications and the International Journal Database Systems, ScienceDirect and EBSCOHost. The EBSCOHost Research Databases that were used in this study included: Academic Search Premier, ATLA Religion Database with ATLASerials, CINAHL, ERIC, Health Source: Nursing/Academic Edition, MasterFilePremier, MEDLINE, Pre-CINAHL, PsycINFO, SocINDEX with Full Text, Humanities International Complete, Academic Search Complete and Education Research Complete.

These specific databases were selected based on the fact that they were freely available at the North-West University and covered a broad study field of human service profession research. A multistage search was used to select relevant studies. In the **first stage** of the search, each database was examined individually and limited to English, Afrikaans or German peer-reviewed articles, published anywhere within the timeframe of January 1992 (when the term compassion fatigue was first coined) to October 2007 (when data collection was performed), with the keywords: "compassion fatigue in AB Abstract or Author-Supplied Abstract, NOT disaster or combat or terroris* or media or journalism in the subject terms". Articles with the subject terms disaster, combat, terroris* (terrorist, terrorism), media and journalism were filtered out of the search, as the researcher only wanted to use those definitions or descriptions of compassion fatigue that had to do with caring for people in human service professions outside of crisis situations. The databases ATLA Religion Database with ATLASerials, ERIC and Education Research Complete were excluded at this point, as none of the articles within these databases complied with the first stage search criteria.

In the **second stage** of the search, studies that depicted duplicate reporting were identified and only the latest or most detailed copy was included in the review. Thereafter, the abstract of each study was scrutinized to determine the relevance

of the article to this study. Exclusion criteria that were used in this stage of the search included:

- Book reviews
- Commentaries
- Editorials
- Letters to the Editor
- Studies that focused on dealing with compassion fatigue in war situations
- Studies that focused on the lack of public response to tragedy and misfortune from the media's point of view
- Studies where compassion fatigue was considered a symptom of another disease/syndrome
- Studies that developed and tested programs for the prevention and management of compassion fatigue
- Studies that focused on compassion fatigue in veterinarians

Table 3.2 provides a summary of the number of relevant articles used.

Table 3.2 Summary of the number of relevant articles used

DATABASE	Number of studies retrieved with search strategy (1st STAGE OF SEARCH)	Number of studies relevant to the research (2nd STAGE OF SEARCH)	Number of studies unique to this database
SAEPublications	**2**	**1**	**1**
ScienceDirect	**11**	**6**	**6**
Health Source: Nursing/Academic Edition	**26**	**12**	**11**
CINAHL and Pre-CINAHL	**15**	**11**	**6**
MEDLINE	**38**	**27**	**13**
PsycINFO	**62**	**34**	**8**
SocINDEX with Full Text	**26**	**18**	**7**
Humanities International Complete	**8**	**1**	**0**
Education Research Complete	**13**	**12**	**0**
MasterFILE Premier	**12**	**8**	**0**
Academic Search Complete	**66**	**46**	**3**
Academic Search Premier	**64**	**45**	**0**
Total number of articles used			**55**

- **Books**

The South African Library Catalogue or SACat was used to search for books using the keyword, "compassion fatigue in SU or subject". Thirteen books were found in South Africa and of these identified books, six were relevant to the

research. One book, although on record on SACat was still in the process of being ordered and was thus unavailable to interlibrary loans, therefore a total of five books were included in this study.

- **Theses and Dissertations**

The Nexus Database System was used to search for theses and dissertations in South Africa, while the Electronic Thesis and Dissertation (ETD) search strategy on Google Scholar was used to search for theses and dissertations nationally and internationally with the keyword "compassion fatigue". A total of seven South African studies were found on the Nexus Database System, of which six were completed research studies. One of these studies was unavailable through interlibrary loans, so a total of five South African studies were included in this study. A further thirty-one national and international studies were found on ETD, of which fifteen were relevant to this study. However, five were duplicates of the South African studies in the Nexus database and one had already been included as an article, thus only nine studies from the ETD were included in this study.

3.2.3.2 Analysis of the data

The words "compassion" and "fatigue" were sought in each of the dictionaries, thesauri and encyclopaedia, and the definitions written down, so that characteristics (connotations) of each word could be identified and listed. The selected sample of journals, books, theses and dissertations, however, were analysed through the identification of the definition, and antecedents and consequences of compassion fatigue, so that the information gleaned from these sources, could be used as an integrative literature control to theoretically ground the findings of the concept analysis.

3.2.3.2.1 Compassion

In this section, the English dictionary definitions, psychology subject definitions, synonyms and antonyms, and encyclopaedic descriptions of compassion were

documented, so that the characteristics (connotations) most commonly associated with this concept could be identified and listed. Nursing and medical subject dictionaries were not included in this part of the study, as they contained no entries for the word, compassion.

The word compassion originates from Middle English via Old French from Ecclesiastical or Late Latin (A.D. 180-600) *compassiō* from the word *compatī* which means to suffer with another or to feel pity (Concise Oxford Dictionary, 1999:290; Partridge, 1990:475).

a) Dictionary definitions

- "Approving a strong feeling of sympathy and sadness for the suffering or bad luck of others and a desire to help them" (Cambridge International Dictionary of English, 1995:273).
- "Fellow-feeling, or sorrow for the sufferings of another, pity" (Chambers 20th Century Dictionary, 1983:256).
- "Sympathetic pity and concern for the sufferings or misfortunes of others" (Concise Oxford Dictionary, 1999:290).
- "A feeling of deep sympathy and sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering" (Dictionary.com, 2007a).
- "A suffering with another, sympathy with distress or misfortunes of another" (English Encyclopedic Dictionary, 1958:164).
- "Pity for suffering, with desire to help or spare; commiseration, sympathy, mercy" (Funk & Wagnalls Standard Dictionary: International Edition, 1967a:266)
- "Sorrow or pity, with desire to help or to spare, excited by the suffering or distress of another or others, sympathy with pain or sorrow that prompts one to relieve, commiseration" (Funk & Wagnalls Standard Dictionary of the English Language, 1964:541).

- "A sympathetic emotion excited by the misfortunes of another, pitying, sorrow or mercy" (New Century Dictionary, 1956a:128).
- "A feeling of pity that makes one want to help or show mercy" (Oxford American Dictionary, 1980:271).
- "1. Suffering together with another, participation in suffering, fellow-feeling, sympathy. 2. The feeling or emotion, when a person is moved by the suffering or distress of another, and by the desire to relieve it, pity that inclines one to spare or succour" (Oxford English Dictionary, 1978a:714).
- "Sympathetic pity and concern for the suffering or misfortunes of others" (Oxford Dictionary of English, 2005:352).
- "A feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause, commiseration, mercy, tenderness, heart, clemency" (The Random House Dictionary of the English Language, 1967:299).
- "Pity inclining one to spare or succour" (Reader's Digest Great Encyclopedic Dictionary, 1978a:191).
- "Fellow-feeling, sympathy, pity with desire to help, relieve or spare" (Universal Dictionary of the English Language, 1936:215).
- "Suffering with another, hence sympathy, a sensation of sorrow excited by the distress or misfortunes of another, pity, commiseration, fellow-feeling, kindness, tenderness, clemency" (Webster's Universal Unabridged Dictionary and Atlas of the World, 1976a:348).
- "Deep feeling for and understanding of misery or suffering and the concomitant desire to promote its alleviation, spiritual consciousness of the personal tragedy of another or others and selfless tenderness directed towards it" (Webster's Third New International Dictionary of the English Language Unabridged, 1976:462).

- "1. A deep awareness of and sympathy for another's suffering. 2. The humane quality of understanding the suffering of others and wanting to do something about it" (WordNet, 2007a).

b) Thesauri

- Sympathy, feeling, fellow-feeling, empathy, understanding, care, concern, solicitude, solicitousness, sensitivity, tender-heartedness, soft-heartedness, warm-heartedness, warmth, love, brotherly love, tenderness, gentleness, mercy, mercifulness, leniency, lenience, tolerance, consideration, kindness, humanity, humaneness, kind-heartedness, charity, benevolence.

  Antonyms: indifference, heartlessness (New Oxford Thesaurus of English, 2000:168).
- Benevolence, charity, clemency, commiseration, compunction, condolence, consideration, empathy, grace, heart, humaneness, humanity, kindness, lenity, mercy, soft-heartedness, softness, sorrow, sympathy, tender heartedness, tenderness, yearning.

  Antonyms: disregard, indifference, unconcern (Thesaurus.com, 2007a).

c) Subject dictionaries

- **Psychology dictionaries**
  - "Literally, a suffering with another; a strong fellowship in feeling" (English & English, 1958:101)
  - "Pity. In current psychiatric circles compassion is good, pity is bad, but the main difference between the two terms appears to lie in the number of letters. Perhaps compassion conveys the idea of wishing to help more than pity does" (Sutherland, 1995:88).

d) Encyclopaedia

- "Compassion is an emotion that is a sense of shared suffering, most often combined with a desire to alleviate or reduce the suffering of another; to show special kindness to those who suffer. Compassion essentially arises through empathy, and is often characterized through actions, wherein a person acting with compassion will seek to aid those they feel compassionate for.

  Compassionate acts are generally considered those which take into account the suffering of others and attempt to alleviate that suffering as if it were one's own.

  Compassion differs from other forms of helpful or humane behaviour in that its focus is primarily on the alleviation of suffering. Acts of kindness which seek primarily to confer benefit rather than relieve existing suffering are better classified as acts of altruism, although, in this sense, compassion itself can be seen as a subset of altruism, it being defined as the type of behaviour which seeks to benefit others by reducing their suffering" (Wikipedia, 2007a).

e) Characteristics of compassion

The characteristics (connotations) most commonly associated with compassion were identified in the above literature sources as follows:

- Desire to help
- Sympathy
- Spare
- Relieve
- Aid
- Alleviate
- Reduce
- Succour
- Remove
- Fellow-feeling

- Sorrow
- Pity
- Suffering with another
- Spiritual consciousness
- Spiritual awareness
- Emotional response to the suffering/bad luck/misfortune/distress/pain/sorrow/tragedy of another
- Mercy
- Care
- Solicitude
- Sensitivity
- Warmth
- Love
- Gentleness
- Lenience
- Tolerance
- Consideration
- Charity
- Benevolence
- Compunction
- Condolence
- Grace
- Softness
- Yearning
- Commiseration
- Concern
- Tenderness
- Clemency
- Understanding
- Kindness
- Humaneness
- Deep feeling
- Deep awareness
- Empathy

3.2.3.2.2 Fatigue

In this section, the English dictionary definitions, subject dictionaries, synonyms and antonyms, and encyclopaedic descriptions of fatigue were documented, so

that the characteristics (connotations) most commonly associated with this concept could be identified and listed.

The word fatigue originated from the Late Latin (A.D. 180-600) word *fatigāre,* with the root *fati-* probably derived from the Latin word *fatis,* which refers to a crevice, a crevasse. The word then became the Medieval French *fatiguer,* with the derivative noun, *fatigue,* later being used in Middle French and being adopted by English (Partridge, 1990:203).

a) Dictionary definitions

- "Extreme tiredness, or (specialized) weakness in something as a metal part or structure, often caused by repeated bending" (Cambridge International Dictionary of English, 1995:507).
- "1. Weariness from labour of body or of mind: toil: lessened power of response to stimulus, resulting from activity: failure under repeated stress as in metal: fatigue-duty (sometimes allotted as punishment). 2. *(Verb):* to exhaust the strength or power of recovery of" (Chambers 20th Century Dictionary, 1983:459).
- "1. Extreme tiredness, especially resulting from mental or physical exertion or illness. 2. Weakness in metal or other materials caused by repeated variations of stress; 3. Menial non-military tasks performed by a soldier" (Concise Oxford Dictionary, 1999:517).
- "1. Weariness from bodily or mental exertion. 2. A cause of weariness; slow ordeal; exertion. 3. *Physiology:* temporary diminution of the irritability or functioning of organs, tissues, or cells after excessive exertion or stimulation. 4. *Civil engineering:* the weakening or breakdown of material subjected to stress, esp. a repeated series of stresses" (Dictionary.com, 2007b).
- "1. Weariness from bodily labour or mental exertion, cause of weariness, toil, the labours of military men, distinct from the use of arms. 2. *(Verb):* to weary with labour or any bodily or mental exertion,

to exhaust the strength or endurance of, to tire" (English Encyclopedic Dictionary, 1958:316).

- "1. *Physiological:* exhaustion of strength by toil, weariness, wearing toil, a condition of lessened activity of an organism or any of its parts, resulting from prolonged exertion. 2. A diminished susceptibility to stimulation of the Central Nervous System, affecting primarily the junction between nerve and muscle fibres. 3. *Metals:* the failure of metals under prolonged or repeated stress, characterized by local deformation of structure. 4. Fatigue duty" (Funk & Wagnalls Standard Dictionary: International Edition, 1967b:461).
- "1. Exhaustion of strength caused by physical toil, languor resulting from continued muscular or mental strain or exertion, weariness, lassitude. 2. Wearing toil or continued exertion. 3. *Physiological:* a condition of organs or cells caused by excessive exertion. It is characterized by the formation of poisonous decomposition products, which are eventually removed by the blood, and by the reduction of the energy brought by the blood in the form of nutriment. 4. *Psycho-physiological:* a condition of diminished ability, or actual inability, to perform a given act, irrespective of the feeling of being fatigued. Thus an isolated frog's muscle is said to be fatigued when its reaction is diminished by prolonged stimulation. 5. Wearing toil or continued exertion, especially of soldiers in the field. 6. *Military:* fatigue-duty, as distinct from the use of arms. 7. *Mechanical:* a weakening resulting from long continued or frequently repeated stress, particularly continued reversals of stress: applied to structural members, as bridge beams and car axles" (Funk & Wagnalls Standard Dictionary of the English Language, 1964:901).
- "1. To weary with bodily or mental exertion, exhaust the strength of, tire, a cause of weariness, labour, exertion. 2. *Military:* fatigue duty. 3. *Mechanics:* the weakening of metal subjected to stress especially a continued series of stresses" (New Century Dictionary, 1956b:235).

- "1. Tiredness resulting from hard work or exercise. 2. Weakness in metals etc. caused by repeated stress. 3. Any of the non-military duties of soldiers, such as cleaning and dishwashing" (Oxford American Dictionary; 1980:473).
- "1. Lassitude or weariness resulting from either bodily or mental exertion. 2. That which causes weariness, fatiguing labour, 'trouble', a fatiguing duty or performance, labour, toil. 3. The extra-professional duties of a soldier, sometimes allotted to him as punishment for misdemeanour. 4. To tire, weary, to harass with toil, to exhaust with labour. 5. To weaken by straining, to strain by overpressure. 6. The condition of weakness in metals caused by repeated blows or long continued strain' (Oxford English Dictionary, 1978b:100).
- "1. Extreme tiredness resulting from mental or physical exertion or illness. 2. A reduction in the efficiency of a muscle or organ after prolonged activity. 3. A lessening in one's response to or enthusiasm for something caused by overexposure. 4. Weakness in metal or other materials caused by repeated variations of stress. 5. Menial non-military tasks performed by a soldier, sometimes as punishment" (Oxford Dictionary of English; 2005:629).
- "1. Weariness from bodily or mental exertion, a cause of weariness, labour, exertion, exhaust the strength of. 2. *Physiological:* temporary diminution of the irritability or functioning of organs, tissues after excessive exertion or stimulation. 3. *Mechanical:* the weakening or breakdown of material subjected to stress especially a repeated series of stresses. 5. *Military:* labour of a generally non-military kind done by soldiers, such as cleaning up an area, digging drainage ditches, or raking up leaves; the state of being engaged in such labour" (Random House Dictionary of the English Language, 1967:518).
- "1. Weariness after exertion. 2. Weakness in metals caused by cyclic variations in stress. 3. Task etc. that wearies; soldiers non-military duty, sometimes allotted as punishment; party to which such a duty is

assigned. 4. *(Verb):* cause fatigue to, exhaust" (Reader's Digest Great Encyclopedic Dictionary, 1978b:320).

- "1. Weariness, exhaustion of body or mind. 2. *Mechanical:* weakness in metal caused by long-continued strain. 3. That which causes fatigue, wearisome toil, tiring occupation, exertion. 4. *Military:* non-military work performed by soldiers. 5. *(Verb):* to tire out, cause exhaustion, to weary by bodily or mental work or strain" (Universal Dictionary of the English Language, 1936:407).
- "1. Weariness from bodily labour or mental exertion, lassitude or exhaustion of strength. 2. The cause of weariness, labour, toil; as the fatigues of war. 3. The labours of military men, distinct from the use of arms; fatigue duty, as a party of men on fatigue. 4. In mechanics the weakening of materials by repeated or continued vibrations and strain. 5. Lassitude, weariness, exhaustion, languor, enervation. 6. *(Verb):* to tire, to weary with labour or any bodily or mental exertion, to harass with toil, to exhaust the strength of by severe or long continued exertion" (Webster's Universal Unabridged Dictionary and Atlas of the World, 1976b:639).
- "1. Weariness from labour or exertion, exhaustion of strength, tiredness or physical or nervous exhaustion from causes other than physical or intellectual exertion (as from anoxia, motion sickness or emotional tension). 2. Loss of power resulting from continued work but removable by rest. 3. Exhaustion in productive power (as of soil). 4. The transitory refractory state induced in a sensory receptor or motor end organ by continued or repeated stimulation. 5. A tiring duty, labour, toil, manual or menial work often assigned as a punishment: such work performed in the course of service by a member of one of the military services other than the navy. 6. The tendency of a material to break under repeated cyclic loading at a stress considerably less than the tensile strength in a static test. 7. The decrease of efficiency (as of a luminescent or light-sensitive material) with use" (Webster's

Third New International Dictionary of the English Language Unabridged, 1976:828).

- "1. Temporary loss of strength and energy resulting from hard physical or mental work. 2. Used of materials, especially metals, in a weakened state caused by long stress. 3. Boredom resulting from overexposure to something. 4. Labour of a non-military kind done by soldiers, cleaning or digging or draining or so on" (WordNet, 2007b).

b) Thesauri

- *(Noun):* tiredness, weariness, exhaustion, overtiredness, drowsiness, somnolence, lethargy, sluggishness, lassitude, debility, enervation, listlessness, prostration, lack of energy, lack of vitality.

  Antonyms: energy, vigour

  (Verb): Tire, tire out, exhaust, wear out, drain, make weary, weary, wash out, tax, overtax, overtire, jade, make sleepy, prostrate, enervate, knock out, take it out of, do in, fag out, whack, poop, shatter, bush, frazzle, wear to a frazzle.

  Antonyms: invigorate, refresh (New Oxford Thesaurus of English; 2000:645).

- *(Noun):* brain fag, burnout, debility, dullness, enervation, ennui, exhaustion, faintness, fatigation, feebleness, heaviness, languor, lassitude, lethargy, listlessness, overtiredness, weakness, weariness

  Antonyms: energy, liveliness, strength, vigour, vitality.

  (Verb): Bedraggle, burn out, bush, conk out, debilitate, deplete, disable, drain, droop, drop, enervate, exhaust, fag, fizzle, flag, jade, knock out, languish, overtire, peter out, poop, poop out, prostrate, sag, sink, succumb, take, tucker, weaken, wear, wear down, wear out, weary, whack.

  Antonyms: energize, invigorate, refresh, rejuvenate, renew, restore (Thesaurus.com, 2007b)

c) Subject dictionaries

- **Nursing dictionaries**
  - "The feeling of weariness and of reduced capacity for mental or physical work, usually resulting from prolonged or excessive labour or exertion. In physiological experiments on muscle the term is used to denote diminishing reaction to stimuli" (Blackwells Dictionary of Nursing, 1997:261).
  - "1. A state of exhaustion or a loss of strength or endurance, such as may follow strenuous physical activity. 2. Loss of ability of tissues to respond to stimuli that normally evoke muscular contraction or other activity. Muscle cells generally require a refractory or recovery period after activity, when cells restore their energy supplies and excrete metabolic waste products. 3. An emotional state associated with extreme or extended exposure to psychic pressure, as in battle or combat fatigue. 4. A nursing diagnosis accepted by the 8th National Conference on the Classification of Nursing Diagnoses. It is defined as an overwhelming sense of exhaustion and decreased capacity for physical and mental work regardless of adequate sleep.
    - Defining Characteristics: The major defining characteristics are verbalization of fatigue or loss of energy and inability to maintain usual routines. Minor characteristics include a perceived need for additional energy to accomplish routine tasks, an increase in physical complaints, impaired ability to concentrate, decreased performance and decreased libido. The individual with fatigue can also be emotionally labile or irritable, lethargic or listless; have disinterest in surroundings or introspection; and be accident-prone.
    - Related factors: related factors include overwhelming psychologic or emotional demands, increased energy requirements to perform activities of daily living, excessive

social or role demands, states of discomfort, decreased metabolic energy production and altered body chemical characteristics such as from medications or drug withdrawal" (Mosby's Medical, Nursing and Allied Health Dictionary, 1998:618).

- "1. Mental or physical tiredness, following prolonged or intense activity. Muscle fatigue may be due to the waste products of metabolism accumulating in the muscles faster than they can be removed by the venous blood. 2. The inability of an organism, an organ or a tissue to give normal response to stimulus until a certain recovery period has elapsed" (Oxford Dictionary of Nursing, 2004:173).

- **Medical dictionaries**
  - "1. That state, following a period of mental or bodily activity, characterized by a lessened capacity for work and reduced efficiency of accomplishment, usually accompanied by a feeling of weariness, sleepiness, or irritability; may also supervene when, from any cause, energy expenditure outstrips restorative processes and may be confined to a single organ. 2. Sensation of boredom and lassitude due to absence of stimulation, monotony, or lack of interest in one's surroundings" (Dirckx, 1997:318).
  - "1. Weariness, usually from overexertion. 2. Decreased excitability of a nerve from repeated stimulation. 3. Toxic material due to tissue degeneration after excessive exercise" (Dorland, 1923:415).
  - "1. A state of increased discomfort and decreased efficiency resulting from prolonged or excessive exertion; loss of power, or capacity to respond to stimulation. 2. The gradual fracturing of a material due to repetitive or cyclic stress" (Dorland, 2003:679).
  - "1. A feeling of exhaustion with decreased efficiency resulting from physical or mental exertion. 2. Battle fatigue – severe anxiety state

seen in front-line soldiers, characterized by loss of effectiveness, poor judgment, physical complaints, and/or feeling of imminent death. 3. Flying fatigue – chronic functional disorder occurring to aviators after prolonged piloting of an aircraft, also called aeroanthenia" (Melloni, 1979:160).

- "1. Mental of physical tiredness, following prolonged or intense activity. Muscle fatigue may be due to the waste products of metabolism accumulating in the muscles faster than they can be removed by the venous blood. Incorrect or inadequate food intake or disease may predispose a person to fatigue. 2. The inability of an organism, or organ, or a tissue to give a normal response to a stimulus until a certain recovery period has elapsed" (Oxford Reference Concise Medical Dictionary, 1990:254).
- "1. A feeling of tiredness or weariness resulting from continued activity. 2. The state or condition or an organ or tissue in which its response to stimulation is reduced or lost as a result of over-activity. 3. To bring about the condition of fatigue; fatigue may be the result of: (a) excessive activity which results in the accumulation of metabolic waste products such as lactic acid, (b) malnutrition (deficiency of carbohydrates, proteins, minerals or vitamins), (c) circulatory disturbances such as heart disease, or anaemia which interfere with the supply of oxygen and energy materials to tissues, (d) respiratory disturbances which interferes with the supply of oxygen to tissues, (e) infectious diseases in which toxic products are produced or body metabolism altered, (f) endocrine disturbances such as occur in diabetes, hyperinsulinism, and menopause, (g) psychogenic factors such as emotional conflicts, frustration, worry, boredom, (h) physical factors such as incorrect posture, flat feet, (i) miscellaneous factors, such as eye strain" (Taber, 1960:F-7).

- **Psychology dictionaries**
  - "1. *Mental:* A qualitative state following upon continued mental activity. Fatigue varies with different functions, and with the degree of mental concentration. A distinction is made between fatigue and weariness. In experimentation, it is directly dependent upon the number of observations taken in a single series, and is indication by a steady decrease in the delicacy of perception and readiness of judgment. It is characterized by (a) a weakening of attention, (b) a diminished capacity for reproduction, and (c) prominence in consciousness of certain organic sensations. 2. *Physical:* Nervous - those changes observed in the nerve cell due to excessive functioning. Experiments have shown that excessive or long-continued activity in nerve cells produces changes in their size and histological appearance. The activity of a nerve cell is at first accompanied by turgescence of the protoplasm, but prolonged activity causes diminution of the size and changes the histologous changes. The nucleus suffers analogous changes. The nucleolus at first increases and then diminishes in size. An excitation continued for six hours produced in one case a shrinkage in ganglion cells" (Baldwin, 1960:374-375).
  - "Diminished productivity, efficiency, or ability to carry on work, because of previous expenditure of energy in doing work; on the subjective side the complex of sensations and feelings, and the increased difficulty of carrying on, experienced after a prolonged spell of work; must be distinguished from boredom, which may be described as a subjective feeling of fatigue, due to monotony or lack of interest, rather than the expenditure of energy. Fatigue may be mental, muscular, sensory or nervous" (Drever, 1964: 97).
  - "1. Diminished ability to do work, either physical or mental, as a consequence of previous and recent work. 2. Impairment of function of sense organ, nerve or muscle due to continued recent

stimulation and activity. 3. Weariness, a specific body feeling. 4. The desire to quit performing a function after prolonged application to it. The four meanings are often confounded" (English & English, 1958:203).

- "The reduction of output, loss of efficiency, and/or development of boredom. Mosso (1890) developed the ergograph for obtaining objective record of fatigue in a voluntary activity (weight lifting), and many theories have been advanced to account for the results of continued activity. Mental fatigue is an elusive topic, and it defies lucid definition. The refractory period a neuron is said to bear a superficial resemblance to whatever the term fatigue connotes" (Harriman, 1947:136).
- "1. The diminution in ability to do work that results from previously carried out efforts. 2. The internal state or condition that results from extended effort and underlies this diminished capacity to perform, a feeling of weariness or tiredness. These meanings are very general; a number of more specific senses are often intended and are usually marked by a qualifier that identifies the source of or the basis for the fatigue. Thus, *sensory fatigue* refers to the reduced responsiveness of a sense organ following prolonged exposure to stimulation; *neuronal or neural fatigue* is a heightened threshold of nerve fibres that occurs as a consequence of previous neural activity; *muscle fatigue* refers to the reduced capacity of muscle tissue to contract owing to a build-up of metabolic waste products like lactic acid; *emotional fatigue* is the general debilitated state resulting from excessive conflicts, frustrations, anxieties etc.; *mental fatigue* refers to a cognitive weariness stemming from either extended mental concentration or boredom; and so forth. Note that these specialized uses are employed to identify the source of the fatigue, some by specifying external condition that produced it (e.g. *emotional, mental*) and some by specifying the underlying

neurological and/or physiological effects that are responsible for it (e.g. *neural, muscle*). Note, some authors will take a behaviouristic stance here and treat fatigue purely in terms of performance decrements, other will take a sharp physiological line and view it in terms of biological dysfunction; still others will treat it more phenomenologically as an experienced internal state; most, alas, will confound all of the meanings" (Reber, 2001:282).

- "The reduction (which can last several seconds) in the tendency of a nerve cell to fire that follows a period of continuous firing" (Sutherland, 1995:166).
- "1. Decreased ability of performance on the part of an organism, or of some member or muscle, resulting from prolonged work. 2. A specific feeling or sensation experienced after prolonged work. Is classified as (a) mental, resulting from prolonged fixation of attention or work upon a problem, etc.; (b) muscular, resulting from prolonged exercise of some group of the skeletal muscles; (c) sensory or (d) reflex" (Warren, 1934:103).

d) Encyclopaedia

Wikipedia displayed two different entries for the word fatigue, namely medical fatigue and metal fatigue. The researcher decided to include both of these entries in the concept analysis, as these definitions of fatigue had been cited throughout the literature examined and contained unique, relevant characteristics of fatigue.

- **Fatigue (medical)**

"The word *fatigue* is used in everyday living to describe a range of afflictions, varying from a general state of lethargy to a specific work-induced burning sensation within one's muscles. Physiologically, "fatigue" describes the inability to continue functioning at the level of one's normal abilities due to an

increased perception of effort. Fatigue is ubiquitous in everyday life, but usually becomes particularly noticeable during heavy exercise.

Fatigue can be dangerous when performing tasks that require constant concentration, such as driving a vehicle. When a person is sufficiently fatigued, he or she may experience micro sleeps (loss of concentration). However, objective cognitive testing should be done to differentiate the neurocognitive deficits of brain disease from those attributable to tiredness" (Wikipedia, 2007b).

- **Fatigue (metal)**

Metal fatigue was included in the concept analysis process as it confirmed and further enriched the characteristics (connotations) of fatigue that had been identified in the previously cited literature sources.

"In materials science, **fatigue** is the progressive and localised structural damage that occurs when a material is subjected to cyclic or fluctuating strains at nominal stresses that cause structural failure. The maximum values are often significantly less than the ultimate tensile stress, and may be below the yield stress of the material. Characteristics of metal failure include: (i) the process starts with a microscopic crack, called the initiation site, which then widens with each subsequent movement, a phenomenon analysed in the topic of fracture mechanics; (ii) failure is essentially probabilistic. The number of cycles required for failure varies between homogeneous material samples. Analysis demands the techniques of survival analysis; (iii) the greater the applied stress, the shorter the life; (iv) fatigue life scatter tends to increase as stress decreases; (v) damage is cumulative, materials do not recover when rested; (vi) fatigue life is influenced by a variety of factors, such as temperature and surface finish, in complicated ways; (vii) some materials (e.g., some steel and titanium alloys) exhibit an endurance limit or fatigue limit, a limit below which repeated stress does not induce failure, theoretically,

for an infinite number of cycles of load. Generally speaking, a steel or titanium component being cycled at stresses below their endurance limit will fail from some other mode before it fails from fatigue. Most other non-ferrous metals (e.g., aluminium, copper and some titanium alloys) exhibit no such limit and even small stresses will eventually cause failure; (viii) in recent years, researchers have determined that many materials fail below their endurance limits due to internal defects. This area of investigation is termed very high or ultra high cycle fatigue; (ix) as a means to gauge fatigue characteristics of non-ferrous and other alloys that do not exhibit an endurance limit, a fatigue strength is frequently determined, and this is typically the stress level at which a component will survive 10^8 loading cycles; (x) composite materials can also suffer fatigue, especially in components which have been under-designed for the loads they have to resist. The appearance of fatigue cracks is however, quite different to those shown by metals, multiple delamination tending to occur within the parts. Discovery of such defects is thus difficult using non-destructive testing and (xi) plastics and rubbers behave like metals, usually with a small number of distinct brittle cracks at surface stress raisers" (Wikipedia, 2007b).

e) Characteristics of Fatigue

The characteristics (connotations) most commonly associated with fatigue were identified in the above literature sources as follows:

- Tiredness
- Weakness
- Failure
- Breakdown
- Tendency to break
- Weariness
- Lessened reaction
- Lessened response
- Diminished susceptibility
- Diminished functioning
- Decreased excitability

- Diminution of irritability to stimulation
- Caused by excessive/ long/ prolonged/ continuous/ cumulative/ intense/ repeated stimulation/ activity/ bending/ blows/ stress/ strain/ overpressure/ exertion/ exposure
- Exertion
- Exhaust
- Loss of strength
- Loss of endurance
- Loss of power of recovery of the body
- Loss of power of recovery of the mind
- Productive power
- Causes deformation/change
- Languor
- Lassitude
- Reduction of energy
- Diminished capacity
- Decreased ability
- Diminished performance
- Reduced productivity
- Decreased libido
- Decreased accomplishment
- Reduced efficiency
- Decreased output
- Lessened enthusiasm
- Boredom due to overexposure
- Enervation
- Loss of power removable by rest
- Temporary
- Impaired ability to concentrate
- Weakening attention
- Increased physical complaints
- Lethargic
- Sleepy
- Drowsiness
- Somnolent
- Sluggish
- Debility
- Prostration
- Dullness

- Burnout
- Ennui
- Feebleness
- Faintness
- Depletion
- Bedraggle
- Disable
- Drain
- Lack of vitality
- Listless
- Irritable
- Disinterest in surroundings
- Disinterest in introspection
- Accident prone
- Energy expenditure outstrips restorative process
- Difficulty carrying on
- Desire to quit performing
- Sense of overwhelming psychological and emotional demands
- Discomfort
- Poor judgment
- Decrease in delicacy of perception
- Emotionally labile
- Progressive
- Greater the stress the less the endurance limit
- Cumulative
- Does not recover when rested
- Influenced by a variety of factors

3.2.4 Determine the defining characteristics

The characteristics (connotations) of compassion and fatigue that had been identified in the literature were then merged in a single list, in no specific order (Table 3.3). This allowed all the identified characteristics (connotations) of compassion and fatigue to appear in one table, which simplified and expedited the ordering and reduction of the characteristics (connotations). Table 3.3 shows the list of characteristics of compassion and fatigue.

Table 3.3 List of characteristics of compassion and fatigue

COMPASSION	FATIGUE
• Desire to help • Sympathy • Spare • Relieve • Aid • Alleviate • Reduce • Succour • Remove • Fellow-feeling • Sorrow • Pity • Suffering with another • Spiritual consciousness • Spiritual awareness • Emotional response to the suffering/bad luck/misfortune/distress/pain/sorrow/tragedy of another • Mercy • Care • Solicitude • Sensitivity • Warmth • Love • Gentleness • Lenience • Tolerance • Consideration • Charity • Benevolence • Compunction • Condolence • Grace • Softness • Yearning • Commiseration • Concern • Tenderness • Clemency • Understanding • Kindness • Humaneness • Deep feeling	• Tiredness • Weakness • Failure • Breakdown • Increased tendency to break • Weariness • Lessened reaction • Lessened response • Diminished susceptibility • Diminished functioning • Decreased excitability • Caused by excessive/ long/ prolonged/ continuous/ cumulative/ intense/ repeated stimulation/ activity/ bending/ blows/ stress/ strain/ overpressure/ exertion/ exposure • Exertion • Loss of strength • Loss of endurance • Loss of power of recovery of the body • Loss of power of recovery of the mind • Loss of productive power • Causes deformation/change • Languor • Lassitude • Reduction of energy • Diminished capacity • Decreased ability • Diminished performance • Reduced productivity • Decreased libido • Decreased accomplishment • Reduced efficiency • Decreased output • Lessened enthusiasm • Boredom • Enervation • Removable by rest • Temporary • Impaired ability to concentrate • Weakening attention

• Deep awareness • Empathy	• Increased physical complaints • Lethargic • Sleepy • Drowsiness • Somnolent • Sluggish • Debility • Prostration • Dullness • Burnout • Ennui • Feebleness • Faintness • Depletion • Bedraggle • Disable • Drain • Lack of vitality • Listless • Irritable • Disinterest in surroundings • Disinterest in introspection • Accident prone • Energy expenditure outstrips restorative process • Difficulty carrying on • Desire to quit • Sense of overwhelming psychological and emotional demands • Poor judgment • Decrease in delicacy of perception • Emotionally labile • Progressive • Greater the stress the less the endurance limit • Cumulative • Does not recover when rested

The characteristics of compassion were stated positively, or as an example of how nurse practitioners should react to their patients, however, to synthesize a true definition of compassion fatigue, the characteristics of compassion had to be restated negatively or as an inability to show compassion (see Table 3.4).

Once the characteristics of compassion had been restated negatively, the researcher compiled a single list of characteristics. These characteristics were then ordered through the process of content analysis into three units of meaning, namely antecedents, process and consequences. In each of these respective units of meaning, characteristics were further reduced by sorting similar characteristics into one group with the aid of dictionaries. The group was then reduced to a single characteristic that most accurately depicted all the characteristics in the group.

When reducing the antecedents two different categories emerged namely the type of exposure or risk factors, and the period of exposure or causes. The characteristics within each of these categories were then further reduced. The reduction of the process presented the researcher with three different and almost opposite characteristics, which necessitated dividing the characteristics into three processes, namely compassion discomfort which is temporary, compassion stress which decreases the endurance limit of the practitioner and compassion fatigue which does not recover, with the characteristics progressive and cumulative describing the process as a whole. Finally the consequences of compassion fatigue were divided into the five dimensions of man, namely physical, social, emotional, spiritual and emotional effects. The entire ordering and reduction process was examined by the study leader, who verified and confirmed the results.

Table 3.4 shows the ordering and reduction of the characteristics (connotations) of compassion and fatigue.

Table 3.4 Reduction and ordering of the characteristics (connotations) of compassion and fatigue

UNITS OF MEANING	CHARACTERISTICS	FIRST REDUCTION	SECOND REDUCTION	CATEGORIES
ANTECEDENTS	• Exposure • Overexposure • Stimulation • Activity • Bending • Blows • Exertion • Stress • Strain • Overpressure	• **Contact** • **Use of self** • **Stress**		Risk Factors
	• Long • Prolonged • Excessive • Continuous • Repeated • Intense	• **Prolonged** • **Continuous** • **Intense**		Causes

PROCESS	• Progressive • Cumulative • Causes deformation/change • Removable by rest • **Temporary** • **Greater the stress the less the endurance limit** • **Energy expenditure outstrips restorative process** • **Does not recover when rested** • **Loss of power of recovery of the body** • **Loss of power of recovery of the mind**	• **Progressive** • **Cumulative** • **Compassion discomfort** • **Compassion stress** • **Compassion fatigue**		Process
CONSEQUENCES	• Tiredness • Sleepy • Weariness • Drowsiness • Somnolent • Weakness • Enervation • Loss of strength • Failure • Debility • Feebleness • Faintness	• Weariness • Loss of strength	**Physical effects**	Manifestations

	• Listless • Reduction of energy • Exhaust • Sluggish • Prostration • Dullness • Depletion • Drain • Lack of vitality • Reduced productivity • Reduced efficiency • Decreased output • Loss of productive power • Disable • Diminished functioning • Diminished performance • Decreased accomplishment • Loss of endurance • Burnout • Decreased libido • Increased physical complaints • Accident prone	• Without energy • Reduced output • Diminished performance • Loss of endurance • Burnout • Increased physical complaints • Accident prone		
	• Inability to show deep feeling • Inability to show deep awareness • Inability to emotionally respond to the suffering/ bad luck/ misfortune/ distress/ pain/ sorrow/ tragedy of another	• Unresponsiveness	**Social effects**	

	• Lack of kindness • Lack of humaneness • Lack of tenderness • Lack of gentleness • Lack of love • Lack of consideration • Lack of tolerance • Lack of mercy • Lack of sensitivity • Lack of warmth • Lack of softness • Lack of charity • Lack of benevolence • Lack of grace • Lack of lenience	• Callousness		
	• Lack of concern • Lack of understanding • Lack of care • Lack of solicitude	• Indifference		
	• Lack of empathy • Inability to commiserate • Lack of fellow-feeling • Lack of sorrow • Lack of pity • Lack of sympathy • Inability to suffer with another • Lack of condolence	• Inability to share in suffering		
	• Inability to help • Inability to spare • Inability to relieve • Inability to aid	• Inability to alleviate		

	• Inability to alleviate • Inability to reduce • Inability to succour • Inability to remove • Inability to show clemency			
	• Decreased excitability • Lessened enthusiasm • Compunction • Increased tendency to break • Breakdown • Lessened reaction • Lessened response • Diminished susceptibility • Lack of yearning • Disinterest in surroundings • Lethargic • Languor • Lassitude • Irritable • Diminished capacity • Decreased ability • Difficulty carrying on • Desire to quit • Sense of overwhelming psychological and emotional demands • Emotionally labile	• Lessened enthusiasm • Breakdown • Desensitized • Apathetic • Irritable • Diminished ability • Desire to quit • Emotionally overwhelmed	**Emotional effects**	

	• Lack of spiritual awareness • Lack of spiritual consciousness • Disinterest in introspection • Poor judgment • Decrease in delicacy of perception	• Lack of spiritual awareness • Disinterest in introspection • Poor judgment • Decrease in delicacy of perception	**Spiritual effects**	
	• Boredom • Ennui • Bedraggle • Weakening attention • Impaired ability to concentrate	• Boredom • Disorderly • Weakening attention • Impaired ability to concentrate	**Intellectual effects**	

The characteristics that are bolded are the defining characteristics of compassion fatigue that are used in the connotative (theoretical) definition of compassion fatigue and the model case.

3.2.5 Connotative (theoretical) definition of compassion fatigue

The meaning of the concept, compassion fatigue, was synthesized from the characteristics (connotations) of compassion and fatigue. The connotative (theoretical) definition of the concept compassion fatigue in this study is as follows:

Compassion fatigue is the final extent of a progressive and cumulative process that is caused by prolonged, continuous, and intense contact with patients, the use of self and exposure to stress. It evolves from a state of compassion discomfort, which if not effaced through adequate rest, leads to compassion stress that exceeds the nurse practitioner's endurance limits and ultimately results in compassion fatigue. Compassion fatigue is a state where the compassionate energy expended by the nurse practitioner has surpassed his/her restorative processes, with recovery power being lost. All these states manifest with marked physical, social, emotional, spiritual and intellectual changes that increase in intensity with each progressive state.

3.2.6 Identify a model case

A model case using a nursing example was constructed to demonstrate all the defining characteristics (connotations) of compassion fatigue, so as to provide insight into the internal structure of the concept and allow clarification of its meaning and context (Walker & Avant, 2005:69).

Mary works as a Professional Nurse in charge of a 40-bed, female, medical ward for 7 years now. She has frequent **contact** with numerous different patients in her 40 hour per week working schedule. Each patient she **serves** has their own specific physical and emotional needs that Mary has to fulfil through **use of herself** and her skills. Oft times, the ward is very busy, there is a shortage of nursing staff, a lack of resources and numerous organizational tasks that need to be completed by her. In

addition to this, the patients in Mary's ward are very sick, terminally ill or dying, and need **intense** emotional support. All of these factors cause Mary much **stress**, as she tries to divide herself between the needs of the patients and the many tasks, that all demand her attention. Mary has been exposed to this working environment for a **prolonged** period of time and this **continuous exposure to the same kind of patients, patient needs**, **stresses** and **self-giving work**, has **cumulated** over time, to the point where Mary no longer takes pleasure in serving in her profession.

Mary used to enjoy her work, but in the last three years things have just gone **progressively** downhill for her. In the beginning the **changes** were **subtle**; in fact, she didn't even recognize the minor variations in her **physical, social, emotional, spiritual** and **intellectual** functioning that her family and co-workers had repeatedly commented about, such as her **weakening attention span**, the **decrease in the delicacy of her perception**, and her decreased **ability to aid** and **alleviate the pain** of her patients. All she experienced was a feeling of (**compassion**) **discomfort** and a sense of **weariness,** that awakened in her a **need to take some time off and rest**. Mary, however, decided to ignore this warning signal and continued to fulfil her professional role, although her usual **enthusiasm, sensitivity** and **ability to give selflessly** of herself to meet patient needs, had noticeably diminished. Not having **effaced** the problem, it further **progressed**.

A few months later she noticed **obvious** changes in every dimension of her life – **physically, socially, emotionally, spiritually** and **intellectually**. She felt that she had lost all of her **physical strength** and **endurance**, and she was **sick more often**, with the result that her **output and performance at work had markedly diminished**. She **lacked spiritual awareness, and her inability to concentrate** and her **forgetfulness** was starting to frighten her, as her profession

allowed no room for error, and she wasn't quite sure that she was able to live up to that standard anymore. Her (**compassion**) **stress** levels had **exceeded her endurance limit** and she felt **emotionally overwhelmed**. This caused a self-protective response to awaken inside of her as she went out of her way to **avoid situations where she would be forced to give of herself emotionally or share in someone's suffering**, and caused her to be immensely **irritated** with anyone that asked anything of her. Truthfully, she felt **bored - bored with her patients, bored with her work and especially bored with all the same everyday problems**.

She downplayed these alarming signals, and the changes in her **physical, social, emotional, spiritual** and **intellectual** functioning just continued to intensify until Mary no longer recognized herself. She was **disorderly** and had been making so many **careless accidents and mistakes** of late, that she began to think of herself as being a danger to others, although she would never admit this to anyone. Even more disturbing to her, was the realisation that she was no longer heeding her nursing call – being **unresponsive** and **disregarding the patients** in her care, while being **callous** and **indifferent** to those with whom she still had contact. She **didn't want to think about it** though, because she already felt **emotionally unstable** and close to **breakdown**. The truth of the matter was, **she had used every last drop of energy and had nothing more left to give – not to others nor to herself** – she honestly just didn't care about anything anymore and **no amount of rest or anything she did made her feel any better**. In fact, she **doubted she would ever be able to return to her previous level of functioning, she just wanted to quit and never have to face any of it ever again.** She was **compassion fatigued.**

Table 3.5 Justification of the characteristics (connotations) of compassion fatigue in the model case

Compassion Fatigue	Reference to the model case (Line number)
Contact	2, 4, 13, 14
Use of self	5, 14
Stress	10, 14
Prolonged	12
Continuous	13
Intense	9
Progressive	17, 18, 29, 30, 48
Cumulative	14
Compassion discomfort	23, 24
Causes change	17
Removable	24, 25, 29
Compassion stress	38
Greater the stress the less the endurance limit	39
Compassion fatigue	62, 63
Energy expenditure outstrips restorative processes	57, 58, 61
Does not recover when rested	59, 60
Physical effects	19, 24, 31, 32, 33, 34, 46
Social effects	19, 22, 31, 41, 42, 47, 53, 54
Emotional effects	19, 27, 31, 39, 43, 47, 56, 61, 62
Spiritual effects	19, 21, 22, 31, 34, 35, 47, 55
Intellectual effects	19, 21, 32, 35, 36, 44, 45, 47, 48, 49

3.2.7 Identify additional cases

Additional cases include borderline, related, contrary, invented and illegitimate cases (Walker & Avant, 2005:70). In this study, use was made of a borderline case and a contrary case. Identification of these two cases allowed the researcher to distinguish between concepts that were similar to and contrary to compassion fatigue.

3.2.7.1 Borderline case

Borderline cases are concepts that contain many or most of the defining characteristics (connotations) of the concept being studied, but not all of them (Walker & Avant, 2005:70). In this study, the borderline case of **Secondary Traumatic Stress Disorder (STSD)** was chosen, as it is used interchangeably and synonymously with compassion fatigue throughout literature, and although it is similar to compassion fatigue in many ways, there are characteristics that differ significantly between the two concepts.

STSD is also identified as being progressive in nature, evolving from a state of Secondary Traumatic Stress (STS) or compassion stress, to the more severe pathology of STSD. STS is defined as: *"the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other - the stress resulting from helping or wanting to help a traumatized or suffering person"* (Figley 1995a:7).

There are currently two predominant definitions used to define STSD and literature is divided in their use of each. For this reason, the characteristics of STSD in both definitions were used, so as to present the concept as comprehensively as possible. The definition of STSD is as follows: *"a state of exhaustion and dysfunction-biologically, psychologically and socially - as a result of prolonged exposure to compassion stress and all that it evokes. Prolonged exposure means an ongoing sense of responsibility for the care of the sufferer*

and the suffering, over a protracted period of time. The sense of prolonged exposure is associated with a lack of relief from the burdens of responsibility, the inability to reduce the STS/compassion stress. Moreover, traumatic recollections are provoked by compassion stress and prolonged exposure. These recollections are of traumatic memories that stimulate the symptoms of Post Traumatic Stress Disorder and associated reactions, such as depression and generalized anxiety. STSD is inevitable if, added to these factors, the helper experiences an inordinate amount of life disruption, as a function or illness or a change in lifestyle, social status, or profession or personal responsibilities" (Figley, 1995b:253). This description was then followed by the more recent definition of STSD, which focuses primarily on the symptoms of the disorder and is defined as: *"a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal (e.g. anxiety) associated with the patient. It is a function of bearing witness to the suffering of others"* (Figley, 2002a:1435).

June has worked as a Professional Nurse in the emergency room, for the last five years now. She **cares for severely traumatised patients and their families** on a daily basis, **listening to their traumatic stories of robberies, hijacks, motor vehicle accidents, health problems and near death experiences. She has fought for the lives of each of her patients** and experienced the joys of patients surviving against all odds, as well as the bitterness of an untimely death, where she has had to comfort support persons in the aftermath. After each **traumatic story, resuscitation or death**, Jane was subjected to certain **behaviours and emotions, as if her body, mind and emotions** were experiencing **Secondary Traumatic Stress** from the exposure. She, however, always accepted that it was **part of the job** and the **result of her caring** nature.

She has been experiencing this stress for a **prolonged** time now and there has been **no sense of relief or reduction** from this tension, which

has left her feeling **exhausted** and markedly influenced her **biological, psychological** and **social** functioning. Worse still, she is **constantly preoccupied** with the **traumatized patients she has been working with** and **persistently re-experiences the traumatic events they described,** even though she tries her very best to **avoid and numb these reminders.** These experiences have left her feeling **anxious and depressed.** Furthermore, Jane is experiencing an inordinate amount of **life disruption** because of her recent promotion. This change in her professional responsibility, however positive it may be, combined with the **relentless** and **prolonged** exposure to **(Secondary traumatic) stress**, has caused Jane to be inflicted with **Secondary Traumatic Stress Disorder.**

Table 3.6 Justification of the characteristics of Secondary Traumatic Stress Disorder (STSD) in the borderline case

Secondary Traumatic Stress Disorder	Reference to the model case (Line number)
Contact	2, 3, 5, 6, 7, 8, 12
Knowing about traumatizing event	2, 3, 4, 5, 8, 9
Compassion stress/STS	9, 10, 11, 24
Prolonged exposure	13, 24
Exhaustion	15
Biological, psychological and social changes	15, 16, 17, 18, 19, 20
Lack of relief from Compassion stress/STS	14, 23
Inability to reduce Compassion stress/STS	14, 23
Life disruption	21, 22, 23
STSD	25

STSD is similar to compassion fatigue, in that it too shares the risk factor of contact with patients, although in STSD, the cause is due to prolonged exposure to the traumatic events and stories of others, while compassion fatigue is caused by the prolonged, intense and continuous care of patients, use of self and exposure to stress. Both STSD and compassion fatigue follow a progressive and cumulative process, which if not relieved leads to more severe pathology, although the development of STSD requires a further element of life disruption in addition to the state of STS/compassion stress before STSD develops.

Furthermore, STSD and compassion fatigue both cause changes in the practitioner's functioning. In STSD the focus of these changes are on the practitioner's experience of trauma symptoms, or Post Traumatic Stress Disorder (PTSD) symptoms, in addition to exhaustion. In compassion fatigue, however, these changes affect every aspect of the practitioner's life, with the most noticeable effect being the nurse practitioner's inability to compassionately care for the patients in his/her care. This results because the compassionate energy that the nurse practitioner has expended over time is exhausted and surpassed his/her restorative processes.

3.2.7.2 Contrary case

A contrary case is the opposite of a model case and aims to give an example of what the concept is not (Walker & Avant, 2005:71-72). In this study, the concept, **compassion satisfaction**, was described as the opposite extreme or example of what compassion fatigue is not.

Although no formal definition of compassion satisfaction was identified in the literature study, aspects of compassion satisfaction as discussed by Radey and Figley (2007:208) and Stamm (2002:115), as well as the characteristics of compassion that were identified during data analyses, were combined to define compassion satisfaction as follows:

Compassion satisfaction is the invigoration and inspiration that a nurse practitioner receives from connecting with and sharing in a patients suffering, with the main focus being to relieve and alleviate the patients pain, through the selfless use of oneself, one's skills and available resources. The ultimate reward of this compassionate and competent care, being the opportunity to see patients suffer less and change for the better, which in turn allows the nurse practitioner to feel a sense of joy and fulfilment, that energizes him/her to retain a high morale, to thrive in the workplace and to enthusiastically meet patient needs regardless of circumstances.

Sarah has worked in a 40 bed orthopaedic ward for eight years now, and she is exposed to the exact same working environment as any other Professional Nurse in South Africa today. Her ward is **overcrowded** and **understaffed**; she works **long hours**, **lacks resources** and juggles an **immense workload** between **meeting patient needs** and **institutional requirements**. Sarah, however, **loves her work**. She can't explain to anyone the **fulfilment** she finds in **emotionally and spiritually connecting** with her patients, not only **being aware of**, but actually **sharing in their suffering** to such an extent that she can **feel their pain as if it were her very own.** This **fellow-feeling** awakens in her an **emotional response** of **kindness, tenderness, gentleness, love, empathy, sensitivity, care, concern, understanding** and **warmth** that sparks to **action** a desire to **respond to those needs** by any means necessary - **using herself, her skills** and available resources to **help, relieve, spare, aid, alleviate, reduce, succour or remove the suffering, distress, pain, sorrow or tragedy felt by her patient**. The most **exhilarating feeling** of all is when she sees the **patient suffer less** and **change for the better**, as a direct result of her **selfless care**. Witnessing this **positive change** in her patients allows Sarah to find a **sense of purpose and meaning in her work**, which **invigorates** and **enhances** her **personal and professional self-worth**, allowing her to become even

22 more **involved and confident in helping** the next patient. The **positive**
23 **aspects that she experiences in her work far outweighs any negative**
24 **experiences she might feel.**

Table 3.7 Justification of the characteristics of compassion satisfaction in the contrary case

Compassion Satisfaction	Reference to the model case (Line number)
Contact	5, 8
Use of Self	5, 14, 18, 22
Stress	3, 4, 5, 6
Connection	7, 8, 9, 10, 22
Emotional Response	11, 12
Action	13, 14, 15, 16
Patient response	17, 18, 19, 20, 21
Positive effects	6, 7, 17, 22, 23, 24
Circular process	16, 17, 18, 19, 20, 21, 22

Compassion satisfaction is the exact opposite of compassion fatigue, because even though the nurse practitioner is exposed to the exact same risk factors of contact, use of self and stress, he/she continues to flourish in these circumstances. In compassion satisfaction the nurse practitioner connects with his/her patient regardless of the circumstances, which leads to meaningful and purposeful interactions between the nurse practitioner and the patient, while in compassion fatigue the nurse practitioner gradually distances and isolates her/himself from the patient because of circumstances, which results in the fact that neither the nurse practitioner nor the patient's needs are fulfilled.

The process of compassion fatigue is cumulative and progressive moving from discomfort to stress and finally to fatigue, while the process of compassion

satisfaction is restorative and circular in nature, presenting a symbiotic relationship between patient and nurse, as each finds fulfilment in the other.

3.2.8 Literature Control

A total of 74 studies were used to determine the definition, and antecedents and consequences of compassion fatigue in human service professions, the professions that were represented in this sample included:

- Nurse practitioners (14 studies)
- Physicians (4 studies)
- Psychologists/counsellors (31 studies)
- Police officials (1 study)
- Emergency medical care workers (2 studies)
- Religious workers (5 studies)
- Hospice caregivers (4 studies)
- Social workers (6 studies)
- Occupational therapists (1 study)
- Interdisciplinary (6 studies)

The types of research that were conducted in these studies include:

- Literature reviews (39 studies)
- Qualitative studies – individual/focus group interviews (8 studies)
- Quantitative studies – use of instruments (22 studies)
- Mixed-method studies – individual/focus group interviews and use of instruments (5 studies)

Originally the researcher wanted to include the definitions of compassion fatigue as they appeared in the different professions of the literature sample, in the concept analysis. However, during data analysis, it became clear that compassion fatigue was most frequently defined using the definitions of Secondary Traumatic Stress (STS) (Sexton, 1999:395; Leon *et al.*, 1999:45; Fox

& Carey, 1999:190; Kinzel & Nanson, 2000:128; Collins & Long, 2003a:19; Collins & Long, 2003b:421; Nelson-Gardell & Harris, 2003:7; Wee & Myers, 2003:33; Coetzer, 2004:201; Sardiwalla, 2004:9; Maytum *et al.*, 2004:172; Mudede, 2004:24; Kraus, 2005:82; Geldenhuys, 2005:13-14; Sabo, 2006:138; Abendroth & Flannery, 2006:347; Adams *et al.*, 2006:103; White, 2006:342; Van den Berg *et al.*, 2006:2; Conrad & Kellar-Guenther, 2006:1072; Jacobson, 2006:134; Bride *et al.*, 2007:155-156), which isn't even synonymous with compassion fatigue, followed by the definition of Secondary Traumatic Stress Disorder (STSD) (Jenkins & Baird, 2002:424; Baranowsky, 2002:157; Inbar & Ganor, 2003:109; Thaele, 2004:2; Costa, 2005:13-14; Baird & Kracen, 2006:182; Martin, 2006:50; Benoit *et al.*, 2007:299; Caldas da Costa, 2001:15; Maxwell, 2001:5; Nkosi, 2002:41; Nene, 2005:10; Chase, 2005:24; Henke, 1995:8; Pfifferling & Gilley, 2000 and Mendenhall, 2006:360).

A further finding, was that the majority of the literature sources included unique aspects of vicarious traumatisation, burnout and traumatic counter-transference in their definitions of compassion fatigue, thus proving the absolute necessity of a specific definition for compassion fatigue, but also resulting in the fact that the literature definitions of compassion fatigue could not be used in the concept analysis process, as it would have influenced the characteristics that were identified, and ultimately weakened the uniqueness of the definition. Therefore, the literature sources were rather used as an integrative literature control to verify the identified characteristics (connotations) and categories of compassion fatigue.

The integrative literature control was conducted in accordance to the categories of compassion fatigue that were identified through the reduction and ordering of the characteristics (connotations) of compassion and fatigue, namely risk factors, causes, process and manifestations (see Table 3.4).

3.2.8.1 Risk Factors (Antecedents)

The risk factors of compassion fatigue that were identified in this research study include contact with patients, the use of self and exposure to stress. The risk of developing compassion fatigue by merely being in contact with patients is widely documented in literature (Clark & Gioro, 1998:85; Keidel, 2002:201; Collins & Long, 2003a:23; Abendroth & Flannery, 2006:351; Joinson, 1992:118; Benoit *et al.*, 2007:305; Figley 1995a:11; Maytum *et al.*, 2004:174; Schwam, 1998:642; Brown, 2002:1447; Sabin-Farrell & Turpin, 2003:453; Huggard, 2003:163; Timm, 2003:25; Salston & Figley, 2003:169; Baird & Jenkins, 2003:73; Buchanan-Barker & Barker, 2004:19; Ribeiro, 2004:10-11; Simon *et al.*, 2005:4; Violanti & Gehrke, 2004:75; Thomas & Wilson, 2004:82; Taylor *et al.*, 2006:40; Pistorius, 2006:15; Radey & Figley, 2007:207; Sinclair & Hamill, 2007; Deighton *et al.*, 2007:64).

The inherent risks of using oneself to meet patient needs is also broadly discussed in literature (Steed & Bicknell, 2001; Ribeiro, 2004:10-11; Taylor *et al.*, 2006:40; Deighton *et al.*, 2007:64; Leon *et al.*, 1999:44; Stevenson-Moessner, 2005:46; Abendroth & Flannery, 2006:351; Figley, 1995a:15; Valent, 1995:45; Costa, 2005:14; Simon *et al.*, 2005:4; Thomas & Wilson, 2004:88; Maytum *et al.*, 2004:176; Coetzer, 2004:211; Radey & Figley, 2007:207; Smith, 2007:195; Benoit *et al.*, 2007:305).

The stresses documented in literature as risk factors include: patient and/or family anger (Collins & Long, 2003a:23; Maytum *et al.*, 2004:174; Benoit *et al.*, 2007:303), a sense of unreasonable or unclear expectations or demands (Maytum *et al.*, 2004:175-176; Chase, 2005:94), emotional and physical demands of work (Pfifferling & Gilley; 2000), role changes (Maytum *et al.*, 2004:176), lack of challenge (Maytum *et al.*, 2004:176), lack of support (Dutton & Rubinstein, 1995:95; Clark & Gioro, 1998:85; Caldas da Costa, 2001:85; Keidel, 2002:201, Maytum *et al.*, 2004:174; Abendroth & Flannery, 2006:351; Linley &

Joseph, 2007:392; Radey & Figley, 2007:207; Chase, 2005:94), lack of self-care (Henke, 1995:29; Brown, 2002:1447; Stevenson-Moessner, 2005:46; Smith, 2007:194; Radey & Figley, 2007:209), environmental and societal stresses (Joinson, 1992:119; Pfifferling & Gilley, 2000; Keidel, 2002:201; Maytum *et al.,* 2004:174; Fahy, 2007:202; Chase, 2005:94), frustration with the health-care system (Joinson, 1992:119; Pfifferling & Gilley, 2000; Keidel, 2002:201; Maytum *et al.,* 2004:174; Abendroth & Flannery, 2006:351), lack of resources (Meldrum *et al.,* 2002:98; Van den Berg *et al.,* 2006:11), exposure to death (Meyers & Cornille, 1995:44; Keidel, 2002:201; Abendroth & Flannery, 2006:351), conflict at work (Van den Berg *et al.,* 2006:11), overtime (Meyers & Cornille, 1995:44), non-compliant patients (Maytum *et al.,* 2004:174), multiple roles (Meldrum *et al.,* 2002:97; Chase, 2005:94), a high workload (Caldas da Costa, 2001:85; Figley, 2002b:5, Maytum *et al.,* 2004:174; Van den Berg *et al.,* 2006:11; Abendroth & Flannery, 2006:351; Taylor *et al.,* 2006:38; Sprang *et al.,* 2007:259; Chase, 2005:94), a feeling of loss of control (Nene, 2005:67; Radey & Figley, 2007:208-209; Benoit *et al.,* 2007:303; Chase, 2005:94), working in the public health care sector (Day & Gray, 2005:309-310; Leon & Mabope, 2005:33; van Rensburg, 2004:355; Gilson *et al.,* 2007:1424), a multi-cultural environment (Gilson *et al.,* 2007:1424), receiving threats of death or threats to physical well-being (Meldrum *et al.,* 2002:98), lack of support services for patients (Meldrum *et al.,* 2002:98), working in rural areas (Meldrum *et al.,* 2002:98), lack of spirituality/belief in Higher Power (Clark & Gioro, 1998:85; Kozier *et al.,* 2000:168; Muller, 2002:5) and lack of appreciation (Benoit *et al.,* 2007:303).

3.2.8.2 Causes (Antecedents)

The causes of compassion fatigue that were identified in this research study include prolonged, continuous and intense exposure to risk factors. In the literature these characteristics in themselves are never mentioned independently, but rather in conjunction with the risk factors described above, so as to augment the nature of exposure.

3.2.8.3 Process

The process of compassion fatigue was identified to be cumulative and progressive, advancing from a state of compassion discomfort, to compassion stress and finally to compassion fatigue. In these states, compassion discomfort was characterized as temporary changes that were removable by rest, compassion stress as the state where stress outweighs the nurse practitioners endurance limit, and compassion fatigue as the state where energy expenditure has outstripped the restorative process, and power of recovery is lost. The literature cites compassion fatigue as being cumulative (O'Brien, 2006:19; Steed & Bicknell, 2001; Pfifferling & Gilley, 2000; Becvar, 2003:472), with progression being discussed in conjunction with the different states of discomfort (Maytum *et. al.,* 2004:174; Figley 2002a:1436; Thomas & Wilson, 2004:88), stress (Radey & Figley, 2007:211; Thomas & Wilson, 2004:88; Figley, 1995a:8; Figley, 1995b:253; Figley, 2002b:3; Figley, 2002a:1435; Chase, 2005:103) and fatigue (O'Brien, 2006:20; Figley 1995a:7; Figley, 1995b:253; Figley 2002b:3; Figley, 2002a:1435; Smith, 2007:195; Chase, 2005:103).

3.2.8.4 Manifestations (Consequences)

The manifestations of compassion fatigue were divided into physical, social, emotional, spiritual and intellectual effects. The main physical effects identified was weariness (Keidel, 2002:201; Collins & Long, 2003a:23; Thomas & Wilson, 2004:88; Maytum *et al.,* 2004:174), loss of strength (Thomas & Wilson, 2004:82), loss of energy (Joinson, 1992:119; Valent, 1995:45; Pfifferling & Gilley, 2000; Figley, 2002b:7; Inbar & Ganor, 2003:109; Thomas & Wilson, 2004:88; Mendenhall, 2006:360; Radey & Figley, 2007:209), reduced output (Yassen, 1995:179), diminished performance (Yassen, 1995:179; Schwam, 1998:645; Pfifferling & Gilley; 2000 Keidel, 2002:200; Meldrum *et al.,* 2002:98; Brown, 2002:1447; Inbar & Ganor, 2003:109; White, 2006:342; Smith, 2007:193), loss of endurance (Thomas & Wilson, 2004:82), burnout (Adams *et al.,* 2006:108; Figley, 2002b:3; Benoit *et al.,* 2007:303), loss of power of recovery of the body (Pfifferling & Gilley, 2000; Mendenhall, 2006:360), increased physical complaints

(Joinson, 1992:119; Pfifferling & Gilley; 2000; Mendenhall, 2006:360; Abendroth & Flannery, 2006:351-352; Meyers & Cornille, 1995:44; Yassen, 1995:184; Keidel, 2002:202; Schwam, 1998:645; Figley, 2002b:7; Meldrum *et al.,* 2002:98; White, 2006:342) and accident proneness (Yassen, 1995:184; Figley, 2002b:7), which was also represented in the literature.

The main social effects identified included unresponsiveness (Valent, 2002:29; Coetzer, 2004:212; Benoit *et al.*, 2007:305; Fahy, 2007:202), callousness (Mendenhall, 2006:360; Benoit *et al.,* 2007:303; Figley, 2002b:7; Keidel, 2002:200; Valent, 2002:29), indifference (Clark & Gioro, 1998:85; Figley, 1995a:8; Figley, 2002b:5; Nene, 2005:67; Yassen, 1995:184; Valent, 2002:29) and an inability to share in or alleviate suffering (Figley, 2002b:7; Inbar & Ganor, 2003:109) which was confirmed in the literature reviewed.

The main emotional effects identified were lessened enthusiasm (Figley, 1995a:8; Figley, 2002b:5; Becvar, 2003:472), breakdown (Yassen, 1995:184; Figley, 2002b:7), desensitization (Joinson, 1992:116; Clark & Gioro, 1998:85; Valent, 2002:29; Simon *et al.,* 2005:4; Van den Berg *et al.,* 2006:11; Mendenhall, 2006:360; Smith, 2007:194), apathy (Valent, 2002:29; Coetzer, 2004:212; Benoit *et al.*, 2007:305; Fahy, 2007:202; Baranowsky, 2002:156), irritableness (Figley, 1995a:8; Yassen, 1995:184; Schwam, 1998:643; Clark & Gioro, 1998:85; Pieper, 1999:479; Pfifferling & Gilley; 2000; Figley, 2002b:5,7; Becvar, 2003:472; Inbar & Ganor, 2003:109; Mendenhall, 2006:360), diminished ability (Pieper, 1999:479; Yassen, 1995:184; Figley, 2002b:7), desire to quit (Fahy, 2007:202; Figley, 1995a:8; Figley, 2002b:5; Smith, 2007:197) and being emotionally overwhelmed (Yassen, 1995:184; Mendenhall, 2006:360; Abendroth & Flannery, 2006:351; Benoit *et al.,* 2007:303; Thomas & Wilson, 2004:88; Pfifferling & Gilley, 2000) which was also documented in literature.

The main spiritual effects were a lack of spiritual awareness and disinterest in introspection (Yassen, 1995:184; Figley, 2002b:7; Becvar, 2003:472; Thomas &

Wilson, 2004:88), poor judgment (Figley, 2002b:5; Yassen, 1995:179) and a decrease in delicacy of perception (Brown, 2002:1447; Becvar, 2003:472; Nene, 2005:67), which was also evidenced in literature.

The main intellectual effects identified were boredom (Maytum *et al.*, 2004:176), disorderliness (Mendenhall, 2006:360; Yassen, 1995:184), loss of power of recovery of the mind (Pfifferling & Gilley, 2000), weakening attention (Schwam, 1998:645; Brown, 2002:1447; Joinson, 1992:119; Keidel, 2002:200) and an impaired ability to concentrate (Figley, 1995a:8; Yassen, 1995:184; Figley, 2002b:5,7), which was also stated in literature.

3.2 EMPIRICAL INDICATORS

The second objective of this study was to determine the empirical indicators from the defining characteristics (connotations) of compassion fatigue and the integrative literature control, so as to synthesize a denotative (operational) definition of compassion fatigue. Table 3.8 presents the ordering and refining of the empirical indicators of compassion fatigue.

Table 3.8 The ordering and refining of the empirical indicators of compassion fatigue

RISK FACTORS	CAUSES	MANIFESTATIONS	PROCESS	EMPIRICAL INDICATORS
• Contact with patient • Use of self • Stress	• Prolonged • Continuous • Intense	**Physical** • Weariness • Loss of strength • Without energy • Reduced output • Diminished performance • Loss of endurance • Burnout • Increased physical complaints • Accident prone **Emotional** • Lessened enthusiasm • Breakdown • Desensitized • Disinterest to exert oneself • Apathetic • Irritable • Diminished ability • Desire to quit • Emotionally overwhelmed **Social** • Unresponsiveness • Disregard • Callousness • Indifference	Cumulative Progressive	
			Compassion Discomfort	**Physical effects** • Weariness **Emotional effects** • Lessened enthusiasm • Desensitized • Diminished ability **Social effects** • Inability to aid **Spiritual effects** • Decrease in delicacy of perception **Intellectual effects** • Weakening attention
			Compassion Stress	**Physical effects** • Loss of strength • Reduced output • Diminished performance • Loss of endurance • Increased physical complaints **Emotional effects** • Irritable **Social effects** • Inability to share in suffering **Spiritual effects** • Lack of spiritual awareness **Intellectual effects** • Boredom • Impaired ability to concentrate
			Compassion Fatigue	**Physical effects** • **Without energy**

		• Inability to share in suffering • Inability to alleviate **Spiritual** • Lack of spiritual awareness • Disinterest in introspection • Poor judgment • Decrease in delicacy of perception **Intellectual** • Boredom • Disorderly • Weakening attention • Impaired ability to concentrate		• **Burnout** • **Accident prone** **Emotional effects** • **Breakdown** • **Apathetic** • **Desire to quit** **Social effects** • **Unresponsive** • **Callousness** • **Indifference** **Spiritual effects** • **Poor judgment** • **Disinterest in introspection** **Intellectual effects** • **Disorderly**

3.3.1 Denotative definition of compassion fatigue

The denotative (operational) definition of compassion fatigue was synthesized from the empirical indicators that were derived from the ordering and refining of the defining characteristics of compassion fatigue and the integrative literature control. The denotative (operational) definition of the concept, compassion fatigue, in this study is as follows:

Compassion fatigue is the final extent of a progressive and cumulative process that evolves from compassion stress after a period of unrelieved compassion discomfort, which is caused by prolonged, continuous, and intense contact with patients, the use of self and exposure to stress. The manifestations increase in intensity with each progressive state, but the indicative signs of compassion fatigue are the physical effects of burnout, absence of energy, and accident proneness; emotional effects of breakdown, apathy and a desire to quit; social effects of unresponsiveness, callousness and indifference towards patients; spiritual effects of poor judgment and disinterest in introspection, and intellectual effects of disorderliness.

It should however be noted that because compassion fatigue is the final extent of cumulative and progressive process, the manifestations of both compassion discomfort and compassion stress are evident and established within the nurse practitioner suffering from compassion fatigue. The physical effects include weariness, loss of strength, reduced output, diminished performance, loss of endurance and increased physical complaints. Emotional effects include lessened enthusiasm, desensitization, diminished ability, irritableness and being emotionally overwhelmed. Social effects include an inability to aid and share in the suffering of patients. Spiritual effects include a decrease in the delicacy of perception and lack of spiritual awareness. Intellectual effects include weakening attention, boredom and an impaired ability to concentrate. The presence of these manifestations will lead to a positive diagnosis of compassion fatigue.

In Figure 3.1 the defining characteristics (connotations) and categories of compassion fatigue are graphically presented. The manifestations of compassion fatigue were divided between the phases of compassion discomfort, compassion stress and compassion fatigue, which serves as empirical indicators of that clearly demonstrate and allows identification of each progressive state of compassion fatigue.

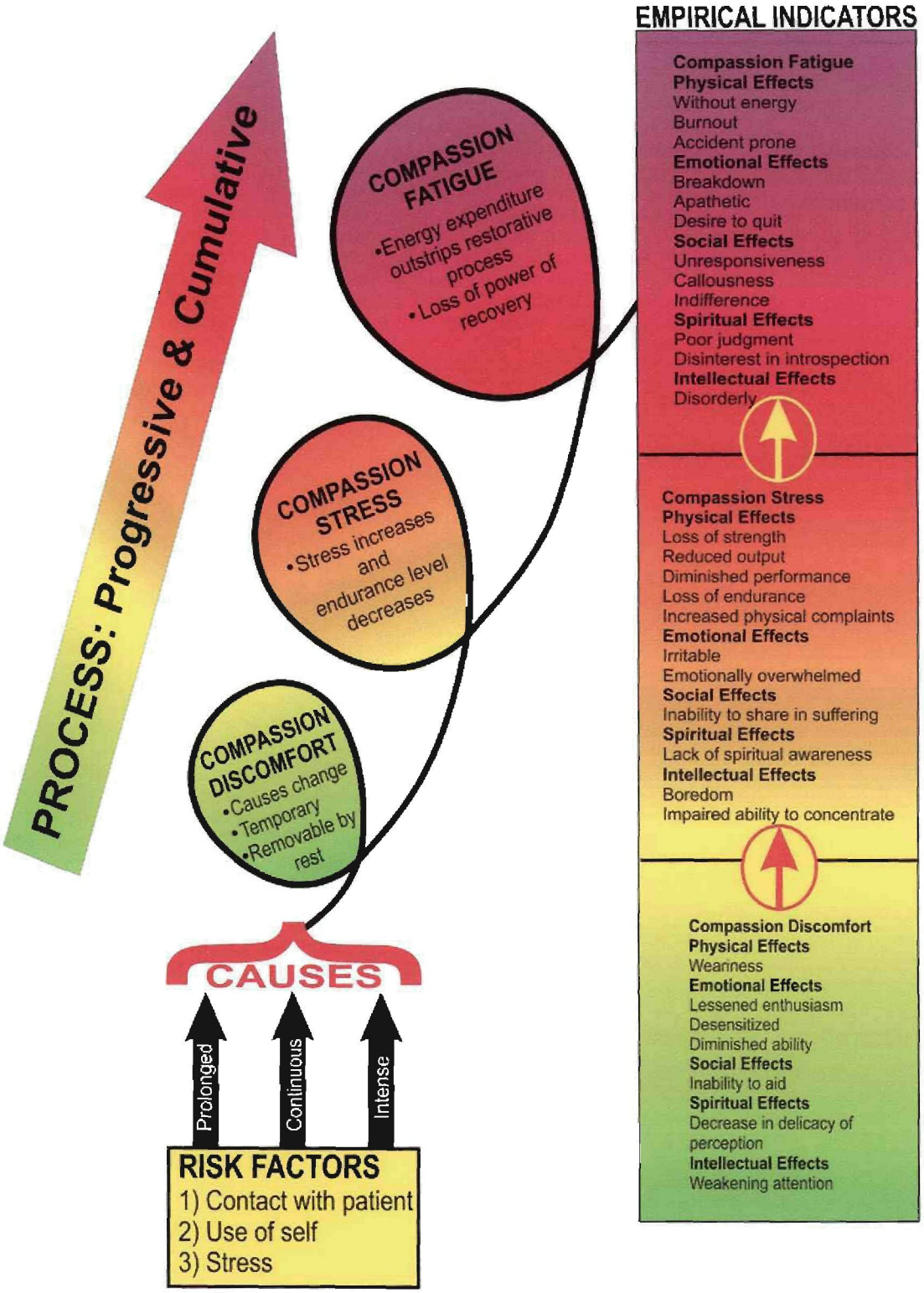


Figure 3.1 Defining characteristics (connotations), categories and empirical indicators of compassion fatigue

3.4 CONCLUSION

In this chapter, a concept analysis of compassion fatigue was performed using the method of Walker & Avant (2005) based on the original method of Wilson (1987). The chapter commenced with an introduction as to why the concept compassion fatigue was selected, followed by a revision of the aims and purpose of its analysis. All the uses of compassion and fatigue were identified, with the aid of dictionaries, thesauri and encyclopaedias. The characteristics (connotations) of compassion and fatigue were listed, ordered and reduced to present the defining characteristics (connotations) of compassion fatigue, which were used to synthesize a connotative (theoretical) definition of compassion fatigue specific to the nursing profession. These defining characteristics (connotations) were used to propose a model case of compassion fatigue, while the borderline case of Secondary Traumatic Stress Disorder (STSD) was used to demonstrate the similarities and differences between the concepts, and the contrary case of compassion satisfaction was used to demonstrate the opposite case of compassion fatigue. The defining characteristics (connotations) and categories of compassion fatigue were then theoretically grounded in the literature and the chapter concluded with the list of defining characteristics (connotations) of compassion fatigue being further ordered and refined. The manifestations identified in Table 3.4 were used as the empirical indicators of compassion fatigue, which allowed the identification of each progressive state of compassion fatigue and the development of a denotative (operational) definition.

CHAPTER FOUR

CONCEPTUAL FRAMEWORK

4.1. INTRODUCTION

Conceptualising refers to the description of key concepts in the research study as well as the grounding and integration of research within the accepted body of nursing knowledge (Botes, 1995:11-12). In this study a conceptual framework was described to accomplish this objective. A conceptual framework is described as the development of an outline that specifically enhances the understanding of a particular phenomenon through the selection and definition of concepts, the proposition of relationships between those concepts, the expression of statements in hierarchical fashion and the development of a conceptual map that expresses the framework (Burns & Grove, 2005:136; Brink, 2006:24). The description of the conceptual framework in this study ensured the usefulness and integration of the research findings within the accepted body of nursing knowledge and accounted for the main constructs in which compassion fatigue is embedded.

In this chapter compassion fatigue within the nursing profession is discussed. The nursing profession refers to the context of nursing, which is inclusive of the environment of nursing, the practice of nursing and the nurse practitioner, as it relates to the concept, compassion fatigue (see 1.5.2.2). To provide structure to this chapter, the conceptual map that expresses the interconnectedness between these different constructs and compassion fatigue commences the chapter, and is followed by the description of the environment, the nursing practice and the nurse practitioner, respectively.

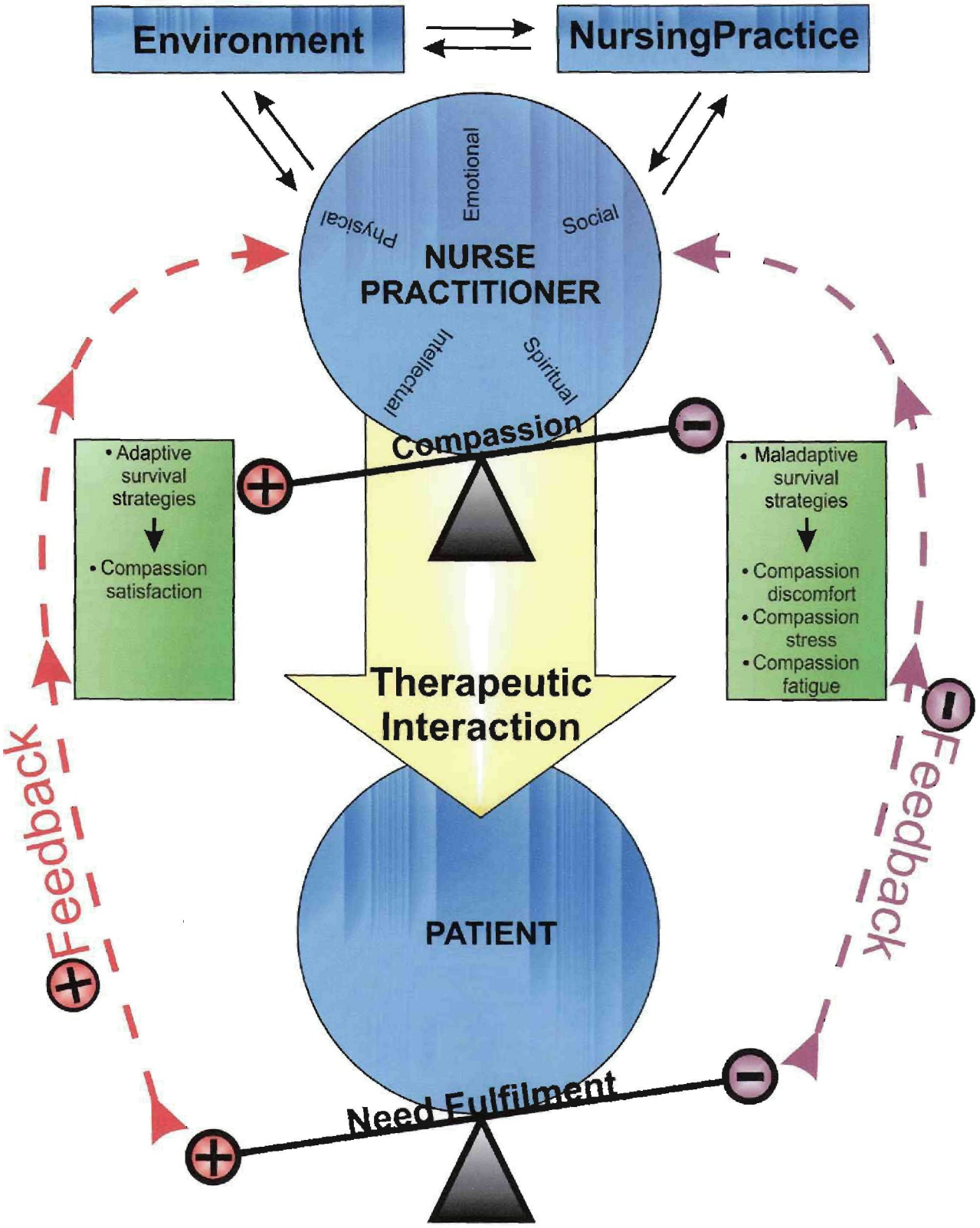


Figure 4.1 Conceptual framework

4.2. ENVIRONMENT

The meta-theoretical statement of environment that was developed in chapter one (see 1.5.1.3) is used to guide the discussion of the environment in this section of the chapter. In the statement, environment refers to the nurse practitioner's workplace, where he/she works in dire circumstances with staff shortages, unbearable workloads, poor working conditions, inadequate management support, a lack of resources, low wages, limited career opportunities, the impact of HIV and AIDS and poor management of health services (Buchan, 2006:21; Ehlers *et al.*, 2003:31), all while caring for the sick, wounded, traumatised and weak patients in his/her professional care that personally exposes the nurse practitioner to the patients' pain, trauma and suffering on a daily basis.

4.2.1 The South African health care system

The transformation of the South African Health Care System started off with two pre-election documents meant to guide the reform. The first document was the *Reconstruction and Development Programme* (RDP) which was used as the African National Congress' (ANC) election manifesto to contest the first democratic elections in South Africa, in April 1994. The RDP further served as a framework for conceptualising and directing the reform process for a new dispensation in health care at the narrower health sector level. The second document was an extension of the RDP, namely the *National Health Plan for South Africa*, which served to draw the broader societal parameters for fundamental reform of the health care system (Van Rensburg & Pelser, 2004:110-115; Vlok, 2001:4; ANC, 1994a; ANC, 1994b).

On the 27th April 1995, the African National Congress (ANC) came into power, with a new post-apartheid health vision for South Africa based on the RDP and the *National Health Plan for South Africa*. This vision included the creation of a unified, comprehensive, equitable and integrated National Health System (NHS),

where the NHS would be structured at central level, or first tier, with a national health authority, followed by a provincial level, or second tier, that would consist of nine provincial health authorities and finally, a district level, or third tier, consisting of a large number of district health authorities. These tiers would ensure that resources be used in the most rational and effective manner, so that every person in South Africa would have the right to achieve optimal health, with the health needs of the most vulnerable groups being prioritized. The NHS would be publicly funded by general tax revenue, with free promotive and preventative health services in the public sector, and free health care for specific patient groups, namely pregnant women and children under the age of 6 years whether citizens of South Africa or not (1994), later free primary health care services were made available to all citizens of South Africa (1996) (Dennill *et al.,* 2002:169-170; ANC 1994a:19-20; Van Rensburg & Pelser, 2004:114-115; Geyer *et al.*, 2002:11; Ntuli & Day, 2004:2).

The underlying philosophy of the restructuring of the health care system was a primary health care (PHC) approach, which was based on full community participation, an inter-sectoral approach to health and health related problems between other governmental spheres, non-governmental organization (NGO's) and the private sector, as well as a closer inter-departmental collaboration with sectors recognized as playing key roles in the attainment and maintenance of health. It was also noted that the transformation of health would call for substantial training and reorientation of existing personnel, to eliminate inequalities in access to health services, especially in rural areas. Finally, a comprehensive health information system would be launched so that systematic collection and analysis of health data could be performed, so as to plan and manage the NHS (Dennill *et al.,* 2002:169-170; ANC 1994a:19-20; Van Rensburg & Pelser, 2004:114-115; Ntuli & Day, 2004:1).

The main health policy after 1994 was the *White Paper for the Transformation of the Health System in South Africa* which was published by the Department of Health in April 1997. This document built upon the policy objectives spelled out in the *Reconstruction and Development Programme* (RDP) and the *National Health Plan for South Africa*, but further expounded on a wide range of policy measures and implementation strategies that would be used to meet the basic needs of South African citizens, and transform health care delivery in South Africa. Five key strategies that were highlighted in this reform of the health sector included (i) the promotion of equity through the development of a unified health system, (ii) emphasis on and implementation of PHC at the district level, (iii) the distinct and complementary roles of the three tiers of national, provincial and district levels, in health promotion and the implementation of PHC, (iv) an integrated package of essential PHC services to be available to all South Africans at the first point of contact and (v) combination of forces between the government, non-governmental organization (NGO's) and the private sector in the promotion of common health related goals (Republic of South Africa,1997a:5; Dennill *et al.,* 2002:170; Van Rensburg & Pelser, 2004:118-119).

Evaluation of the progress of the reform for the South African Health Care System, more than ten years later, shows that many of the planned changes has taken place, but this has not been without numerous constraints, setbacks and failures. The outcomes of the transformation are evaluated according to the five key strategies that were highlighted in the *White Paper for the Transformation of the Health System in South Africa:*

i) Promotion of equity through the development of a unified health system

The new dispensation has brought about many positive changes, evidenced by the fact that apartheid institutions and discriminatory practices have been largely dismantled, with both patients and staff being freed from race and gender

discrimination. This has allowed a perceptible merging of formerly fragmented and segregated health authorities and services, which has provided greater equity, appropriateness, accessibility and efficiency of public health care (Van Rensburg & Pelser, 2004:162). The rapid dissolution of the apartheid system through affirmative action was however loaded with problems, as significant amounts of experienced staff were laid off and less, or even totally inexperienced staff, were raised to key management positions which not only led to the demoralisation and demotivation of existing staff, but further led to concerns that public health service standards were dropping, deteriorating and even collapsing, with ample signs that justified these concerns (Van Rensburg & Pelser, 2004:164).

A further positive transformation that has taken place is that there has been greater community involvement and participation in health matters. Numerous representative, and participative structures and mechanisms have been created to give effect to an evolving climate of participatory health care, which has counteracted apartheid's prolonged domination in the health sphere. Legitimization and the right of patients to consult with complementary and alternative forms of health care, including African traditional healing has also been promoted to ensure a unified, representative health system (Van Rensburg & Pelser, 2004:163).

ii) Emphasis on and implementation of PHC at the district level

The development of the district health PHC based system as the centre of the whole health system, has facilitated the decentralization of state powers and functions to local governments and health facilities, allowing them to take responsibility and make decisions regarding health and development (Van Rensburg & Pelser, 2004:162). The District Health System, however, is still not well functioning and has many unresolved issues, as it continues to be subjected to confusion, intermittent disruptions, and hindered by a lack of leadership,

indecision, capacity deficiencies of many local governments and the power struggles among many interest groups (Van Rensburg & Pelser, 2004:163).

iii) The distinct and complementary roles of the three tiers of national, provincial and district levels, in health promotion and the implementation of PHC

The protracted absence of a national legislative framework has resulted in disjointed restructuring of the District Health System and dissimilarity in the structuring and function of the provincial and local spheres of government with respect to health care (Van Rensburg & Pelser, 2004:163). Furthermore, there are persistent and obvious distributive differences and inequities in health provision, health service coverage and utilization of health services both inter-provincially and intra-provincially. This occurrence provides evidence that the National Government's control is rather weak, compromised and failing in respect to equalizing such inequalities, and this situation will continue to present itself and become even more aggravated among the health districts, if effective measures to ensure equity are not put in place, especially with increasingly stringent budgets confronting all spheres of the Government (Van Rensburg & Pelser, 2004:164; Ntuli & Day, 2004:2).

iv) An integrated package of essential PHC services to be available to all South Africans at the first point of contact

The shift from a fragmented, mainly curative, hospital-based service to an integrated, primary health care, community-based service has reprioritised the health budget to benefit PHC more, so as to improve accessibility to health care in the public domain and specifically to the vulnerable groups in society. This was ensured through more equitable geographical allocations of health care and an extensive clinic-building and upgrading programme, especially in rural areas. In these clinics, an array of free PHC programmes that focus on the most acute needs and conditions have been initiated, with a comprehensive PHC service

package being available to all South Africans at the first point of contact (Van Rensburg & Pelser, 2004:162-164; Geyer *et al.*, 2002:11).

The introduction of free health care was, however, not adequately planned and budgeted for, and has led to an increased use and attendance of most public health facilities and services, resulting in overcrowding, limited resources, poor working conditions, poor staff morale, excessive use and even abuse of scarce resources and an unfortunate deterioration in the quality of care. It is not clear whether the policy resulted in any real benefit in terms of health outcomes, or whether it indeed benefited those who most require health care, but it is obvious that the overloaded, impoverished health system is not able to keep up with the demand (Van Rensburg & Pelser, 2004:164).

v) Combination of forces between the government, non-governmental organization (NGO's) and the private sector in the promotion of common health related goals

This strategy has shown the least reform, partly due to the backlogs created by the previous government system, as well as the continuation of typically race-based provision in a class-segregated system, where the wealthy and insured minority of the population are catered for by the private sector, while the less wealthy majority of the population rely on the less effective, overburdened and impoverished public health sector. There is little evidence of the public sector becoming stronger as resources are increasingly being lost, with the influx of profits, staff and health insured patients to the private sector escalating. Furthermore, the private sector continues to grow, whilst part of the public sector is increasingly being infiltrated by and relinquished to the private sector and private enterprise. (Van Rensburg & Pelser, 2004:165; Ntuli & Day, 2004:10).

Of further concern is that the government has not succeeded in creating unity among the different role players, stakeholders and interest group in the health

sectors, but rather caused estrangement, because of conflicting interests and endeavours between the public and private sectors, confusion between the national, provincial and local spheres of government, disagreeing relations between local government structures and civil organizations, and frustrated interests of private health providers, medical professionals and pharmaceutical companies (Van Rensburg & Pelser, 2004:163).

The transformation of the health care system was evaluated to portray the current status of the broader health care environment, in which the nurse practitioner of South Africa functions. Although several major milestones have been achieved and planned changes have taken place, many impediments, flaws and failures, which have not yet been mastered, are rampant in the system and dramatically affect the work environment of the nurse practitioner. Nurse practitioners are considered the backbone of the health care system, which demonstrates the fact that these changes in the health care system, whether for better or worse, rests squarely on the shoulders of nurse practitioners who are the first point of contact for patients in the health care system (Van Rensburg & Pelser, 2004:163).

4.2.2 Health care sectors

The most disconcerting aspect that health care practitioners have to deal with in the health care system is the ever yawning chasm between the private and public health care sectors. Not only are there huge financial disparities between the two sectors, but there is also an uneven distribution of human resources, all of which causes a great difference in workloads, working conditions, quality of care and health workers' experience of health care provision in the two diverse sectors (Heunis, 2004:475).

4.2.2.1 Public health sector

The public health sector is divided into tiers, such as those based on the National Data Directory, namely district, regional, provincial and national. These tiers

allow hospitals to be divided into levels, with different degrees of service specialisations offered, medical specialists available and sources of referral. The District level receives referrals from clinics and general practitioners, and consists of generalists who provide level one care. The Regional level receives additional referrals from District hospitals and provides mostly level two care with the aid of generalists and specialists. The Provincial level receives referrals from clinics, general practitioners, District Hospitals and Regional hospitals, and provides level three care, with the assistance of super-specialist services. These super-specialist services include: medical oncology, cardiology, gastroenterology, ENT, nephrology, ophthalmology, urology, MRI and CT scans, intensive care and orthopaedics. Finally, the National level receives referrals from all health care facilities in addition to Provincial hospitals, and provides high cost, multi-disciplinary level three care, in conjunction with the services of super-specialists (Heunis, 2004:475; Bouille *et al.,* 2000:233). In theory, adhering to this referral system was supposed to reduce the health expenditure of hospitals, but in practice it has seldom been abided to, as there seems to be no effective referral system between the different levels of hospital administration, and this allows people to bypass primary health care services, which they consider to be inferior (Bloom & McIntyre, 1998:1532).

Primary health care was to be the means used to provide basic health care to all South Africans. The Government aimed to do this by decreasing the annual budget expenditure of academic, provincial and district hospital complexes, while accelerating the growth of primary health care expenditure, but financial reports don't reflect this, as the bulk (60%) of the health care budget continues to be spent on hospitals (Department of Health, 2001). This expenditure is understandable when you consider the fact that the public health sector provides 82% of the population with health care services each year (Van Rensburg, 2004:355) and specialized care to over 3,3 million people who are admitted to public hospitals, where over a 100 000 beds are in use each year (Department of

Health, 2001). Further explication of this expenditure shows that there is a national bed usage rate of 68% at District hospitals with an average length of stay of 4 days, 77% at National hospitals with an average length of stay of 7 days and 73% at Regional hospitals with an average length of stay of 5 days for 2003/04 (Day & Gray, 2005:309-310) at an average cost of R710 for District Hospitals per person per day, R984 for Regional Hospitals per person per day and a staggering R1 637 for National hospitals per person per day for 2001/02 (Burn & Shongwe, 2002:40).

More alarming, however, is the fact that in 1998/99 South Africa devoted R70.2 billion to health care, which represented 8.6% of the Gross Domestic Product (GDP). This is an incredibly high figure, when you consider that the equivalent average for other middle income countries was 5.7% (Doherty *et al.,* 2002:14) and there has been no sign of this expenditure decreasing, with 8.6% of the GDP being spent on health care in 2004 (WHO, 2007a). This expenditure is, however, shared between the private and public sector, with the public sector using 41% of the total health funding to provide health care to 82% or 34 611 881 South Africans, while the private sector spends approximately seven times more per capita than the public sector on less than 20% or 7 597 709 South Africans (Leon & Mabope, 2005:33; Van Rensburg, 2004:355). This trend has resulted in the fact that large sections of the population still experience problems with accessing and experiencing quality health care, even though South Africa continues to devote ever increasing amounts to health care (Doherty *et al.,* 2002:15).

4.2.2.2 Private Health Sector

The private health sector in South Africa is characterized by six dominant corporate hospital owner groups, namely Netcare, Medi-Clinic, Life Healthcare, Presmed, Hospiplan and Afrox. These hospital groups own over 357 health facilities in South Africa with a total of 35 830 beds, compared to the public sector which has 382 health facilities with a total of 100 147 beds (Day & Gray,

2005:309-310). Furthermore, while the public health sector struggles to provide for even the most basic health care needs, the private sector provides over 86 different service types, with the majority of the health care facilities providing 16 services which are considered essential for private hospital service provision and include: gynaecology, radiology, orthopaedics, ENT, 24-hr casualty, paediatrics, maternity, urology, MRI and CT scans, plastic surgery, psychiatry, ophthalmology, gastroenterology, dermatology and neurology (Heunis, 2004:485). These hospital groups employ only nurse practitioners and do not own their own health professionals, rather providing their facilities to doctors and other health professionals who bill patients or insurers independently from the hospital (Heunis, 2004:280).

The private sector still dominates financing and provision of health in terms of total resource use, although only a limited number of South Africans have access to this sector and only about 18% have comprehensive access to private health care through medical scheme coverage (Van Rensburg, 2004:355). Moreover, private sector coverage declined as a proportion of the total population between 1996 and 1999, suggesting that an increasing proportion of the population became reliant on public services, even as the public sector received a declining share of health care finances, and HIV and AIDS began to impact on health care needs. This occurrence reflects the increasing unaffordability of medical schemes as costs escalate in the private sector (Cornell *et al.,* 2001).

The private sector has responded to this occurrence by establishing managed health care, which is a method used mostly by medical administrators or funders, to implement measures or interventions with which to control and direct health care activity, so as to reduce its cost without adversely affecting its quality (Heunis, 2004:484). Initially this movement was met with much resistance as medical professionals felt that funders were interfering with client care, but over time it has come to be accepted, as funders have become less prescriptive and

medical professionals have better represented their interests. Managed health care has also lead to weaker funders being cut from the private hospital sector, giving a small handful of investors great power and further monopolizing the private hospital sector (Heunis, 2004:485). This proves that amidst implementation of managed care and legislation inhibiting medical scheme growth, the private sector is still expanding and strengthening, thus continuing the distortions and inequalities of market-driven and provider-driven initiatives that leads to excessive health spending and the resultant cost escalation (Van Rensburg & Pelser, 2004:164; Heunis, 2004:485).

4.2.2.3 Human Resources

Financial inequality is not the only aspect differentiating the private sector from the public sector; the system is riddled with even more inconsistencies, with great inequality in the division of human resources. The government is the main source of producing trained health practitioners for both the public and private health care sectors, but the majority of health practitioners work in the private sector, which not only results in a disproportionate distribution of human resources between the private and public sectors – accompanied by acute shortages in the public sector – but also directly influences the education of new health practitioners, as specialists abandon their training roles in the public sector to work in the private sector (Leon & Mabope, 2005:40). In all listed professional categories, enormous disparities exist between the public and private sector as represented in Table 4.1.

Table 4.1 Public-private distribution of health workers for 1998/99

Professional Category	Public sector Estimated 82% Dependants	Private sector Estimated 18% Dependents
General Practitioners	27,4%	72,6%
Medical Specialists	24,8%	75,2%
Nurse Practitioners	58,9%	41.1%
Dentists	7,4%	92,6%
Pharmacists	23,7%	76,3%
Physiotherapists	13,6%	86,4%
Occupation therapists	19,5%	80,5%
Speech therapists and audiologists	8,6%	91,4%
Dental therapists	39,5%	60,5%
Psychologists	5,8 %	94,2%

(Goudge, 1999:72; Van Rensburg, 2004:355)

Although more than half of nurse practitioners are still employed by the public health sector, this is still an inequitable distribution as 58.9% of nurse practitioners carry the burden of serving 82% of the population, while in comparison the private sector is lavishly staffed to serve a mere 18% of the population. This unbalance is one of the main reasons staff are migrating in increasing numbers from the public to the private sector with 'pull' factors being reduced workloads, higher remuneration, more favourable work conditions and improved professional resources, while 'push' factors are a high workload, public health systems and management problems, poor infrastructure, poor remuneration, poor working conditions and despondency about the effects of HIV and TB epidemics on the health system (Day & Gray, 2005:311).

Gilson *et al.* (2005:1423) recently conducted a study with practitioners employed at private and public health sectors and found that health practitioners working in

the private sector liked their work, with only 16.7% desiring to work elsewhere. These practitioners felt that they offered good quality health care with no discrimination towards patients and felt that there was minimal (33.3%) abuse of services at the facility, with patients being very appreciative and grateful towards them. In contrast, health practitioners in the public sector showed less enjoyment of their work with 25% desiring to work elsewhere. These health practitioners felt they offered care of a lower quality and admitted to displaying some discrimination towards patients - treating some patients better than others and having a bad attitude towards some. They also felt that patients severely (93.8%) abused the services, and were often ungrateful and unappreciative. In this same study, consumers of the different sectors confirmed these findings with their overall judgments of private sector being almost always positive, while displaying largely negative attitudes towards the public sector.

After evaluation of the two health care sectors it is clear that the vast financial and human resource disparities between the public and private health care sectors, has devastating effects on health practitioners in the public sector. These practitioners carry the burden of serving the majority of South Africa's population with minimal funds and insufficient personnel, which not only increases their workloads and results in poor working conditions, but further influences the quality of care provided and diminishes health workers' experience of satisfaction in providing health care to patients. Although these inequalities exist between the public and private sector, this is just the point of the ice berg, when you consider the vast disparities between the South African health care system and that of the world at large.

4.2.3 Nurse Practitioner Staffing

There is an overall shortage of nurse practitioners around the world, which is leaving in its wake a serious crisis in terms of adverse impacts on the health and well-being of not only the populations at large, but also the nurse practitioners

who have to counterbalance this shortage. These detrimental effects are most sorely felt by Africa who carry 25% of the world's disease burden, but have only 1.3% of the world's health care workforce (WHO, 2004), with an estimated shortage of over 600 000 nurse practitioners (WHO, 2003). In South Africa, the shortages are acutely felt with an estimated nurse shortage of 32 000 (Oulton, 2006:35).

4.2.3.1 Staffing in South Africa

Nurse practitioners in South Africa are classified in either professional or sub-professional categories based on the training received. The professional category includes professional nurses who have undergone a comprehensive four year diploma or degree in general health nursing, community health nursing, psychiatric health nursing and midwifery, or have undergone a bridging course and are registered as either a generalist or psychiatric professional nurse. Sub-professional categories include enrolled nurses who have undergone a two-year certificate program and enrolled auxiliary nurses who have undergone a one-year certificate program (Van Rensburg, 2004:335). Registers of all economically active, qualified professional nurses and rolls of all enrolled and auxiliary nurses are kept by the South African Nursing Council (SANC), so as to ensure effective statutory and professional control of nurse practitioners in South Africa.

According to the South African Nursing Council there is a total of 47 390 800 South African citizens, who are served by 101 295 registered nurses, at a ratio of 468 patients to one registered nurse, 39 305 enrolled nurses, at a ratio of 1206 patients to 1 enrolled nurse and 56 314 nursing auxiliaries, at a ratio of 842 patients to 1 nursing auxiliary, with nurse practitioners as a whole serving at a ratio of 241:1 (SANC, 2006), while a first world country, such as Norway, has 14.84 registered nurses per 1 000 population and a ratio of 67 patients to one registered nurse. This comparison exemplifies the disparate workloads of nurse practitioners across the world, where South African registered nurses care for an

additional 401 patients when measured against their nursing counterparts in Norway (WHO, 2007b).

The trends in the number of nurse practitioners registered are of a serious concern, as the demand for nurses continues to grow because of increasing population growth rates, increased primary health care services (where nurses are the main service providers), increased usage of the public sector health services and increased morbidity due to the HIV and AIDS epidemic - all of which have increased the workload of nurses in South Africa (Subedar, 2005:90). Another disturbing progression is the increasing ageing workforce as presented in Figure 4.2.

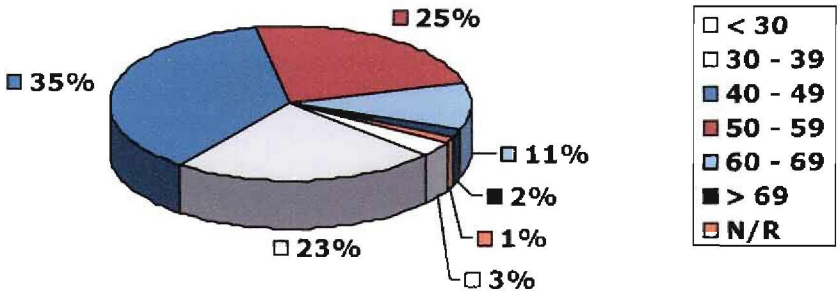


Figure 4.2 Age Distribution of Professional Nurses (SANC, 2006)

Of the 101 295 professional nurses registered at the South African Nursing Council, more than half (57 201) of the professional nurses are over the age of 45 years, with a mere 12 451 professional nurses being under the age of 35 years (SANC, 2006). These numbers don't seem like they will improve any time soon, as the intake of new students continues to decline.

Professional nurses are trained at either nursing colleges or universities, while enrolled and auxiliary nurses are permitted to qualify as professional nurses through a two-year bridging programme. Nursing colleges showed a decrease in intake since 1996, where 2 629 nurses were trained compared to 1 716 in 2004. Universities and bridging courses, however, showed an increase since 1996, with 360 and 1,169 trained professional nurses increasing to 428 and 2,103 in 2004 respectively. Although the overall number of professional nurses produced by universities is relatively small compared to that of nursing colleges and bridging courses, nurses that graduate from university programmes are more academic and research-focused, often following a career in academia, which is imperative for the professional status of nursing (SANC, 2006; Subedar, 2005:91-93).

Overall nurse training from 1996 to 2004, produced a total of 34 364 professional nurses in South Africa, with nursing colleges producing 15 824 of this number, universities 3 576 of this number and bridging courses the remaining 14 864. Shocking though, is that during this exact time the SANC register had a growth of only 10 707 nurses on their register, representing 31.5% of those produced and further indicating an attrition rate of 68.5%. This occurrence was explained as a combination of reaching retirement age, morbidity and mortality, moving to other jobs and nurse migration (SANC, 2006; Subedar, 2005:93). This nurse shortage directly influences the nurse practitioner's ability to provide compassionate care, as he/she is exposed to the continuous stress of an increased workload, which increases his/her risk for developing compassion fatigue.

4.2.3.2 Migration

An estimated 300 nurses are leaving South Africa every month (Health Systems Trust, 2000). At the end of 2001, over 23 000 South African born nurses were employed in the United States of America, Britain, Canada and Australasia (Bateman, 2005:906). This is actually an appalling revelation when you consider

that South Africa, a middle income country is indirectly subsidizing first world countries, by carrying the burden of training costs.

The reasons for migration are numerous and varied including: low wages, few incentives, inadequate management support, work overload, staff shortages, poor working and living conditions, lack of resources, limited professional development and career opportunities, aggressive overseas recruitment, the impact of HIV and AIDS, unsafe work environments, poor management of health services, general decline of public services in South Africa, unstable work environments, economic instability, high crime rate, political insecurity, affirmative action policies, high cost of living, taxation levels and lack of educational opportunities for children (Buchan, 2006:21; Ehlers *et al.*, 2003:31; Connell *et al.,* 2007:1882; Sanders & Lloyd, 2005:80-81). This trend of nurse practitioners leaving South Africa can be seen as a negative downward spiral, because the more nurse practitioners emigrate, the more facilities become understaffed, with remaining nurse practitioners becoming even more overworked and increasingly demotivated, creating the desire within remaining nurse practitioners to follow this trend (Buchan 2006:22; Sanders & Lloyd, 2005:81).

The government has tried to combat this occurrence by introducing measures geared towards the recruiting and retaining of nurses. The one measure has been the provision of rural and scarce skills allowance, using monetary reward as an incentive to retain staff, with another measure being the increase of nurse practitioners' salary, which will take effect in 2008. An experienced intensive care or theatre nurse currently earns around R90 000 per annum, but with the new salary scale she will earn between R235 659 and R265 236 (DENOSA, 2007) depending on her experience. Although this shows a marked improvement, it is still not comparable to the salaries offered by rich world states. In Saudi Arabia a nurse practitioner will earn between R228 000 and R360 000 per annum, tax free, while in the UK a nurse practitioner will earn between R256

000 and R448 000, with nurses in Australia and Canada earning about twice as much as they would in South Africa (Sanders & Lloyd, 2005:80).

Another measure that has already been documented in the Nursing Act 33 of 2005, and will be implemented for the first time at the end of 2007, is the initiation of a compulsory community service year for professional nurses. This measure aims to distribute professional nurses throughout the country in a more equitable manner, to further educate professional nurses in the current health care setting, to lessen the burden of overworked public sector health care nurses, to counteract the loss of professional nurses to private and overseas migration and to regain some dividends on the huge state investments that training of professional nurses usurps. However noble and justified these aims may be, one cannot get around the fact that this measure is coercive in nature, and that professional nurses may experience this approach negatively (Van Rensburg, 2004:360). Only time will tell whether this measure has succeeded in delivering on the intended aims or has resulted as a further 'push' factor for nurse practitioners to migrate.

When evaluating the measures the government have thus far implemented to recruit and retain nurses, one has to wonder why they solely focus on monetary incentives, as improved wages alone will not fulfil most of the needs that have been voiced as reasons for migration. Furthermore, the fact that coercion has to be made use of to retain professional nurses is questionable, when there are many non-coercive, more positive approaches that can be used to retain nurses, such as strengthening work autonomy, encouraging open leadership, supporting career development, providing opportunities for training and promotion, adapting working time and shift work, reducing violence in the workplace and providing a safe work environment (Connell *et al.*, 2007:1886; Adams & Kennedy, 2006:45).

Evaluation of nurse practitioner staffing in South Africa presents with a bleak picture, not only for the population whose health and well-being is directly influenced by this shortage, but especially for nurse practitioners who are currently serving in health care services, and are literally overworked and underpaid. Even more devastating is that this dilemma shows no evidence of being mitigated, as nurse practitioner numbers continue to dwindle because of migration and an ageing workforce that surpasses the recruitment and production of newly qualified nurse practitioners. Although the government has tried to counteract this trend through monetary and coercive measures, it does not begin to address the numerous frustrations nurses have voiced, or alleviate the strain and distress of nurse practitioners currently in the profession, who are seemly disheartened and losing their fervour for compassionate caring in a country where the population is becoming ever more dependent on health care services. The continuous and prolonged exposure to these stressors has resulted in an increase of compassion fatigue amongst nurse practitioners.

4.2.4 Health status of the South African population

One cannot discuss the environment of the nurse practitioner, without focusing on the health of the population that he/she serves. With an ever increasing amount of money being invested into health care, and more equitable, appropriate, accessible, representative free health care being provided to South African citizens, the expectation would be that health care indicators would improve, but the present status in South Africa does not reflect this. Life expectancy at birth has decreased from 57 years to 51.4 years between 1996 and 2004 (Day & Gray, 2005:277), whilst the infant mortality rate has increased from 45 per 1000 live births to 52 per 1000 live births between 1990 and 2002, with child mortality rate having increased from 60 per 1000 live births to 65 per 1000 live births during the same time period and maternal mortality ratio has remained unchanged between 1990 and 2002, at 230 deaths per 100 000 live births (Day & Gray, 2005:328-330).

The HIV and AIDS epidemic is an often cited reason for nurse practitioners migrating out of Africa, which is understandable if you consider that Sub-Saharan Africa carries 71.5% of the world's HIV and AIDS infections (Ehlers, 2006; UNAIDS, 2006); add to this the TB epidemic which is in no way starting to level off and a very gloom future unfolds. There was an estimated 5 500 000 adults and children living with HIV and AIDS in South Africa in 2006, with an accompanied 320 000 deaths in that same year (UNAIDS, 2006). The HIV and AIDS prevalence rate has increased from 4.5% in 1995 to 11.4% in 2002, with the antenatal prevalence rate increasing from 10.4% in 1995 to 29.5% in 2005. The HIV and AIDS death rate has increased from 26.4% in 2000 to 55.8% in 2004, doubling the amount of AIDS orphans from 338 932 in 2002 to 626 000 in 2004 (Day & Gray, 2005:288-290). Furthermore, the incidence of TB has increased from 359.6 per 100 000 in 1999 to 550.1 per 100 000 in 2003, although DOTS population coverage and the cure rate have dramatically increased, with the fatality rate decreasing (Day & Gray, 2005:284-285).

Other aspects of the South African population that directly influence nursing, is the population growth and the ethnicity of the population. The mid-2005 population was estimated at approximately 46.9 million, compared to the census figure of October 2001, which was 44.8 million. Of this population the majority (72%) are Africans or an estimated 37.2 million, the white population an estimated 4.4 million, the coloured population an estimated 4.1 million and the Indian/Asian population an estimated 1.1 million (Day & Gray, 2005:265). The population growth has the obvious impact of an increased workload for an already understaffed health care system, while the ethnic composition of South Africa presents nurse practitioners with a multi-cultural environment, which places a further demand on nurse practitioners to become culturally competent.

Cultural competence has been defined as a process of integrating knowledge, attitudes and skills that enhances cross-cultural communication and allows the

nurse practitioner to function effectively in the context of cultural difference, or diversity (French, 2003:254; Andrews & Boyle, 1999:8). Cultural competence, requires of the nurse practitioner to become skilled and flexible in understanding their own and others' cultural values, beliefs, attitudes and practices that affect health, illness and health seeking behaviours, so as to accommodate different cultural needs and provide compassionate care with good outcomes (Adams & Kennedy, 2006:30).

Evaluation of the public health sector by health consumers does not portray this competency in nurse practitioners, where health care provision is experienced as largely negative and nurse practitioner's attitudes are seen as rude, lacking respect and racist, with patients even commenting that nurse practitioners have no love and make them *"feel like a piece of rubbish,"* while nurse practitioners counter that they provide good quality care, and although they admit to sometimes presenting with negative attitudes towards patients, it is because they abuse the health care services by coming in for trivial complaints and demanding treatment, even when it is not necessary (Gilson *et al.,* 2007:1424).

Both parties have valid points, but this situation proves that nurse practitioners are not considerate of patients' cultural values, beliefs, attitudes and practices of health seeking behaviour, and one has to wonder if in this current overcrowded, understaffed environment where time is of the essence and hundreds of patients are often served by one practitioner, cultural competence is truly attainable, when providing even the most basic care is proving impossible. For this reason, the multi-cultural environment in which nurse practitioners work, can be seen as just another encumbrance on already overburdened nurse practitioners.

In this section, the environment of the nurse practitioner has been discussed with specific focus on the transformations of the health care system, the financial and human resource disparities between the public and private sector, the declining

number of nurse practitioners in an already understaffed health care system, the growing population with declining general health, and the ever-increasing demands made of the nurse practitioner in a multi-cultural environment, all of which paints a very desperate picture of the nurse practitioners working environment. Discussion of these elements have shown that not only is the nurse practitioners' level of job satisfaction diminishing, but the prevalence of compassion discomfort, stress and fatigue is increasing, which directly affects compassionate care, as nurse practitioners become increasingly despondent and unfeeling in a situation that shows no signs of a swift recovery. In the next section of this chapter, the nursing practice is discussed and the philosophical, theoretical and legal frameworks that guide the nurse practitioner in her duty to care are explored.

4.3. NURSING PRACTICE

The meta-theoretical statement of nursing that was developed in chapter one (see 1.5.1.4) is used to guide the discussion of the nursing practice in this section of the chapter, in addition to the description of the philosophical, theoretical and legal boundaries that direct the nursing practice. In the statement, nursing practice refers to the art and science of compassionately caring for the individual, family and community to promote, maintain and restore health, as well as care for the dying. Promotion of health includes all the activities the nurse practitioner performs to assist the patient in attaining a higher level of health. Maintenance of health is all the activities the nurse practitioner performs to prevent illness and preserve health, while restoration of health includes all the nursing activities the nurse practitioner performs to reinstate the individual, family or community's previous level of functioning or health. The nursing activities that are provided by the nurse practitioner are adaptive and holistic in nature, catering to the individual, family and community's physical, psychological, social, intellectual and spiritual needs (Kozier *et al.*, 2000:8-9).

4.3.1 The philosophical framework of nursing in South Africa

A philosophical framework is comprised of the beliefs, convictions and foundations of a profession. The philosophical framework of nursing in South Africa directs the nursing practice and reflects the majority view of South African nurse practitioners regarding how nursing should be practiced. This philosophical framework has been published in the form of two documents, namely the Nurses' Pledge and the Credo (Muller, 2002:4).

4.3.1.1 The Nurses' Pledge

The ethical foundation of the nursing profession is vested in the Nurses' Pledge (derived from the Nightingale Pledge) and has been in use since the institution of nurse training in South Africa (Muller, 2002:4). The South African Nurses' Pledge is as follows:

I solemnly pledge myself to the service of humanity and will endeavour to practise my profession with conscience and with dignity.
I will maintain by all the means in my power the honour and the noble traditions of my profession.
The total health of my patients will be my first consideration.
I will hold in confidence all personal matters coming to my knowledge.
I will not permit consideration of religion, nationality, race or social standing to intervene between my duty and my patient.
I will maintain the utmost respect for human life.
I make these promises solemnly, freely and upon my honour.

When taking the Nurses' Pledge, the nurse practitioner enters into a verbal agreement with the community, promising to always put the patients' needs first - even above his/her own interests – through the provision of the best service-directed compassionate care (Muller, 2002:5). This is a considerable promise to make and one which is not to be taken lightly, however, looking at the nursing

practice of South Africa today, it is questionable whether this promise is being upheld or even considered by the majority of nurse practitioners.

4.3.1.2 The Credo

The Credo, which is also described as the *philosophical light beacons* (Searle *in* Muller, 2002:5), is a synopsis of South African nurse practitioners beliefs and convictions about nursing and includes:

i) Nursing is *belief* – in the fundamental worth of every human life and in the divine reason for the existence of this life; it is a belief that each human being is unique and irreplaceable and that the Creator of this world has charged humankind with grave responsibility for her or his own personal well-being and for the well-being of the rest of humankind. For nurses, this belief has deep significance, as it is the realisation that we are called to care, which makes our work and existence meaningful, and is something from which we derive support when our burden has become almost unbearable.

ii) Nursing is *faith* – in a Higher power that will assist us in doing what is expected of us, and that will guide us in our decisions and actions.

iii) Nursing is *yearning* – to be a worthy servant of humanity and an effective instrument of medical science.

iv) Nursing is *acceptance* – of the fact that every human being is unique with distinctive needs that have to be met on an individual basis; it is acceptance of the fact that nursing consists not only of a series of tasks that have to be performed or a set of procedures that have to be followed, but that it is a professional service to humankind that includes instrumental and expressive functions – the use of self, skills and resources.

v) Nursing is *transcending* the so-called nurse-patient relationship to a human being–human being relationship, where the nurse practitioner

respects all interpersonal relationships, has a positive view of the world and fosters hope within herself and others.

vi) Nursing is *conservation* and *change* – the conservation of a precious human life through different interventions of prevention, promotion, maintenance and rehabilitation.

vii) Nursing is *assistance* and *support* – not only for those who are dependent on the health staff, but also to colleagues who render health care services.

viii) Nursing is a *scientific process* – the nurse practitioner applies scientific skills during the treatment and care of the human being, so as to provide the best quality comprehensive care possible.

ix) Nursing is the *therapeutic use of the self*; it is using oneself to meet the needs others, making love visible.

Although the Credo embodies a super-ordinate Christian view of the profession, it is the philosophical stance taught to South African nurse practitioners. The Credo embraces at its central core the concept of **care**, which holds a three-fold accountability for the nurse practitioner - to God, mankind and the nursing profession - **caring** for mankind as a fellow human-being and as a nurse practitioner called by God with a specific purpose, in a profession whose business is **compassion** and **caring**.

As previously stated in the methodological statements (see 1.5.3), nursing consists of three orders; namely the nursing practice, the theories of nursing and the paradigmatic perspectives of nursing, which are interrelated and dependent on one another. The paradigmatic perspectives which influence and guide the beliefs of nurse practitioner have been discussed and in the next sections the theories of nursing and the nursing practice are discussed in greater detail.

4.3.2 Theories of Care

The nursing practice is based on a philosophy of care, thus nurse practitioners are expected to compassionately and caringly assist individuals, families and the community to obtain, retain, and maintain a state of health. In order to assume this responsibility of **compassionate caring**, nurse practitioners must also have a foundation of theoretical knowledge which is based on research findings. The two main nursing theories that direct compassionate care in the nursing profession are Martha Rodgers' theory (1970) and Jean Watson's theory (1979).

4.3.2.1 Martha Rogers' theory

Rogers' theory is dedicated to compassionate care, based on humanistic science and the knowledge bases of anthropology, sociology, astronomy, religion, history and mythology (Falco & Lobo, 1990:211-212). The theory reveals the essentialism of compassionate nursing care and the fact that nursing is the only science that studies the person as a whole. In her theory Rogers' has five underlying assumptions and they are:

1) Man is a holistic, unified energy field possessing his own integrity and manifesting characteristics that are more than and different from the sum of his parts.
2) Man and environment are continuously exchanging matter and energy with one another, resulting in mutual change.
3) The life process evolves irreversibly and uni-directionally along the space-time continuum.
4) Order, complexity, pattern and heterogeneity identify the man and reflect his innovative wholeness.
5) Man is characterized by the capacity for abstraction and imagery, language and thought, sensation and emotion (Quillin & Runk, 1983:252).

The central components of Rogers' model are of the unitary man and environment engaged in the life process, with these components being derived

from the combination of Rogers' four building blocks of her conceptual model, namely energy fields, openness, pattern and organization, and four dimensionality (Quillin & Runk, 1983:249-253). Although, this model in its entirety influences the nursing practice, it exceeds the scope of this study; and therefore only Rogers' view of nursing will be specified.

Rogers views nursing activity as creative and imaginative, rooted in abstract knowledge, intellectual judgment and compassion. She emphasizes the use of the nurse's own self, combined with the safe utilization of the skills and technology of the time, declaring that the focus of nursing is compassionate concern for the maintenance and promotion of health, the prevention of illness and caring of and rehabilitation of the sick and the disabled (Quillin & Runk, 1983:246).

4.3.2.2 Jean Watson's Theory

Watson's theory of care focuses on carative factors, based on a humanistic philosophy that is combined with a scientific knowledge base and includes the theories of existential humanism from Maslow, Rogers, Heidegger and Erikson, theories of stress and care from Selye and Lazarus, and theories of nursing from Leininger and Henderson (Talento, 1990:293).

In her theory Watson proposes assumptions and ten primary carative factors about the science of caring which form the framework of her work. These fundamental assumptions are:

1) Caring and love are the most basic and universal values that demonstrate our humaneness and they can only be practiced on an interpersonal level.
2) Caring consists of carative factors that satisfy human needs, nourish humanity and develop civilisation.

3) Caring and love must first be imposed on the caregiver, so that in treating him/herself with gentleness and dignity, he/she will be able to care for others in the same way.
4) Effective human caring promotes health and individual or family growth.
5) Caring responses accept a person not only as he/she is now, but as what he/she may become.
6) A caring environment is one that offers the development of potential, while allowing the person to choose the best action for him/herself at a given point in time.
7) The practice of caring integrates biophysical knowledge with knowledge of human behaviour to promote health and to provide assistance to those who are ill. A science of caring is therefore complementary to the science of curing.
8) The practice of caring is the most central and unifying focus for nursing practice.

These assumptions illustrate that caring is the essence of nursing and that health care must be based on human values and concern for the welfare of others (Watson 1988:32-33; Talento, 1990:293).

Watson further contends that moment-to-moment human caring by the nurse practitioner can assist a patient to gain control, become knowledgeable and implement health changes, and attain health or die a peaceful death. She explained this caring process by developing 10 carative factors which are achieved during the actual caring moment between the nurse and patient:

1) The formation of a *humanistic-altruistic system of values* shapes the basis of the other carative factors. Caring must be grounded in the values of kindness, concern, and love of self and others, which is mediated through one's own life experiences, the learning one gains, and exposure to the humanities that allows examination of one's own views, beliefs and

interactions with others and brings meaning to one's life (Watson 1988:34-35; 73).

2) The *instillation of faith-hope,* which emphasises the spiritual, and is essential to both carative and curative interventions, as it provides a sense of well-being through those beliefs which are important and meaningful to the individual (Watson 1988:49; 73).

3) The *cultivation of sensitivity to one's self and others,* involves the recognition of one's feelings which causes the nurse practitioner to become more authentic, promoting self-growth and self-actualization. This further leads to the recognition and acceptance of the feelings of others, which fosters growth in both the nurse practitioner and the patient with whom she interacts (Watson 1988:57-58; 73).

4) The *development of a helping-trust relationship,* through a mode of genuine, empathetic, warm and effective communication that establishes rapport and caring, which is the essential and most important element in helpful care (Watson 1988:59-60; 73).

5) The *promotion and acceptance of the expression of positive and negative feelings,* involves the acknowledgment of one's own feelings which improves self-awareness and ultimately the control over one's behaviours and actions. This further enables the nurse practitioner to help the patient accept his/her feelings as well, which allows both the nurse practitioner and the patient with whom he/she interacts to reach deeper levels of consciousness and personal growth (Watson 1988: 33; 73).

6) The *systematic use of the scientific problem-solving method for decision making,* which allows the nurse practitioner to synthesize information and make nursing decisions that affects patient care, within practice boundaries (Watson 1988:17-18; 73).

7) The *promotion of interpersonal teaching-learning,* provides patients with both information and alternatives to care for themselves, and determine personal needs. In order to fulfil this factor, the caring nurse tries to

understand the person's perceptions of the situation, his cognitive level, affect, readiness and motivation when sharing information, allowing the patient to individualise the information, and ultimately shifting the responsibility of health and wellness on the patient (Watson 1988:58-60; 73).

8) The *provision of a supportive, protective and corrective mental, physical, socio-cultural, and spiritual environment*, which include external factors, such as the environment, and internal factors, such as mental, spiritual or cultural activities the nurse practitioner uses to fulfil patient needs, and support and protect the patients' well-being (Watson 1988:54-55; 73).

9) *Assistance with gratification of human needs*, which consists of lower order biophysical needs or survival needs, such as the need for food and fluid, lower order psychosocial needs or functional needs, such as activity-inactivity or sexuality, higher order biophysical needs or integrative needs, such as achievement and affiliation and higher order psychosiocial needs or growth-seeking needs, such as self-actualization. Awareness of these needs by the nurse practitioner is important in helping the patient to attain optimal health and wellness (Watson 1988:73; 108).

10) The *allowance for existential-phenomenological forces*, which permits the nurse practitioner to view the patient holistically, understanding the meaning the person finds in life or helping the patient find meaning in difficult life events, while at the same time dealing with the patient as he/she is in relation to what he/she would like to be (Watson 1988:54; 73).

These assumptions and carative factors provide the foundation for the delivery of caring and helping behaviour from the nurse to the patient, and are summarized in Watson's description of nursing as: a human science of persons and human health-illness experiences that is concerned with promoting and restoring health, preventing illness and caring for the sick, mediated by professional, personal,

scientific, aesthetic and ethical human care transactions that help the person to achieve an optimal degree of inner harmony to promote self-knowledge, self-healing and insight into the meaning of life (Watson 1988:53-54; Talento, 1990:294-299).

These theories were discussed as they specifically root the **compassionate** caring philosophy of nursing in the theoretical foundation of the nursing profession, and so provide the basis on which nursing education, research and practice is centred; confirming that **compassionate care** is intrinsic to the provision of nursing care. The philosophy and theories of nursing guide the internal nursing identity of the nurse practitioner, while the laws of the country and regulations of the council direct and control the his/her professional actions.

4.3.3 Legal–Ethical Framework of the Nursing Practice

The practice of the nurse practitioner lies within a specific legal-ethical framework, with the broadest division being the legislation and legal reforms of South Africa, the next division including the legislation and legal reforms of the nurse practitioner as a member of the multi-disciplinary team and the last division including the legislation and legal reforms for the multi-dimensional nature of nursing interaction, as presented in Figure 4.3.

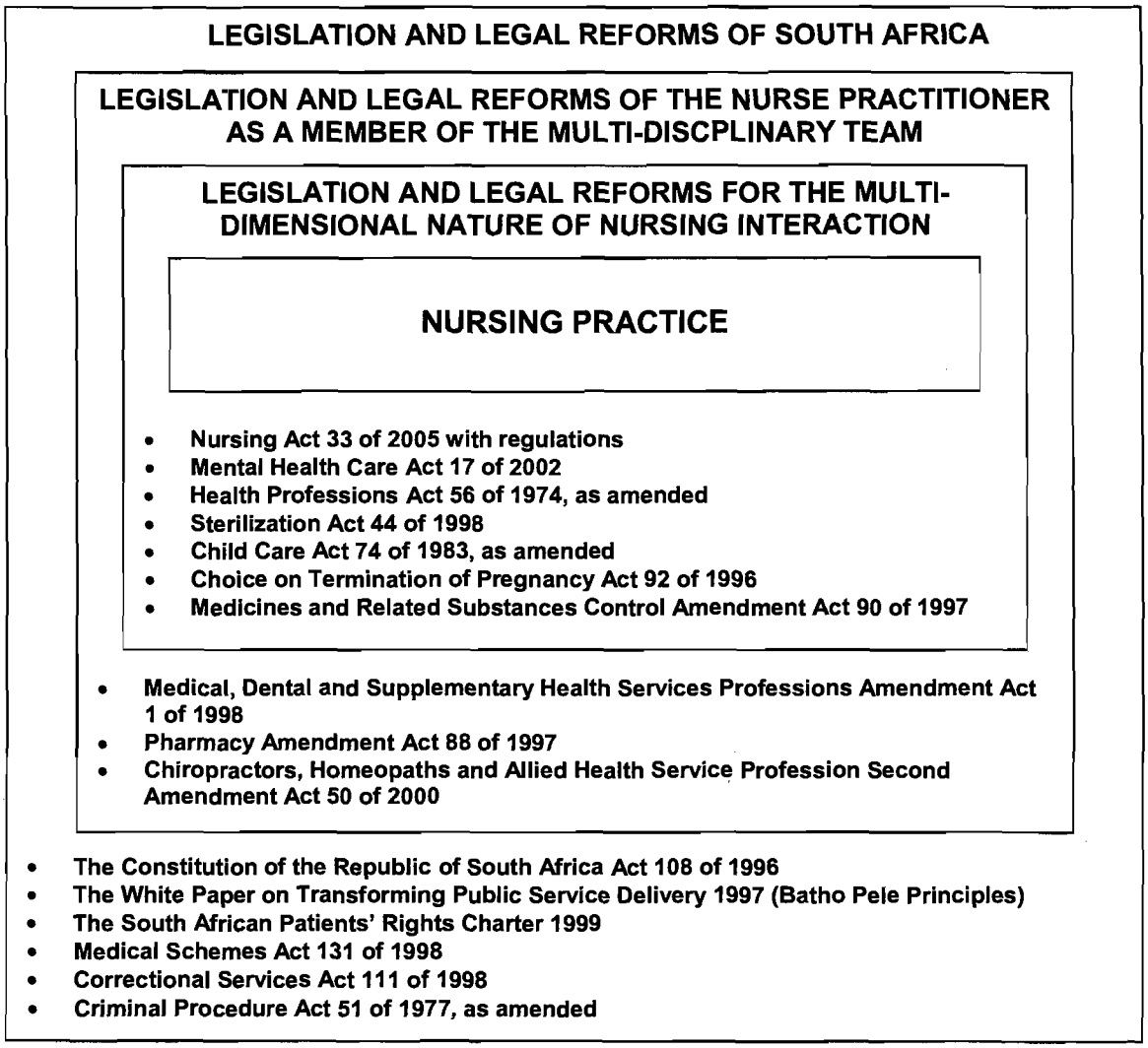


Figure 4.3 The legal-ethical framework of the nursing practice (Adapted from Klopper, 1994:139)

4.3.3.1 Legislation and legal reforms of South Africa

The Constitution of South Africa (1996), in particular Chapter 2, which describes the Bill of Rights, is the cornerstone of service delivery in the nursing profession, as it enshrines the rights of all people in the country and affirms the democratic rights of human dignity (Van Rensburg & Pelser, 2004:117). There are several

rights in the Constitution that either protect health rights or are related to health rights, these are reflected in Table 4.4.

Table 4.4 Constitutional rights related to health

Section (Paragraph)	The right
s12(2)	The right to bodily and psychological integrity, which includes the right: (a) to make decisions concerning reproduction (b) to security in and control of their body; and (c) not to be subjected to medical or scientific experiments without their informed consent
s24(a)	The right to an environment that is not harmful to their health and wellbeing
s27(1)(a)	The right to have access to health care services, including reproductive health care
s27(3)	The right to emergency medical treatment
s28(1)(c)	The right to basic nutrition, shelter, basic health care services and social services
s35(2)(e)	The right to conditions of detention that is consistent with human dignity, including at least, exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment.

(Republic of South Africa, 1996; Van Rensburg & Pelser, 2004:117)

In 1997, the Government released the *White Paper on Transforming Public Service Delivery* – also known as the *Batho Pele* or "people first" document. This public service transformation program set out eight transformation priorities with the goal of improving service delivery. These priorities called for new ways of working that were more responsive to and put the needs of the public first. The principles of Batho Pele require the nurse practitioner to comply with the following:

- *Consultation:* The citizens of South Africa should be consulted about the level and quality of public services they will receive, and wherever possible, should be given a choice about the services offered.

- *Service Standards*: The citizens of South Africa should be told what level and quality of public services they will receive so that they are aware of what to expect.
- Access: All citizens of South Africa should have equal access to the services to which they are entitled.
- Courtesy: All citizens of South Africa should be treated with courtesy and consideration.
- Information: All citizens of South Africa should be given full, accurate information about the public services that they are entitled to receive.
- Openness and Transparency: The citizens of South Africa should be informed about the administration of national and provincial departments.
- Redress: If a promised standard of service is not delivered, the citizen has a right to complain and should receive a sympathetic, positive response – including an apology, a full explanation, and a speedy and effective remedy.
- Value for money: public services should be provided economically and efficiently in order to give citizens the best possible value for money.

These principles are stated in broad terms so that the national and provincial departments, and even the nurse practitioners, can apply this in accordance to their own needs and circumstances (Republic of South Africa, 1997b; Muller, 2002:8; Van Rensburg & Pelser, 2004:119).

In 1999, the National Department of Health adopted the *Patients' Right Charter* as a common standard to help ensure the realization of patients' constitutional right of access to health care services. According to this Charter, the patient has the right to the following:

- a *healthy and safe* (health care) *environment*, including adequate water supply, sanitation and waste disposal, as well as protection from all forms of environmental danger such as pollution, ecological

degradation and infection, so as to as to ensure physical, mental and spiritual health or well-being of the patient;

- *access to health care*, including receiving timely emergency care; treatment and rehabilitation; provision for special needs; counselling that is free of discrimination; appropriate health information and health workers who are courteous, compassionate and tolerant;
- *confidentiality and privacy*, concerning the patients' health, treatment, management and health facility used, which may only be disclosed with informed and appropriate consent of the patient, except when required in terms of the law or duty;
- *informed consent* must be sought from the patient after he/she has been given full and accurate information by the health care provider, who is responsible for the execution of the interaction for which consent is required, in a language understood by the patient;
- a *second opinion* when at any stage he/she should consider it necessary, and in the case of referral, the choice of the clinician should be acceptable to the patient;
- a *choice in health care*, including use of other preferred health care;
- *continuity of health care*, which should be established through cooperation on the part of relevant health care workers or establishments that may be involved in the provision of health care;
- *complain* if treated in a manner experienced as being unacceptable, with necessary justification and feedback being received;
- *participate in decision making process* when it concerns his/her health;
- treatment *by a named health care provider* who can be clearly identified;
- *refuse treatment* after being provided with appropriate and accurate health care information in order to enable him/her to make an informed choice; and

- *knowledge of health care insurance* including full disclosure of all services that are not covered by the insurance and the opportunity to process an appeal (Department of Health, 1999; Muller, 2002:7-8; Van Rensburg & Pelser, 2004:119-120).

These three documents serve as the foundation of service delivery in the nursing profession and stipulate the rights of every South African citizen to good, quality, safe health care, of which the nurse practitioner is the primary provider. Additional legislation and legal reforms that influence the nursing practice are the *Medical Schemes Act 131 of 1998*, which aims to protect the interests of members of medical schemes by setting out guidelines on the terms and conditions for membership of schemes, the *Correctional Services Act 111 of 1998* and the *Criminal Procedure Act 51 of 1977 as amended* (Van Rensburg & Pelser, 2004:122)

4.3.3.2 Legislation and legal reforms of other health care practitioners

The *Medical, Dental and Supplementary Health Services Professions Amendment Act 1 of 1998*, the *Pharmacy Amendment Act 88 of 1997* and the *Chiropractors, Homeopaths and Allied Health Service Profession Second Amendment Act 50 of 2000* guide the practice of the respective health care practitioners, but also impact on the nurse practitioner who serves as a member of the multi-disciplinary team and has to carry knowledge of these acts (Van Rensburg & Pelser, 2004:121-123).

4.3.3.3 Legislation and legal reforms for the nursing profession

The most important Act guiding the nursing practice is the *Nursing Act 33 of 2005* along with regulations *G.K. No. 2598 of 30 November 1984*, which relates to the scope of practice of persons who are registered or enrolled under the nursing act and *G.K. R387 of 15 February 1985*, which contains the rules setting out the acts or omissions in respect of which the Council may take disciplinary steps.

The essential purpose of the *Nursing Act 33 of 2005* is: 1) to ensure societal approval of the nursing profession by providing competent and ethically controlled nursing service to society, through the regulation of the profession by statute; 2) to exclude all those who have not become or are not members of the profession in terms of the provisions of the Act for practicing for gain; 3) to provide for the aspirations of the profession by providing for peer group control in the form of a prescribed statutory body, which ensures an orderly co-operative statutory relationship between the nursing profession and other professions, and 4) to ensure contribution of the nursing profession to the development of health services by ascertaining that the training and education of the needed nurse practitioners takes place in an orderly manner that will not only safeguard the public well-being, but will also enable the practitioner to acquire recognised qualifications which have value as marketable commodities and ultimately enhance the socio-economic status of the profession (Searle, 2005:36-37; Republic of South Africa, 2005).

The fundamental purpose of *G.K. No. 2598 of 30 November 1984* is to delineate the scope of practice of persons who are registered or enrolled under the Nursing Act, with the largest part focussing on the provision of scientifically based physical, chemical, psychological, social, educational and technological care by the registered nurse, so as to promote health, prevent illness, restore health and care for the dying. While *G.K. R387 of 15 February 1985*, contains the rules setting out the acts or omissions in respect of which the council may take disciplinary steps. The main acts or omissions elaborated in this regulation includes: 1) wilful or negligent omission to maintain the health status of a patient under the nurse practitioners care or charge, including that of an emergency situation, 2) advertising, canvassing, itinerant practice, financial interest, acts and exhibition of certificates, tendering and cooperation, partnership and service contracts in private practice, 3) violation of the rights of the patient in the case of identification, trauma, injury, infection, professional secrecy and treatment of a

patient and 4) contravention of the nurse practitioners' role as a member of the multi-disciplinary team through acts or omissions in collaboration, referral, co-ordination, supersession, harming professional reputation and exploitation.

Other Acts that directly have an impact on and control the nursing practice are:

- *Mental Health Care Act 17 of 2002*, which provides for the care, treatment and rehabilitation of persons who are mentally ill; explains the different procedures to be followed in the admission of such a person; institutes Review Boards in respect of every health establishment, ascertaining their powers and functions; provides for the care and administration of the property of mentally ill persons; and repeals certain laws (Madela-Mntla, 2004:89).
- *Health Professions Act 56 of 1974, as amended,* establishes the Health Professions Council and provides control over the training, registration and practices of other health professionals in the multi-disciplinary team, with mention being made of nurse practitioners in this team (Madela-Mntla, 2004:115).
- *Sterilization Act 44 of 1998*, ensures that decisions about sterilization are made in a manner that is responsible and considerate, respecting the human dignity of persons and in particular those who are incapable of consenting or who are mentally disabled (Madela-Mntla, 2004:114).
- *Child Care Act 74 of 1983, as amended*, which provides for the establishment of Children's Courts and the appointment of commissioners of child welfare; sees to protection and welfare of certain children; adoption of children; presents the establishment of certain institutions for reception and treatment of children; and for contribution by certain persons towards the maintenance of certain children for incidental matters (Madela-Mntla, 2004:111).
- *Choice on Termination of Pregnancy Act 92 of 1996,* determines the circumstances and conditions under which the pregnancy of a woman may be terminated (Madela-Mntla, 2004:113).

- *Medicines and Related Substances Control Amendment Act 90 of 1997*, controls the possession, supply, administration and prescription of medicines by registered nurses and other professionals (Madela-Mntla, 2004:108).

These Acts and regulations serve to specifically direct and control the nursing practice and guide the nurse practitioner in fulfilling the needs of her patients through holistic, compassionate care which aims to promote health, prevent illness, restore health and care for the dying.

In this section the philosophical framework of nursing in South Africa, which is based centrally on the concept of care, was discussed at the hand of the Nurses' Pledge and Credo. Theories further expounding this concept of compassionate care were then explored, as they provide the knowledge that guide educational programs, research and professional practice. These theories, along with the legislation and legal reforms of South Africa, other health professions and the nurse profession itself prescribe the kind of nursing care to be delivered, so as to ensure that the rights of the public are respected. It was also documented in this section that while the philosophy, theory and practice of the nursing profession stipulates compassionate care, and although nurse practitioners are knowledgeable and undertake an oath to fulfil this calling, it is not reflected in the nursing practice of South Africa today.

4.4 NURSE PRACTITIONER

The meta-theoretical statement of man that was developed in chapter one (see 1.5.1.1) is used to guide the discussion of the nurse practitioner in this section of the chapter. The nurse practitioner, is a God-created, unique, multi-dimensional being that is called by God to love his/her fellow man as much as he/she loves himself, and to love God with all his/her heart, mind, soul and strength. The nurse practitioner therefore has a duty in his/her profession to deliver compassionate care to the sick, weak, traumatised and wounded patients in

his/her care, so as to act as an instrument of service and demonstrate the loving heart of God towards his/her fellow man.

This definition serves as the heart when discussing the nurse practitioner. According to Vander Zyl (2002:4-5), in order for nurse practitioners to be successful caregivers, they must be able to find meaning in their work. This requires involvement, commitment, and a sense of purpose in caring for others who are sick, weak, traumatised and wounded, with the nurse practitioner's perceptions of personal and professional self-worth being directly dependent on emotional connections with patients. However, when we refer back to Figure 3.1, the very first manifestations in the process of compassion fatigue is an inability to aid and a state of being desensitized, which increases in intensity with each progressive stage, ultimately resulting in a nurse practitioner who is callous, indifferent and unresponsive. Therefore, if emotional connection is the source of a nurse practitioners well-being, then compassion fatigue is a calamity for the nursing profession.

It deserves further mention that the nurse practitioner is a multi-dimensional being that consists of physical, social, emotional, intellectual and spiritual dimensions (see 1.5.1.1), which are integrated and dependent on one another, thus a process such as compassion fatigue directly impacts the nurse practitioner as a whole, with equally detrimental effects manifesting in all dimensions of the nurse practitioner (see 3.2.7.4) and affecting every area of his/her life – not only on a professional level, but also on personal level.

The causes of compassion fatigue have been identified in the connotative (theoretical) (see 3.2.5) and denotative (operational) definitions (see 3.3.1) as prolonged, continuous, and intense contact with patients, the use of self and exposure to stress. These causes were grounded in the literature (see 3.2.8) with specific stressors being identified (see 3.2.8.4) and further discussed in the

conceptual framework which focused on the environment (see 4.2) and the nursing practice (see 4.3). With all these stressors directly impacting on the nurse practitioner, his/her equilibrium is disturbed to such an extent that survival strategies are implemented to counteract the effects.

Valent (1995:28) describes survival strategies as stress responses of a higher level of complexity, which includes ideas, emotions and social interactions. These stress responses express themselves in biological, psychological and social arenas and may be either adaptive, where stresses are dealt with in such a way that life is not compromised, or maladaptive, where stresses are incorrectly or insufficiently dealt with, and life is compromised through strain, trauma and illness. When maladaptive survival strategies are implemented, defences are summoned to minimise the damage or prevent repetition of strain, trauma or illness, through numbing and fragmentation in the early stages and repression, phobias and displacement in the later phases.

Valent (2002:21) proposes eight different survival strategies which people use to counter stresses, in either an adaptive or maladaptive way; these include rescuing (caretaking), attaching, asserting (goal achievement), adapting (goal surrender), fighting, fleeing, competing and cooperating. The survival strategies of rescuing, asserting, adapting, and cooperating are most commonly used in nursing and are discussed according to the adaptive or maladaptive responses that a nurse practitioner may present with when faced with stressors.

- The survival strategy of rescuing is associated with the need to save others. The adaptive mode responds with care, empathy, devotion, responsibility, nurturing and altruism, but when nurse practitioners use maladaptive responses, there is a sense of depletion of one's resources and resentment towards the needy, which results in neglect, and even rejection, of the unwanted burdens of patients, with altruism turning into self-concern (Valent, 1995:32-33).

- The survival strategy of asserting is associated with goal achievement. The adaptive mode is associated with feelings of strength, high morale, potency, success and control, while maladaptive responses present with feelings of frustration, low morale, powerlessness, failure and loss of control (Valent, 1995:32; 34-35).
- The survival strategy of adapting is associated with surrendering goals, such as in the case of death. Adaptive responses including that of acceptance, mourning, hope, yielding and turning to new, while the maladaptive mode is associated with helplessness, depression, despair, withdrawal, being overwhelmed and giving in (Valent, 1995:32; 36).
- The survival strategy of cooperating is evoked when it appears necessary to become a trusting partner with others to create mutual essentials. The nurse practitioner responds adaptively by displaying generosity, creativity, mutuality, reciprocity and sharing, while feelings of exploitation, identification with anger, stagnation and disintegration are characteristics of maladaptive responses (Valent, 1995:32; 40-41).

The survival strategies represent the fact that the nurse practitioner's response to stress directly affects his/her ability to provide compassionate care; with adaptive responses resulting in compassion satisfaction and maladaptive responses resulting in compassion fatigue, which impedes compassionate care. The reasons for the nurse practitioner assuming either adaptive or maladaptive survival strategies in response to stress, is not evident in the literature and therefore lends itself to further research.

4.5 CONCLUSION

In this chapter, the three main constructs in which compassion fatigue is embedded, namely the environment, the nursing practice and the nurse practitioner was described and explicated by means of a conceptual framework. The interconnectedness between these different constructs were graphically

expressed in a conceptual map (see figure 4.1), which portrayed the fact that the stressors from the environment and nursing practice directly affect the nurse practitioner as a whole – physically, emotionally, socially, spiritually and intellectually. These stressors disturb the equilibrium of the nurse practitioner to such an extent that survival strategies are implemented to counteract the effects.

These survival strategies are either adaptive or maladaptive in nature. Adaptive survival strategies result in compassion satisfaction, where the nurse practitioner is able to provide compassionate care. The ability to provide compassionate care leads to meaningful and purposeful interactions between the nurse practitioner and the patient, which fulfils the patient's needs and enables the nurse practitioner to find meaning in his/her work. Maladaptive survival strategies, on the other hand, result in compassion fatigue, which causes the nurse practitioner to gradually distance and isolate her/himself from the patient, as the process of compassion fatigue progresses from compassion discomfort, to compassion stress and finally to compassion fatigue. These processes directly interfere with the nurse practitioner's ability to emotionally connect with and compassionately care for patients, which leaves both the patient and nurse practitioner unfulfilled and dissatisfied, directly affecting the personal and profession self-worth of the nurse practitioner and bringing into question his/her meaning and purpose as a nurse. The compassion satisfied or fatigued nurse, in turn, influences the environment and nursing practice in which he/she serves (see figure 4.1).

CHAPTER FIVE

EVALUATION OF THE STUDY AND RECOMMENDATIONS FOR PRACTICE, EDUCATION AND RESEARCH

5.1 INTRODUCTION

In this chapter the study is evaluated, limitations are identified and recommendations are made for practice, education and further research.

5.2 EVALUATION OF THE STUDY

The overall aim of this study was to define compassion fatigue within the nursing profession, and in order to achieve this aim, three research questions were asked, with the philosophical inquiry design guiding all aspects of the research process. The first research question asked was, "What is compassion fatigue within the context of the nursing profession?" To realise this objective, a concept analysis of the root words of compassion fatigue, namely 'compassion' and 'fatigue' was performed using the method of Walker and Avant (2005), which is based on the original method of Wilson (1987). Through the process of concept analysis, the characteristics (connotations) of compassion and fatigue were listed, ordered and reduced to identify the defining characteristics (connotations) and the four categories of compassion fatigue, namely *risk factors*, *causes*, *process* and *manifestations* (see 3.2.4). These defining characteristics (connotations) and categories were then used to clarify the meaning of compassion fatigue through the synthesis of a connotative (theoretical) definition (see 3.2.5). A model case (see 3.2.6), borderline case (see 3.2.7.1) and contrary (see 3.2.7.2) case was then described to confirm the defining characteristics (connotations) of the concept. The categories and defining characteristics were

further established through an integrative literature control (see 3.2.8) that grounded the findings of the concept analysis.

The second question presented was "what are the empirical indicators of compassion fatigue?" The empirical indicators of compassion fatigue were identified from the characteristics (connotations) of compassion fatigue and the integrative literature control, with the listed empirical indicators being ordered and reduced (see 3.3), so as to permit the formulation of a denotative (operational) definition of compassion fatigue (see 3.3.1).

The last research question expressed was "what are the constructs of the conceptual framework?" This question was answered through a literature review of the main constructs embedded in compassion fatigue, namely the environment, the nursing practice and the nurse practitioner. These constructs were described in detail and the relationship between these constructs and compassion fatigue explicated, with their interconnectedness being graphically presented in a conceptual map (see Figure 4.1). Through the achievement of all these objectives, the central theoretical argument stated in Chapter 1 (see 1.5.2.1) was attained.

The significance and uniqueness of this study is evidenced by the fact that it is the first study to synthesize a connotative (theoretical) and denotative (operational) definition of compassion fatigue, specific to the nursing profession. Furthermore, the fact that literature sources were used from the nursing discipline, in addition to both the medical and psychology disciplines, as well as the findings being grounded in literature of the nursing, medicine, psychology, occupational therapy, social work, police, emergency medical services, religious and hospice professions makes this definition applicable to the broader human service professions as well. As a result, this study is essential to the knowledge base of the nursing profession, and even to the broader human service professions, where there has been no specific definition for the concept of

compassion fatigue to date, as evidenced by the literature, where confusing, ambiguous, vague and amalgamated definitions of various concepts have been used to define compassion fatigue.

This study also presents the urgency of dealing with compassion fatigue in our profession, with the analysis presenting the cumulative and progressive nature thereof. More disturbing is the finding that if compassion fatigue is not effaced in its early stages of compassion discomfort and compassion stress, it seems that power of recovery is lost and full restoration of the previous level of compassionate functioning is unattainable. The manifestations of this cumulative process and especially the final phase of compassion fatigue are calamitous for the nursing profession, which requires as a basis, a caring and compassionate practitioner. This study will allow nurse practitioners and human service professionals to identify compassion discomfort and compassion stress within themselves and their colleagues, giving them the opportunity to take action before the progression to compassion fatigue.

Furthermore, the empirical indicators, the denotative (operational) definition and the conceptual framework which expounded the constructs embedded in compassion fatigue, provide the content and theoretical basis for future instrument development, which will make measurement of compassion fatigue within nurse practitioners possible.

5.3 LIMITATIONS OF THE STUDY

The following aspects have been identified as limitations of the study.

- The lack of an empirical phase may be seen as a limitation of this study. As previously mentioned this is the first study that has defined compassion fatigue within the nursing profession, which implies that the concept first had to be studied in depth, before it could theoretically clarified and scientifically grounded. As a result of the profundity and magnitude of this

process, it was decided that adding a further empirical phase to this study would not be attainable. Therefore, the researcher will use the empirical indicators and conceptual framework identified in this study as the content and theoretical basis for the development of an instrument in a future study, which will be validated and empirically tested in the nursing practice to ensure reliability and validity in the measurement of compassion fatigue amongst nurse practitioners.

- Limited sources on compassion fatigue were available, especially in the nursing profession, and the sources that were available made use of uncharacteristic, ambiguous, vague and amalgamated definitions of various concepts to define compassion fatigue, which further emphasizes the need for this study.
- Use of the popular internet encyclopaedic resource, Wikipedia, may be seen as a limitation, but the fact that it validated and further enriched the identified characteristics of compassion and fatigue, justified its inclusion in the concept analysis process.

5.4 RECOMMENDATIONS FOR PRACTICE, EDUCATION AND FURTHER RESEARCH

The following serve as recommendations for the practice, education and further research in nursing.

5.4.1 Practice

The researcher makes the following recommendations for the nursing practice:

- The findings of this study can be used to give in-service training to nurse practitioners about the risk factors and causes of compassion fatigue, the cumulative and progressive process of compassion fatigue, as well as the manifestations of compassion discomfort, compassion stress and compassion fatigue, so that nurse practitioners can be aware of and take adequate measures to prevent the development and progression of compassion fatigue.

- The increased knowledge of the existence of compassion fatigue and its manifestations would enable nurse practitioners to become aware of others that may be suffering form compassion fatigue and would facilitate the development of a peer support network, which will make it possible for nurse practitioners to seek assistance in dealing with the detrimental effects of compassion fatigue.
- An employee assistance programme should be established in every health care institution, with free counselling and life skill education services being offered to every nurse practitioner, which will afford them the opportunity to seek assistance in dealing with the emotional burdens of their work, so as to prevent the development and progression of compassion fatigue.

5.4.2 Education

The researcher makes the following recommendations for nursing education:

- The findings of this study can be used to educate nursing students about the risk factors and causes of compassion fatigue, the cumulative and progressive process of compassion fatigue, as well as the manifestations of compassion discomfort, compassion stress and compassion fatigue. This will arm nursing students with pertinent and useful information that will allow them to cope with work stressors, develop protective measures and implement self-care skills as novices in the field, so as to prevent the development and progression of compassion fatigue.

5.4.3 Research

The researcher makes the following recommendations for further nursing research:

- To develop a reliable, validated instrument to measure compassion fatigue amongst nurse practitioners, and even human service profession at large.

- To determine the factors that contribute to the progression from compassion discomfort to compassion stress and finally to compassion fatigue, and the average time-line involved in this progressive process.
- To investigate what interventions can be implemented to prevent, reduce and efface compassion discomfort and compassion stress.
- To explore the reasons for the nurse practitioner assuming either adaptive or maladaptive survival strategies in response to stress.
- To determine whether recovery from compassion fatigue is indeed possible, or whether compassion ability is permanently altered.

5.5 CONCLUSION

In this final chapter, the study was evaluated, limitations were stated and recommendations for practice, education and future research were made. The aim of this study was to define compassion fatigue within the nursing profession and through the methods of a concept analysis, identification of empirical indicators and the development of a conceptual framework, the objectives stated in this study were achieved and the overall aim of the study was successfully accomplished.

This study had a dynamic impact on the researcher, not only creating insight into the concept of compassion fatigue, but arousing in the researcher an awareness of the extreme threat that compassion fatigue is to the nursing profession. It further inspired the researcher to plan future studies within this subject field, so as to combat this seemingly compassionless culture developing amongst nurse practitioners.

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