

Compassion Fatigue among Nurses: The Cost of Having a Relationship with HIV-Positive Patients

Mercia Tellie

<https://orcid.org/0000-0002-7559-040X>
University of South Africa
tellimj@unisa.ac.za

Ronell Leech

<https://orcid.org/0000-0002-6088-2717>
University of Pretoria, South Africa
ronell.leech@up.ac.za

Neltjie van Wyk

<https://orcid.org/0000-0002-9456-2121>
University of Pretoria, South Africa
neltjie.vanwyk@up.ac.za

Abstract

In the public healthcare sector in South Africa, nurses treat a large number of patients who are infected with the human immunodeficiency virus (HIV) on an outpatient basis. Many patients consult the nurses only when they experience symptoms due to the delayed onset of antiretroviral (ARV) treatment. The large number of patients and often poor outcome of treatment could result in compassion fatigue in the nurses. The aim of the current study was to describe the cost of having a relationship with HIV-positive patients on nurses who work in outpatient ARV clinics. A qualitative, single, embedded case study design was used, and six registered nurses (RNs) and one enrolled nurse (EN) were individually interviewed. The data analysis revealed two themes, namely: (1) the risk of developing compassion fatigue; and (2) the manifestation of compassion fatigue. The themes were discussed with reference to the extant literature. Many research reports have focused on compassion fatigue in nurses in hospital-based settings, but few on the manifestation of compassion fatigue in nurses who work in outpatient settings. The authors concluded that nurses who take care of HIV-positive patients on an outpatient basis are at risk of developing and do manifest compassion fatigue, and it is thus recommended that programmes be instituted to support them.

Keywords: outpatient ARV clinic; compassion fatigue; nurse-patient relationship; manifestation; HIV-positive patients



Africa Journal of Nursing and Midwifery
<https://upjournals.co.za/index.php/AJNM/index>
Volume 22 | Number 2 | 2020 | #6937 | 19 pages

<https://doi.org/10.25159/2520-5293/6937>
ISSN 2520-5293 (Online)
© Author(s) 2020



Published by Unisa Press. This is an Open Access article distributed under the terms of the Creative Commons Attribution-ShareAlike 4.0 International License (<https://creativecommons.org/licenses/by-sa/4.0/>)

Introduction and Background

Compassion fatigue is often referred to as the “cost of caring” for others who are suffering (Boyle 2015, 49). Nurses who work in antiretroviral (ARV) clinics play a pivotal role in providing care for patients who are infected with the human immunodeficiency virus (HIV) and require complex care, which may cause nurses to feel overburdened (Haoses-Gorases, Katjire and Goraseb 2013, 90; 92). Working in these demanding circumstances often results in nurses feeling overwhelmed with heightened stress levels placing them at an increased risk of developing compassion fatigue (Bam and Naidoo 2014, 14). Unfortunately, helping others in distress may adversely affect nurses (Turgoose and Maddox 2017, 172) and they may develop compassion fatigue (Adwan 2014, 334).

Compassion fatigue among nurses has recently been studied in diverse settings. People who work in caregiving professions experience compassion fatigue and it is associated with exposure to patients’ and their families’ emotional/physical trauma, loss or grief (Kotula 2015, 2). Compassion fatigue affects nurses physically, emotionally and spiritually, with the result that nurses are unable to demonstrate caring or empathy towards others (Lachman 2016, 275). The current study aimed to describe nurses’ experiences of working in outpatient ARV clinics and the cost of having a relationship with HIV-positive patients.

Problem Statement

Nurses who work in outpatient ARV clinics face many challenges, such as having to care for large numbers of traumatised patients under demanding circumstances that have a negative impact on their health. The patients that they care for are often the same age as them or their children causing them either to overidentify with or distance themselves from their patients. Bearing witness to their patients’ suffering increases nurses’ vulnerability to developing compassion fatigue. Subsequently, suffering from compassion fatigue negatively affects nurses’ ability to feel compassion towards their patients (Turgoose and Maddox 2017, 172). In turn, this may cause nurses to neglect their patients’ needs (Harris and Griffin 2015, 83) resulting in the quality of nursing care being compromised. Thus, there is a need to recognise that caring for HIV-positive patients can have a negative effect on nurses’ wellbeing and result in substandard nursing care. In some instances, nurses may either leave the profession or request a transfer to another unit, which would exacerbate the issue of short-staffed ARV clinics. Hence, the current study aimed to identify factors that cause nurses to be at risk of developing compassion fatigue when caring for HIV-positive patients.

Research Questions

The following research questions guided the study:

1. What is the risk of nurses developing compassion fatigue?
2. How does compassion fatigue manifest among nurses who work in outpatient ARV clinics?

Aim and Objectives of the Study

The aim of the study was to describe the cost of having a relationship with HIV-positive patients for nurses who work in outpatient ARV clinics. The objectives of the study were to:

- identify the risk of nurses developing compassion fatigue; and
- describe how compassion fatigue manifests among nurses who work in outpatient ARV clinics.

Theoretical Framework

The researcher used Watson's Theory of Human Caring (1988), Erikson's Theory of Human Development (1997) and Figley's Compassion Fatigue Etiological Model (2002) as the basis for the theoretical framework to better understand the risk of developing and the manifestation of compassion fatigue among nurses who work in outpatient ARV clinics. Caring is the core of nursing and nurses are mandated to provide compassionate care to help their patients to achieve optimal health and wellbeing (Watson 1988). Being a caring nurse requires compassion, a positive attitude and a desire to relieve patients' suffering; thus, nurses do become emotionally involved with their patients and this can increase their vulnerability to develop compassion fatigue (Figley 1995). According to Erikson's Theory of Human Development (1997), people experience eight "psychosocial crises" which play a role in their development and personality.

However, for the current study the researcher focused only on the first developmental stage, namely, the development of basic trust and mistrust. A sense of trust is acquired during the first year of life according to Erikson's Theory of Human Development (1997). It is important for nurses to develop a sense of trust and maintain a helping, trusting relationship with their patients (Watson 1988) because it will give nurses the hope that they may contribute positively towards their patients' wellbeing. However, being exposed to their patients' trauma may shatter nurses' sense of trust thereby causing them to experience a sense of hopelessness (Erikson 1997). This is exacerbated by the lack of a cure for HIV/AIDS which causes nurses to feel that they are incapable of contributing positively towards their patients' health. People who are mistrusting cannot connect with others as ascribed by Watson (1988), and in such instances, nurses will withdraw from their patients in an attempt to protect themselves and will lose faith and hope for the future, which according to Figley (1995), are some of the signs and

symptoms of compassion fatigue. Compassion fatigue negatively affects the caring relationship between nurses and patients because nurses may either over identify with, or distance themselves from, their patients. Thus, there is a cost related to having a relationship with HIV-positive patients. It is important to be aware of the impact that caring for HIV-positive patients has on nurses' wellbeing since awareness is the key to preventing compassion fatigue.

Definitions of Keywords

- An **antiretroviral (ARV)** clinic is a healthcare setting that is situated either in a hospital, an outpatient department, a community health centre or a primary healthcare clinic that provides ARV treatment to HIV-positive patients who meet the eligible criteria.
- **Compassion fatigue** is the result of nurses' progressive, cumulative, prolonged, continuous and intense contact with traumatised patients, therapeutic use of self, and exposure to a multitude of stress factors that lead to compassion discomfort that exceeds the endurance level of professionals in the caring profession (Zhang et al. 2018, 1). For the purpose of the study, nurses who suffer from compassion fatigue have the ability to show empathy towards their patients; however, working with traumatised patients under difficult circumstance over a prolonged period; caring for terminally ill patients; and the therapeutic use of self, increase their risk of developing compassion fatigue. Compassion fatigue affects nurses' physical, psychological, emotional and behavioural wellbeing. Some of the symptoms exhibited by nurses in the study that can be associated with compassion fatigue include loss of passion for work, guilt, physical and emotional exhaustion, frustration, irrationality, hopelessness, depression, grief, overidentification with patients, despondency, anger, and intrusive recollection of events.
- The **human immunodeficiency virus (HIV)** causes HIV infection resulting in the destruction of the immune system with the result that individuals become more prone to infections (WHO 2017).
- A **nurse** is a person registered with the South African Nursing Council (SANC) in terms of section 31(1) of the Nursing Act (No. 33 of 2005), according to either Regulation R.425, R.683, or enrolled according to Regulation R.2175 (SANC 1993).

Research Methodology

A qualitative, single, embedded case study design, with three subunits as defined by Yin (2014), was used to explore and describe the risk of developing and the manifestation

of compassion fatigue among nurses working in the different outpatient ARV clinics. The three embedded subunits provided an opportunity to extensively explore the case while considering the influence that the different ARV clinics have on the risk of developing and the manifestation of compassion fatigue.

Research Setting

The study was conducted at three outpatient ARV clinics (embedded units) which formed the unit of analysis in a tertiary hospital where care for HIV-positive patients was provided free of charge. The study explored the risk of developing and the manifestation of compassion fatigue in nurses working in the three subunits, namely, the adult, paediatric and antenatal ARV clinics (see Figure 1). An operational manager managed these clinics, which were well resourced. At the time of the study, the services provided in the ARV clinics were doctor-centred and provided from Monday to Friday in the adult and paediatric clinics. In the antenatal clinic, care was provided by doctors and nurses, but the clinic only operated on Fridays. Several doctors and medical students did rotations at these clinics. Three registered nurses (RNs) and one enrolled nurse (EN) were allocated to the adult clinic, while two RNs worked in the paediatric clinic. A non-governmental organisation (NGO) seconded two RNs to work in the antenatal clinic.

Population and Sampling

After ethics approval was obtained from the Research Ethics Committee and the Gauteng Department of Health and the hospital management granted permission to conduct the study, the researcher made an appointment with the unit manager of the ARV clinics. During the meeting, the researcher used a study summary sheet that contained the nature, aim, purpose, procedure, risk and benefits of the study as well as the researcher's contact details. The researcher asked the unit manager to use the same information when she addressed the nurses in the different ARV clinics. The unit manager compiled a list of those nurses who showed an interest to participate in the study. The researcher used the list obtained from the unit manager and with her permission made appointments with potential participants on a day and time that was convenient for them to conduct the interviews. All the nurses who were recruited to participate in the study had been working on a permanent basis for at least six months. The sample consisted of six female RNs and one female EN. The participants' characteristics are listed in Table 1. Purposive sampling was used, and the sample size was determined by the number of nurses who worked in the outpatient ARV clinics, who fitted the selection criteria, and who were willing to participate in the study. They were labelled P1 to P7.

Data Collection

Individual semi-structured interviews were conducted. Aspects of trust, despair, hope, caring for patients infected with HIV, stress, compassion and empathy, compassion fatigue and the role of nurses in the outpatient ARV clinics were covered during the interviews. The interviews were conducted over two days in October 2009 and lasted approximately 60 minutes. All the interviews were audio recorded with the consent of the participants.

Data Analysis

The data was analysed using inductive content analysis guided by the steps as described by Elo and Kyngäs (2008). Subcategories were generated manually, then related subcategories were collapsed into categories. Through a process of abstraction two themes were generated. The researcher used two independent coders who signed a confidentiality agreement to verify all relevant themes, categories and subcategories. Consensus between the researcher and the independent coders was reached on the themes, categories and subcategories that were identified.

Ethical Considerations

Informed consent in writing was obtained from the participants, who retained the right to withdraw at any time. The participants were informed that participation was voluntary and all information provided would be kept confidential. The Faculty of Health Sciences Research Ethics Committee of the University of Pretoria approved the proposal, and permission to involve nurses from the clinics was granted by the Gauteng Department of Health and the chief executive officer of the tertiary hospital. The privacy of the participants and the hospital was respected, and the participants' names and the institution's identity were kept confidential in all reports.

Trustworthiness

Trustworthiness was ensured through a process of credibility, transferability, dependability and confirmability as described by Guba and Lincoln (1985). The researcher stayed in the field during data collection and used multiple data collection sources and two independent qualitative researchers to verify all the themes, categories and subcategories that had been identified. The researcher provided detailed descriptive information that will allow readers to decide whether the research findings can be applied to new situations. A process of triangulation using individual interviews and field notes, literature control and two independent coders, was used to ensure transferability of the findings. The researcher used two independent coders to verify the themes, categories and subcategories that were identified during the data analysis. The researcher used an interview guide and probing was allowed during the interviews to ensure that the

participants’ voices were heard. The researcher also reflected on her biases prior to data collection and analysis.

The researcher further ensured authenticity by keeping an audit trail. The raw data, interview guide, recorded interviews, written field notes, survey results, analysed data and process notes were kept. During the interviews, field notes were made to keep a record of the participants’ emotions and nonverbal expressions. The transcripts used will kept locked for 15 years for use by auditors.

Description of Participants

Seven nurses who worked in the adult, paediatric and ante-natal ARV clinics participated in the study. All the participants were trained in HIV care except for the EN (see Table 1 for the participants’ characteristics).

Table 1: Characteristics of participants

ARV clinic	Category of nurse	Age range	Years in clinic
Adult	Two RNs and one EN	47–64	5–6
Paediatric	Two RNs	43–48	3–11
Antenatal	Two RNs	41–45	3

Results

The analysis process yielded two themes, namely: (1) the risk of developing compassion fatigue; and (2) the manifestation of compassion fatigue (see Figure 1).

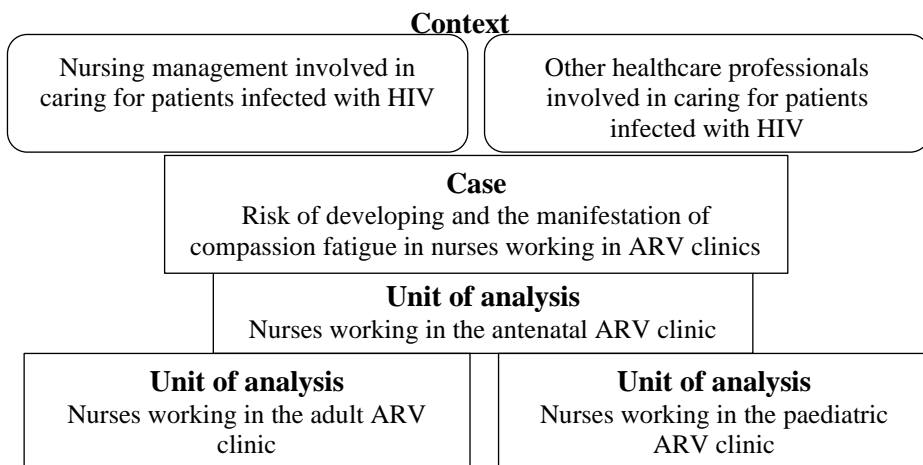


Figure 1: The case and its context

The Risk of Developing Compassion Fatigue

The participants were exposed to factors that increased their risk of developing compassion fatigue. They had to take care of traumatised patients who associated HIV infections with death, “They all say, ‘Oh I am going to die’” (P2), or who wanted to “commit suicide because of the diagnosis of HIV” (P1).

Some patients waited until they developed problems, which then forced them to seek medical help. When they consulted the participants, they were very ill:

They don’t seek help at an early stage, they waited until they developed some problems.
(P1)

The participants believed that the fear of the stigma associated with HIV infection prevented their patients from seeking treatment at an early stage:

The patients were suffering from denial and stigmatisation. A lot of patients do express the feeling of fear of dying ... they had one thing on their mind, [having] HIV means death. (P1)

The participants were frustrated when the patients discontinued their treatment and lied that they were still taking their medication regularly:

The viral load is up ... some of them will tell lies. (P3)

Other patients were not prepared to take the medication as they were afraid that their sex partners would know that they were HIV positive:

Women [were] not disclosing their status to their partners. (P3)

When children were involved, the participants felt heartbroken:

Sometimes I would cry seeing those babies suffering. (P3)

They were often unable to distance themselves from patients’ pain:

It makes you feel you are suffering yourself. (P1)

When women who have children got sick, the participants were very worried about the children’s future:

You become worried and you think that this mother is sick ... how [are] the children going to grow up without a mother? (P3)

The participants grieved when a patient passed away:

When they die, you grieve. (P2)

Talking about the death of their patients caused the participants to become emotional and the sadness was evident in their voices:

The deaths affect me ... it affects me big time ... the death of mothers ... knowing that they will leave these kids without a mother ... (P7)

However, due to the high caseload, the participants could not afford to grieve for too long over the death of patients:

I grieve and then let go because I have other patients to take care of. (P3)

The participants experienced guilt when they felt that they could have done more to prevent a patient's death:

If things were done differently maybe the patient would still be alive. (P6)

One participant stated that she could not stop thinking of her patients who died, and questions arose as to whether she had done enough for these patients:

You think about them when you are at home ... if maybe we had done this or that differently maybe they wouldn't have died. (P5)

Intrusive thoughts made them relive the events at work:

You think about them when you are at home. (P7)

Often it affected them mentally:

When you are alone, you'll think about the patients and it is affecting you mentally. (P5)

Some of the participants were unable to disengage from their patients and became pre-occupied with them:

You start going back reliving the events ... all those things ... remembering them ... you think about them when you are at home. (P7)

The participants could not maintain professional boundaries, which had negative consequences for them and their families:

You think of them when you are at home. (P2)

Another participant could not leave her responsibility towards patients at the clinic:

I took my job home. (P3)

After a busy day at the clinic the participants felt too tired to take care of their families:

Most of the time you don't give much attention to your family due to tiredness and fatigue. (P4)

When they got home, some participants could not attend to the challenges that their children presented:

You don't feel like being with your kids, you don't want them to disturb you ... you only want to rest. (P7).

The large number of patients made them feel despondent:

The more the numbers ... the less hope you have. (P2)

When their patients refused to use condoms, they felt hopeless:

That's when you feel you are fighting a losing battle. (P7)

Their high case load made them feel that they could not spend enough time with their patients:

We are short staffed ... we need more time with our patients. (P6)

The Manifestation of Compassion Fatigue

The participants indicated various ways in which compassion fatigue presented. Their physical energy levels were depleted:

... fatigue ... very tired ... you're drained. (P4)

One participant complained that she experienced dizziness:

Sometimes I am having this dizziness and become tired, whereas before I would not get tired. (P5)

Psychologically they were irrational, irritable, angry and depressed: "being irrational, angry" (P1) to the extent that one of them started shouting, "very irritable and I would just speak loudly" (P2). They also felt "tired of feeling pity" (P1) towards others.

Unfortunately, it also happened that some participants felt numb and no longer cared for their patients:

You come to a point when you lose that passion and that is compassion fatigue. (P3)

The way the participants identified compassion fatigue in their colleagues was in signs of tardiness:

They do not care anymore ... you can see it in the way they dress ... or maybe the hairstyle ... they do not comb their hair. (P6)

Discussion

Nurses are by nature caring and compassionate and they have an innate capacity to nurture and embrace another person's suffering to alleviate it. The researcher used Watson's Theory of Human Caring (1988) because it roots the compassionate caring philosophy of nursing and provides the basis on which nursing practice is centred. However, the nurses' ability to be compassionate and show empathy comes at a cost and makes them vulnerable to develop compassion fatigue (Figley 2002, 1436–1438). Their empathetic ability puts nurses at risk of developing compassion fatigue (Harris and Griffin 2015, 80). Nurses can show so much empathy towards their patients that they become exposed to the traumatic suffering of their patients (Harrowing 2011, 1). In noticing their patients suffer health care professionals such as nurses will make an effort to relieve their suffering through empathetic understanding. They project themselves into the perspective of their patient to have insight into their thoughts, feelings and behaviour (Watson 1988). However, being empathetic and getting emotionally involved in a caring relationship with HIV-positive patients comes at a cost (Boyle 2015, 49), and affects them physically, emotionally and psychologically (Ramathuba and Davhana-Maselele 2013, 15). Nurses are exposed to their patients' traumatic events daily (Wentzel and Brysiewicz, 2014, 82) and regard caring for HIV-positive people as stressful, demotivating and emotionally exhausting (Mohangi and Pretorius 2017, 153), causing an increased risk of them developing compassion fatigue. According to Figley (2002, 1437), nurses come into direct contact with their patients' traumatic experiences resulting in compassion stress and an increased risk of developing compassion fatigue.

Patients who have to come to terms with being HIV positive experience a range of negative emotions that cause them to delay seeking medical help (Bidwell 2014, 1). In addition, the fear of being associated with having an HIV infection often contributes to delays in getting treatment (Ramathuba and Davhana-Maselele 2013, 10). When these patients eventually visit the clinic, they are almost dying with a low CD4 count (Marshal, De Brouwere and Kegels 2005, 300). In such situations, clinic nurses – similar

to the study participants – are the first healthcare professionals to take care of the newly diagnosed and already very ill patients. Nurses may experience frustration when they work hard to encourage their patients to adhere to treatment (Boyle 2015, 50), while the patients are traumatised to the extent that they want to die (Chaponda et al. 2018, 8).

Caring for HIV-positive patients is very challenging. In the current study, the participants revealed that some of their patients contemplated committing suicide. Due to ignorance, people may view HIV infection as a death sentence and suicidal thoughts are thus not uncommon after a positive HIV diagnosis (Bidwell 2014, 3; Chaponda et al. 2018, 7). Patients feel that they are in any case going to die, therefore they may as well end their lives before they get very ill. Nurses have the daunting task of supporting patients with HIV-infection to adhere to treatment and to look forward to productive and healthy lives (Bam and Naidoo 2014, 7).

The study participants were frustrated by their patients' refusal to use condoms to prevent secondary HIV infection of themselves and to prevent the spread of HIV infection. Patients who are in denial and who do not want to take responsibility for their HIV status may exhibit negative behaviour (Zhou et al. 2017, 95), such as not using condoms. The participants in the study felt that they were fighting a losing battle when their patients refused to use condoms. According to them, HIV-positive patients who do not want to use condoms are increasing the number of newly diagnosed patients thus exacerbating the hopeless situation that the participants have to cope with. Feeling hopeless relates to prolonged exposure to trauma and having to deal with difficult situations (Harris and Griffin 2015, 83). Caring for HIV-positive patients traumatises nurses and, in turn, these traumatic experiences shatter nurses' assumptions of trust because they violate the nurses' sense of basic trust. Consequently, this leads to a breakdown of interpersonal trust which then leads to a sense of hopelessness (Figley and Barnes 2005, 390). Risky sexual behaviour and not using condoms among people living with HIV are the drivers of the HIV epidemic (Manjengwa, Mangold, Musekiwa and Kuonza 2019, 1). Patients who fear the social stigma of being HIV positive may refuse to use condoms when they do not want their partners to know about their HIV status (Ramathuba and Davhana-Maselele 2013, 10). It may also be that they want to have more children (Samuelsen, Norgaard and Ostergaard 2012, 67).

The number of HIV/AIDS-related deaths is still high (Bam and Naidoo 2014, 3). Nurses are faced daily with the death of their patients, which affects them emotionally and psychologically causing their vulnerability to compassion fatigue (Haoses-Gorases, Katjire and Goraseb 2013, 93). Dealing with the death of a patient can be traumatising and may result in compassion stress that in turn can result in compassion fatigue that may cause nurses to experience intrusive thoughts and memories related to the traumatic event (Figley 2002, 1438). In the current study, the participants became very emotional when children were suffering due to HIV infection. Without proper care, the children

of HIV-positive women are born with the HIV infection. These children receive care from nurses such as the participants of this study who worked in paediatric ARV clinics. Caring for very sick or terminally ill children can be emotionally exhausting and traumatising and affect nurses' ability to render compassionate care. It becomes very painful to witness the suffering of children and how they react when painful procedures are performed (Enerholm and Fagrell 2012, 12), and may result in compassion fatigue. Participants were also worried about the children's future when they noticed that the mothers were becoming sick. Millions of children in South Africa are orphaned due to HIV-related illnesses and the impact on these children of losing a parent is devastating. The death of a parent due to HIV/AIDS causes high rates of depression and post-traumatic stress among their children (Breckenridge, Black-Hughes, Rautenbach and McKinley 2019, 503).

The death of a patient is regarded as a traumatic experience for nurses and even more so when children die (Fisackerly et al. 2016, 370). The study participants cared for the patients (including children) who visited the clinics for the first time at a very late stage of infection. When the patients passed away, the nurses experienced grief. According to Rapp (2012, 75), being aware of the death of a patient creates an existential crisis for healthcare professionals. When nurses are confronted with many deaths within a short space of time, they often do not have time to grieve properly as they have to move on because there are many other patients who need their care; this unresolved grief affects nurses' wellbeing and makes them vulnerable to compassion fatigue. Due to their personal relationship with their patients and the vulnerable nature of their patients, nurses do experience intense emotions when their patients die (Kapoor et al. 2018, 1337; 1339). Feelings of guilt for not having been able to save the patients from dying are common (Granek et al. 2015, 134). The study participants also experienced guilt. Nurses may also experience a sense of defeat because they could not save their patients from dying or they feel that their actions could have hastened their patients' death (Harrowing 2011, 6). The inability of nurses to save their patients' lives can make them experience frustration (Granek et al. 2015, 137). HIV-positive patients should be able to live healthy and productive lives. When this does not happen, compassion fatigue may occur in the nurses who work with them (Adwan 2014, 335).

The participants could not distance themselves from the suffering of their patients. Nurses who become emotionally involved with their patients may end up being unable to attain a balance of empathy and objectivity resulting in them blurring boundaries and unable to distance themselves from their patients' pain and suffering (Figley 2002, 1438). According to Sheppard (2015, 57), when nurses become emotionally involved in their patients' suffering, they become susceptible to compassion fatigue. It can happen that nurses become so focused on their patients' health that they do not care for the negative impact it has on their own wellbeing (Bam and Naidoo 2014, 14). When nurses

are unable to disconnect from their patients, compassion fatigue occurs (Sheppard 2015, 58).

Furthermore, the participants complained about fatigue; they were very tired and felt emotionally drained. Nurses who are vicariously exposed to the traumatic experiences of their patients can develop compassion fatigue. Circumstances that make healthcare professionals vulnerable to compassion fatigue include over-identifying with patients, which results in the blurring of boundaries (Tosone, Nuttman-Shwartz and Stephens 2012, 233). With prolonged exposure to patients' trauma nurses may overidentify with their patients' memories of the traumatic event and this leads to an increase in the risk of developing compassion fatigue (Figley 2002, 1438). In the current study, the researcher found that some participants did have problems in separating their home and work life; they could not stop thinking about their patients when at home. In a study done by Sheppard (2015, 59) the participants had similar findings and they could not disconnect from their patients when away from work. They kept on thinking about them and on how their HIV-positive status affected them. Being exposed to patients' traumatic events may cause the nurses to have persistent, intrusive, distressing recollections of the events (Harrowing 2011, 8; 9). According to Figley (2002, 1438), being exposed to patients' traumatic experiences may cause nurses to recollect memories that could lead to an emotional reaction and increase their risk of developing compassion fatigue. Nurses become pre-occupied with their patients when the patients are the same age as them or their children (Tosone, Nuttman-Shwartz and Stephens 2012, 233) thus increasing their vulnerability to compassion fatigue (Sheppard 2015, 58).

Healthcare professionals who suffer from compassion fatigue feel emotionally exhausted to the extent that they may neglect their patients (Harris and Griffin 2015, 83). They consider the demands of caring for their patients overwhelming (Bam and Naidoo 2014, 14). To protect themselves from vicarious trauma they distance themselves from their patients' suffering (Boyle 2015, 50). According to Figley (1995, 12) a person who suffer from compassion fatigue will gradually feel worn down and overwhelmed by everything happening and will withdraw from the situation. Compassion fatigue does not only affect nurses but also their family members as they may transfer the negative energy from caring for traumatised patients to their own families (Sheppard 2015, 57). The study participants also complained of feeling hopeless and overwhelmed because of the size of the HIV epidemic; they became despondent, irrational, irritable, angry and depressed. In a study done by Rapp (2012, 8; 64) providers of HIV services experienced the same signs and symptoms; they lost their compassion, they just did not care anymore, and felt overwhelmed and irritable.

Recommendations

Recommendations for Practice

The needs of HIV-positive patients are complex. Some patients are initially in denial and thus delay seeking treatment until they experience symptoms that they can no longer ignore. These patients also tend to associate an HIV infection with a death sentence. Their need for comprehensive psychosocial support may cause compassion fatigue to manifest in the nurses who take care of them. It is recommended that nurses who treat HIV-positive patients in outpatient ARV clinics be made aware of the possibility that they can develop compassion fatigue. An increased knowledge of the existence and manifestation of compassion fatigue could enable nurses to become aware of their colleagues who may be suffering from compassion fatigue. It could also help them to identify their own risk of developing compassion fatigue and even the manifestation thereof in themselves. Clinic managers should be encouraged to establish support systems for nurses.

Recommendations for Future Research

Further research should focus on the risk of developing and the manifestation of compassion fatigue among nurses who work in primary healthcare settings where HIV care is nurse-driven, and nurses are responsible for the diagnosis, management and care of HIV-positive patients. It is recommended that male nurses be included in the study.

Limitations of the Study

The study findings cannot be generalised because the study took place in a tertiary hospital. A further limitation is that all the participants were female. Compassion fatigue may manifest differently in men; thus, the findings cannot be generalised for male nurses.

Conclusion

There is a cost related to caring for large numbers of traumatised patients over a long period of time (Figley 1995); thus, ascribing to Watson's Theory of Human Caring (1988), nurses enter into a caring relationship with their patients and show empathy towards them. Nurses' empathetic ability causes them to become vulnerable to developing compassion fatigue (Figley 1995). According to Erikson (1997), a sense of trust will cause nurses to have faith and hope that they will contribute positively towards the wellbeing of their patients. However, since there is no cure for HIV/AIDS and the number of new HIV infections continues to rise, nurses feel that irrespective of the care they provide to their patients, they are still going to die. Subsequently, nurses develop a sense of hopelessness and a feeling of guilt because they feel they are not doing enough to save their patients' lives. These factors have a negative effect on nurses' wellbeing.

Hence, programmes to identify nurses who are at risk of developing compassion fatigue and those who are already manifesting compassion fatigue need to be implemented at outpatient ARV clinics to eliminate risk factors and mitigate symptoms of compassion fatigue.

References

- Adwan, J. Z. 2014. "Pediatric Nurses' Grief Experiences, Burnout and Job Satisfaction." *Journal of Pediatric Nursing* 29 (4): 329–366. <https://doi.org/10.1016/j.pedn.2014.01.011>
- Bam, N. E., and J. R. Naidoo. 2014. "Nurses' Experiences in Palliative Care of Terminally-Ill HIV Patients in a Level 1 District Hospital." *Curationis* 37 (2): 1–19. <https://doi.org/10.4102/curationis.v37il.1238>
- Bidwell, R. 2014. "Supporting Patients." In *Human Resources and Services Administration Guide for HIV/AIDS Clinical Care*. Rockville: US Department of Health and Human Services.
- Boyle, D. A. 2015. "Compassion Fatigue: The Cost of Caring." *Nursing* 45 (7): 48–51. <https://doi.org/10.1097/01NURSE.0000461857.48809.a1>
- Breckenridge, T., A. Black-Hughes, C. Rautenbach, and M. McKinley. 2019. "HIV/AIDS Orphans in South Africa: NGO Interventions Supporting Transitions to Alternative Care." *International Journal of Social Work* 62 (2): 502–517. <https://doi.org/10.1177/0020872817732377>
- Chaponda, M., N. Aldhouse, M. Kroes, L. Wild, C. Robinson, and A. Smith. 2018. "Systematic Review of the Prevalence of Psychiatric Illness and Sleep Disturbances as Co-Morbidities of HIV Infection in the UK." *International Journal of STD and AIDS* 29 (7): 1–9. <https://doi.org/10.1177/0956462417750708>
- Enerholm, E., and L. Fagrell. 2012. "Registered Nurses' Experiences of Caring for Children with HIV/AIDS in South Africa." Accessed October 4, 2015. <http://catalogue.saf aids.net/sites/default/files/publications/FULLTEXT02.pdf> PRIMARY.pdf
- Elo, S., and H. Kyngäs. 2008. "The Qualitative Content Analysis Process." *Journal of Advanced Nursing* 62 (1): 107–115. <https://doi.org/10.1111/j.1365-2648.2007.04569.x>
- Erikson, E. H. 1997. *The Life Cycle Completed*. New York: W.W. Norton.
- Figley, C. R. 1995. *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York: Brunner/Mazel.

- Figley, C. R. 2002. "Compassion Fatigue: Psychotherapists' Chronic Lack of Self Care." *Psychotherapy in Practice* 58 (11): 1433–1441.
- Figley, C. R., and M. Barnes. 2005. "External Trauma and Families." In *Families and Change*, edited by P. C. McKenry and S. J. Price, 379–402. 3rd ed. <http://charlesfigley.com/publications/96-2/>
- Fisackerly, B. L., N. Sira, P. Priti, D. McCammon, and S. McCammon. 2016. "An Examination of Compassion Fatigue Risk in Certified Child Life Specialists." *Children's Health* 45 (4): 359–375. <http://dx.doi.org/10.1080/02739615.2015.1038716>
- Granek, L., U. Bartels, K. Scheinemann, M. Labrecque, and M. Barrera. 2015. "Grief Reactions and Impact of Patient Death on Pediatric Oncologists." *Pediatric Blood and Cancer* 62 (1): 134–142. <https://doi.org/10.1002/pbc.25228>
- Haoses-Gorases, L., M. Katjire, and M. Goraseb. 2013. "HIV/AIDS Workplace Stress and Fear among Nurses: Experiences in Windhoek (Namibia)." *Online Journal of Medicine and Medical Science Research* 2 (8): 90–96.
- Harris, C. H., and M. T. Q. Griffin. 2015. "Nursing on Empty: Compassion Fatigue Signs, Symptoms, and System Interventions." *Journal of Christian Nursing* 32 (2): 80–87. <https://doi.org/10.1097/CNJ.0000000000000155>
- Harrowing, J. N. 2011. "Compassion Practice by Ugandan Nurses Who Provide HIV Care." *Online Journal of Issues in Nursing* 16 (1): 1–15. <https://doi.org/10.3912/OJIN.Vol16N001Man05>
- Kapoor, S., C. K Morgan, M. A. Siddique, and K. K. Guntupalli. 2018. "'Sacred Pause' in the ICU: Evaluation of a Ritual and Intervention to Lower Distress and Burnout." *American Journal of Hospice and Palliative Medicine* 35 (10): 1337–1341. <https://doi.org/10.1177/1049909118768247>
- Kotula, K. R. 2015. "Compassion Fatigue in Critical Care Nursing and Development of an Educational Module." MSc dissertation, North Dakota State University. Accessed August 20, 2015. <https://library.ndsu.edu/ir/handle/10365/24813>
- Lachman, V. D. 2016. "Compassion Fatigue as a Threat to Ethical Practice: Identification, Personal and Workplace Prevention/Management Strategies." *MEDSURG Nursing* 25 (4): 275–278.
- Manjengwa, P. G., K. Mangold, A. Musekiwa, and L. R. Kuonza. 2019. "Cognitive and Behavioural Determinants of Multiple Sexual Partnerships and Condom Use in South Africa: Results of a National Survey." *Southern African Journal of HIV Medicine* 20 (1): 1–9. <https://doi.org/10.4102/sajhivmed.v20i1.868>

- Marshal, B., V. de Brouwere, and G. Kegels. 2005. "Viewpoints: HIV/AIDS and the Health Workforce Crisis: What Are the Next Steps?" *Tropical Medicines and International Health* 10 (4): 300–304. <https://doi.org/10.1111/j.1365-2005.01397.x>
- Mohangi, K., and S. Pretorius. 2017. "On the Periphery of HIV and AIDS: Reflection on Stress as Experienced by Caregivers in a Child Residential Care Facility in South Africa." *Journal des Aspects Sociaux du VIH/SIDA* 14 (1): 153–161.
- Ramathuba, D. U., and M. Davhana-Maselele. 2013. "Nurses' Perceptions of Support in Caring for People Living with HIV and AIDS (PLWHA) in Vhembe District, Limpopo Province." *International Journal of Research in Medical and Health Science* 3 (2): 7–17.
- Rapp, M. K. 2012. "Occupational Stressors among Providers of HIV Prevention and Support Services" MA dissertation, University of South Florida. Accessed October 10, 2019. <https://scholarcommons.usf.edu/etd/4210>
- SA (South Africa). 2005. Nursing Act 33 of 2005. Pretoria: Government Printer.
- Samuelson, H., O. Norgaard, and L. R. Ostergaard. 2012. "Social and Cultural Aspects of HIV and AIDS in West Africa: A Narrative Review of Qualitative Research." *SAHARA-J: Journal of Social Aspects of HIV/AIDS* 9 (2): 64–73. <https://doi.org/10.1080/17290376.2012.683580>
- SANC (South African Nursing Council). 1993. "Regulations Relating to the Course Leading to Enrolment as a Nurse." Accessed October 10, 2019. <https://www.sanc.co.za/regulat/Reg-nen.htm>
- Sheppard, K. 2015. "Compassion Fatigue among Registered Nurses: Connecting Theory and Research." *Applied Nursing Research* 28 (1): 57–59. <https://dx.doi.org/10.1016/j.apnr.2014.10.007>
- Tosone, C., O. Nuttman-Shwartz, and T. Stephens. 2012. "Shared Trauma: When the Professional is Personal." *Clinical Social Work Journal* 40 (2): 231–239. <https://doi.org/10.1007/s10615-012-0395-0>
- Turgoose, D., and L. Maddox. 2017. "Predictors of Compassion Fatigue in Mental Health Professionals: A Narrative Review." *Traumatology* 23 (2): 172–185. <https://doi.org/10.1037/trm0000116>
- Watson, J. 1988. *Nursing: Human Science and Human Care: A Theory of Nursing*. New York: National League for Nursing.

- Wentzel, D. L., and P. Brysiewicz. 2018. "A Survey of Compassion Satisfaction, Burnout and Compassion Fatigue in Nurses Practicing in Three Oncology Departments in Durban, South Africa." *International Journal of Africa Nursing Sciences* 8: 82–86. <https://doi.org/10.1016/j.ijans.2018.03.004>
- WHO (World Health Organization). 2017. "HIV/AIDS." Accessed October 10, 2019. www.who.int/features/qa/71/en/
- Yin, R. K. 2014. *Case Study Research: Design and Methods*. 5th ed. London: Sage.
- Zhang, Y-Y., C. Zhang, X. R. Han, W. Li, and Y. L. Wang. 2018. "Determinants of Compassion Satisfaction, Compassion Fatigue and Burnout in Nursing: A Correlative Meta-Analysis." *Medicine* 97 (6): e11086. <https://doi.org/10.1097/MD.00000000000011086>
- Zhou, Q., Y. Wu, Y. A. Hong, C. Yang, W. Cai, Y. Zhu, Z. Guo, and Y. Guo. 2017. "Association between Perceived Social Norm and Condom Use among People Living with HIV/AIDS in Guangzhou, China." *AIDS Care* 29 (1): 91–97. <https://doi.org/10.1080/09540121.2016.1198752>