

Research Article / Araştırma

The effect of COVID-19 pandemic period upon nurses' compassion fatigue

COVID-19 pandemi sürecinin hemşirelerin merhamet yorgunluğu üzerine etkisi

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ABSTRACT

Objective: Compassion fatigue is also defined as a physical, emotional, and mental decrease in working capacity together with burnout. This study was done to determine the effect of the COVID-19 pandemic period upon nurses' compassion fatigue. **Materials and methods:** This descriptive and cross-sectional study was done with 73 nurses between the 30th of January and the 28th of February, 2021. The data were gathered using an information request form developed in line with the literature and Compassion Fatigue Scale- Short Form. To assess the data; descriptive statistics, Independent Sample t-Test, One-Way ANOVA, and Pearson Correlation tests were employed. A difference was considered statistically significant if $p < 0.05$. **Result:** Nurses' average score in Compassion Fatigue Scale- Short Form (CFS/SF) was found to be 76.72 ± 19.58 . It was identified that those who were married showed significantly higher average scores in CFS/SF-secondary trauma subscale as compared to those who were single ($p < 0.05$) and those who used alcohol had higher scores in CFS/SF-trauma and burnout subscales and in total CFS/SF considerably as compared to those who did not use alcohol ($p < 0.05$). A significant, positive, and strong correlation was found between CFS/SF total and subscale average scores ($p < 0.001$). **Conclusion:** Nurses' compassion fatigue scores were determined to be above the average level. It may be recommended that nurses' compassion levels should be improved and nurses should be strengthened against negative effects of compassion fatigue and provided with psychological support at intervals.

Key Words:

COVID-19, Nursing, Compassion, Compassion Fatigue.

Anahtar Kelimeler:

COVID-19, Hemşirelik, Merhamet, Merhamet Yorgunluğu

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ÖZ

Amaç: Merhamet yorgunluğu, tükenmişlikle birlikte çalışma kapasitesinde fiziksel, duygusal ve zihinsel bir azalma olarak da tanımlanmaktadır. Bu çalışma COVID-19 pandemisi döneminin hemşirelerin çalışma alışkanlıkları üzerindeki etkisini belirlemek amacıyla yapılmıştır. merhamet yorgunluğu. **Gereç ve Yöntem:** Bu tanımlayıcı ve kesitsel tipteki bu çalışma, iki grup arasında 73 hemşire ile yapılmıştır. 30 Ocak ve 28 Şubat 2021 tarihleri arasında gerçekleştirilmiştir. Veriler bir "Bilgi Talep Formu" kullanılarak toplanmıştır Literatür doğrultusunda geliştirilen "Merhamet Yorgunluğu Ölçeği- Kısa Formu" kullanılmıştır. **Bulgular:** Hemşirelerin Merhamet Yorgunluğu Ölçeği- Kısa Form (CFS/SF) ortalama puanı 76.72 ± 19.58 . Evli olanların anlamlı bir şekilde CFS/SF-ikincil travma alt ölçeğinde daha yüksek ortalama puanlara sahip olanlara kıyasla bekar olanların ($p < 0.05$) ve alkol kullananların puanları daha yüksekti. CFS/SF-trauma ve tükenmişlik alt ölçeklerinde ve toplam CFS/SF'de alkol kullananlara kıyasla önemli ölçüde azalma görülmüştür ($p < 0.05$). CFS/SF toplam ve alt ölçek ortalama puanları arasında anlamlı, pozitif ve güçlü bir korelasyon bulunmuştur ($p < 0,001$). COVID-19 pandemi döneminde hemşirelerin en çok hissettiği beş duygu sırasıyla tükenmişlik (%27,4), yorgunluk (%15,1), korku %13,7 ve anksiyete; üzüntü (%9,6) olarak belirlendi. **Sonuçlar:** Hemşirelerin merhamet yorgunluğu puanlarının ortalamasının üzerinde olduğu belirlenmiştir. Hemşirelerin merhamet düzeylerinin geliştirilmesi ve hemşirelerin merhamet yorgunluğunun olumsuz etkilerine karşı güçlendirilmesi ve aralıklarla psikolojik destek sağlanması önerilebilir.

INTRODUCTION

The ease of transmission of the COVID-19 virus, the lack of population immunity on a global scale, delayed testing, limited medical equipment, uncertainty about the course of the pandemic, and the level of anxiety in society were factors that created risk in the health care system (Emilia et al., 2022). In the fight against the COVID-19 pandemic, nurses have been at the forefront of healthcare professionals and have been at

risk. During the pandemic, nurses found themselves with an intense care burden and long working hours (Katran et al., 2021). This stressful situation and long-term in-depth contact with patients and excessive empathy have caused mental health problems such as traumatic stress, burnout and compassion fatigue in nurses (Kock et al., 2021; Zhuang et al., 2020). Compassion is defined as the feeling of sympathy and sorrow in case of a misfortune that one faces (Özdelikara & Babur, 2020).

While providing health care services are being offered; compassion and compassionate care are considered as a key concept (Peters, 2018) because nursing is one of the professions that witnesses people's worst situations and offers them care and treatments by sympathizing with them (Berger et al., 2015). Compassion is a value that facilitates nursing care to be given by nurses (Şirin & Yurttaş, 2015). That nurses demonstrate compassion and empathy towards pains, traumas and discomforts of patients and they are constantly subjected to these situations makes them suffer from compassion fatigue (Duarte & Pinto-Gouveia, 2017; Nolte et al., 2017). In the literature, the concept of compassion fatigue has been defined as "the cost of care," "a unique burnout that affects caregivers," "empathy fatigue," or the emotional impact of trauma experienced indirectly while helping traumatized patients (Kock et al., 2021; Zhuang et al., 2020). In literature; compassion fatigue is used as "empathy fatigue", too (Dikmen, Aydın, & Tabakoğlu, 2016; Gök, 2015; Hiçdurmaz & Figen, 2015; Şirin & Yurttaş, 2015). Compassion fatigue is also defined as a physical, emotional and mental decrease in working capacity together with burnout (Nolte et al., 2017).

The term of compassion fatigue in nurses explains anger and helplessness feelings that nurses feel as a result of stress, anxiety and fear that they experience while offering care and treatment to patients who suffer from diseases or traumas. It is especially stated that health care professionals (physicians, nurses, psychologists, social service experts) and other professionals such as lawyers, judges, policemen and firefighters often suffer from compassion fatigue as a problem (Hevezi, 2016; Hiçdurmaz & Figen, 2015). Compassion fatigue is emphasized to be seen by 25%-50% in those who help people who are exposed to stress (Injeyan et al., 2011; Sinclair et al., 2017; Smith & Publicity, 2012). With COVID-19 pandemic period, work load of nurses increased and nearly all of the services in clinics were changed into pandemic services, nurses were banned from taking their day-offs and they had to isolate themselves from their beloved ones. Besides; numerous factors such as losses, virus contraction and death fear lead to fatigue and burnout in nurses. In literature; it is pointed out that compassion fatigue causes physical, emotional and sociological burnout in nurses as well as inability to give a compassionate care and treatment and a decrease in care quality and patient satisfaction by creating negative effects upon nurses (Makic, 2015; Wentzel & Brysiewicz, 2014), work dissatisfaction, impaired decision-making power, excessive working, a decrease in helping capacity, loss of empathy, intolerance, reluctance to go to work, fear, making errors, quitting work and a reduce in dependence (Hooper et al., 2010; Ruiz-Fernández et al., 2020; Şirin & Yurttaş, 2015).

The quality of care nurses provide to patients is closely related to their experience of compassion fatigue. Nurses who experience compassion fatigue may be reluctant, irritable, and insensitive in their caring role (Alcan et al., 2021; Katran et al., 2021). Depersonalization leads to an increase in medical errors, communication problems, and a decrease in the quality of patient care. This situation has been shown to be a major cause of decreased nurse satisfaction and turnover (Emilia et al., 2022; Katran et al., 2021).

The risk of nurses experiencing compassion fatigue and unknown uncertainties increased with the COVID-19 pandemic process (Katran et al., 2021; Söyler et al., 2023; Alcan et al., 2021). Therefore, the purpose of this study was to determine the increasing anxiety, fear, stress, workload, and compassion fatigue of nurses with the pandemic, to improve the quality of care, and to develop recommendations.

. We are of the opinion that this study will be making contributions to the literature so that necessary measures in nursing profession and patient care can be taken by determining the feelings and compassion fatigue levels of nurses caused by the work load which has already existed and elevated more during pandemic period and ambiguity of the pandemic period.

MATERIAL AND METHODS

Aim

The study was carried out in order to explore nurses' compassion fatigue and to shed light upon the relevant measures to be taken.

Type of The Study

The study was done in a descriptive and cross-sectional model.

Population and Sample of The Study

The population of the study consisted of nurses (n=83) working at a public hospital in Turkey. The sample of the study consisted of 73 nurses who did not take day-offs, met the inclusion criteria of the study, and agreed to join the study between the 30th of January and the 28th of February, 2021. No sampling was made and the whole population was targeted. 2 nurses who did not want to join the study, 3 nurses who filled in the forms incompletely, 5 nurses who took day-offs during the study were excluded from the study. The participation rate of the nurses was 87.9%. Inclusion Criteria; Working at a public hospital in Turkey and voluntariness to join the study were the inclusion criteria. Exclusion Criteria; Those nurses who did not want to join the study, those

who wanted to quit the study, those who filled in the forms incompletely, and those who took day-offs during the study were excluded from the study.

Data Collection and Data Collection Tools

The data were gathered using “Information Request Form” developed by the researchers in line with the literature (Dinç & Ekinci, 2019; Jenkins & Warren, 2012; Şirin & Yurttaş, 2015) and Compassion Fatigue Scale-Short Form (Dinç & Ekinci, 2019). Owing to the specific measures recommended during the pandemic; an online information request form was designed in order to prevent close contact and physical contact. To collect the data; the information request forms were administered to nurses with a link via Google form due to the COVID-19 pandemic. At the beginning of the information request forms; the objective of the study was explained, the participants were informed of the study with a consent-box, and informed consents of the participants were obtained. Data collection took nearly 5-10 minutes.

Information Request Form: Information Request Form was consisted of three parts: demographic data, questions relating to COVID-19 and Compassion Fatigue Scale questions. In the information request form designed by screening the literature (Dinç & Ekinci, 2019; Jenkins & Warren, 2012; Şirin & Yurttaş, 2015); there are a total of 18 questions -12 questions that involved nurses' socio-demographic characteristics (age, gender, educational status, marital status, number of children, income status, residence place, working-length (in years), presence of chronic diseases, habits) and 6 questions that addressed COVID-19 pandemic period (being COVID-19 contacted/ testing positive, having significant others that contracted with COVID-19/lost lives, providing care to COVID-19 patients, emotions/signs experienced most during pandemic period).

Compassion Fatigue Scale-Short Form (CFS/SF): CFS/SF was developed by Adams et al. (2006) and is a valid and reliable measuring scale to assess compassion fatigue (Adams et al., 2006). The scale is a self-rated scale and the participants are requested to mark how much the scale items reflect their experiences. It is a 10-point Likert scale with the coding ranging from rarely/never (1) to very often (10). The scale is consisted of two subscales: secondary trauma and professional burnout. In the scale; “c, e, h, j, l” items measure secondary trauma whereas “a, b, d, f, g, i, k, m” items measure professional burnout. The subscales' Cronbach alpha coefficients vary between 0.80 and 0.90 and the scale demonstrates a satisfactory internal reliability. No scoring algorithm or cutting point was stated. The lowest score to be obtained from the scale is 13 and the highest score is 130. As the scores to

be obtained from the scale go up so does compassion fatigue level of the individuals (Adams et al., 2006). The scale were performed Turkish validity and reliability tests of (Dinç & Ekinci, 2019). Cronbach α coefficient was 0.876 for CFS/SF; 0.748 for secondary trauma subscale and 0.852 for professional burnout subscale. In the current study; Cronbach α coefficient was 0.866 for CFS/SF; 0.696 for secondary trauma subscale and 0.783 for professional burnout subscale.

Ethical Considerations

Permission from the Ministry of Health Scientific Research Platform (2020-12-XXX), XXX School (XXX/ 04.12.2020 permission), XXX University Faculty of Medicine Local Ethics Committee (2020/25), permissions were obtained from the scale owners. Explanations were made to the nurses about the purpose, process and questionnaire form via the online link, and the written consents of the nurses were also obtained, stating that participation in the study was voluntary. This research was conducted in accordance with the Declaration of Helsinki, Principles of Good Clinical Practice.

Data Analysis

The data obtained through information request forms were processed with Statistical Package for the Social Sciences (SPSS) 24 program. Descriptive statistical figures of the data were calculated and Kolmogorov-Smirnov test was employed for normality test. In the statistical analysis; numbers, percentage distributions, standard deviation, means, minimum-maximum values were calculated. To compare means of the two groups' data that followed a normal distribution; Independent Sample t Test was employed whereas to compare the means of the multiple groups; One-Way ANOVA tests were used. The accepted level of significance for all analyses was $p < 0.05$.

Results

In the study; according to the analyses done with nurses' socio-demographic characteristics, 79.5% of the participants were female, 52.1% of them were aged 30 years, 63.0% of them were married, 57.5% of them had children, 71.2% of them had an undergraduate degree, 65.8% had an income lower than expenses, 80.8% of them resided in counties, 38.4% of them worked for 6-10 years, 89.0% of them did not have any chronic diseases, 79.5% of them did not smoke and 97.3% of them did not drink alcohol (Table 1). In the study; no significant correlation was found between CFS/SF-secondary trauma and professional burnout subscales and total scores and such socio-demographic

characteristics as age, gender, number of children, educational status, income status, residence place, working-length (in years), presence of chronic diseases and smoking ($p>0.05$) (Table 1). In the analysis done in terms of marital status; it was identified that those married participants demonstrated considerably higher average scores in CFS/SF-secondary trauma subscale as compared to the single participants ($p=0.044$). It was seen that drinking alcohol had significantly higher average scores in CFS/SF-secondary trauma subscale, CFS/SF-professional burnout subscale, and CFS/SF total average as compared to those not drinking alcohol ($p=0.017$, $p=0.000$, $p=0.000$; respectively) (Table 1).

In Table 2; no significant correlation was found between whether or not nurses had COVID-19 positive, were contacted with COVID-19 patients, one of the family members had COVID-19, they lost significant others/beloved ones due to COVID-19, they provided care and treatments to COVID-19 positive patients, they experienced intense emotions during COVID-19 and CFS/SF-secondary trauma subscale and CFS/SF-professional burnout subscale and scale total scores ($p>0.05$) (Table 2). During COVID-19 pandemic period; the most intense emotions experienced by nurses are burnout (27.3%), fatigue (15.1%), fear and anxiety (13.7%), sorrow (9.6%), unrest (5.5%), helplessness-unhappiness-sleeplessness (4.1%), and concern (2.7%); respectively (Table 2).

It was identified in the study that nurses' average score in CFS/SF was 76.72 ± 19.58 , their average score in CFS/SF-secondary trauma subscale was 29.63 ± 8.28 and their average score in CFS/SF-professional burnout subscale was 47.09 ± 12.16 . Cronbach Alpha values were 0.866 for CFS/SF, 0.696 for CFS/SF-secondary trauma subscale and 0.783 for CFS/SF-professional burnout subscale (Table 3).

When the correlation between participant nurses' average scores of CFS/SF and of subscales was investigated in Table 4; a strong and positive correlation was found between CFS/SF total score and CFS/SF-secondary trauma subscale ($p=0.000$) and CFS/SF-professional burnout subscale ($p=0.000$). Likewise; a significant and positive correlation was found between CFS/SF-secondary trauma subscale ($p=0.000$) and CFS/SF-professional burnout subscale ($p=0.000$) (Table 4).

DISCUSSION

It is stated that nurses who suffer from compassion fatigue generally experience physical, emotional and psychological burnout (Hiçdurmaz & Figen, 2015; Nolte et al., 2017). If compassion fatigue that nurses experience is not intervened in time, it may cause work-absenteeism, low health care quality, low ability to give

a compassionate care, poor patient satisfaction, low professional commitment level and low quality of life (Makic, 2015; Peters, 2018; Wentzel & Brysiewicz, 2014). It is argued that burnout feeling that health care workers have is associated with compassion fatigue (Crawford et al., 2014) and 40%-75% of the workers are negatively affected (Powell, 2020). It is important that compassion fatigue of nurses who are obliged to work more and need to be supported psychologically should be prevented and decreased. Therefore; in this study compassion fatigue of nurses was discussed with literature by exploring the effects of COVID-19 pandemic period upon their compassion fatigue.

In the study; nurses' CFS/SF total score, CFS/SF-secondary trauma score and CFS/SF-professional burnout average score were found to be above the average level. Additionally; it was seen that 27.3% of the nurses had burnout, 15.1% of them had fatigue, 13.7% of them had fear and anxiety, 9.6% of them had sorrow. In the study of Edmunds (Edmunds, 2010); 15.8% of the nurses suffered from compassion fatigue and 7.6% of them from burnout.

Nurses who work at busy clinical services may be affected by severe emotional discomforts correlated with the development of compassion fatigue and/or burnout (Alharbi et al., 2020). When the literature is looked at, there are studies that indicate that nurses' compassion fatigue and burnout average scores are lower (Hunsaker et al., 2015) and moderate (Mangoulia et al., 2015). COVID-19 pandemic leads to such symptoms that may influence nurses and other health care workers negatively as anxiety, stress, fear, fatigue (Jackson, 2020; Usher et al., 2020). These findings emphasize the importance of identifying nurses' compassion fatigue levels and compassion fatigue associated with these symptoms. It is one of the crucial steps that the institutions where nurses are employed should detect the critical situation and take necessary measures in order to protect both nurses' and patients' health before nurses go through compassion fatigue.

In the study; no significant correlation was detected between compassion fatigue level and variables of age, gender, number of children, educational status, income status, residence place, working-length (in years), presence of chronic diseases and smoking ($p>0.05$). When the literature is examined; it is seen that there are studies that have explored results similar to ours by stating that age, gender, educational status, working-length (in years) and compassion fatigue are not correlated (Edmunds, 2010) and those studies with results dissimilar to our findings (Ruiz-Fernández et al., 2020). It is underlined that compassion fatigue levels of nurses who work longer hours and who provide home

Table 1. Distribution Of Compassion Fatigue Short Scale Sub-Dimension And Total Score Averages According To The Sociodemographic Characteristics Of The Nurses (N = 73)

Sociodemographic Properties				CFS/SF Sub-Dimensions		CFS/SF Total score
N	%	Secondary Trauma X±SS	Occupational Burnout X±SS			
Age						
22-25	14	29.1	28.53±6.53	44.23 ±12.72	72.76±18.04	
25-28	21	28.8	29.57±10.42	45.57±13.60	75.14±23.56	
30 years and older	38	52.1	29.78±7.61	48.76±11.28	78.55±17.99	
F/p			F=0.496, p=0.689	F=0.657, p=0.581	F=0.525, p=0.667	
Gender						
Woman	58	79.5	30.12±7.92	48.29±11.35	78.41±18.33	
Male	15	20.5	27.73±9.62	42.46± 14.40	70.20±23.36	
t/p			t=0.995, p=0.323	t=1.674, p=0.099	t=1.459, p=0.149	
Marital status						
Married	46	63.0	31.04±8.73	48.71±12.06	79.76±20.11	
Single	27	37.0	27.22±6.95	44.33±12.04	71.55±17.82	
t/p			t=2.057, p=0.044	t=1.499, p=0.138	t=1.809, p=0.075	
Child situation						
Yes	42	57.5	29.92±8.44	47.28±11.85	77.21±19.56	
No	31	42.5	29.22±8.18	46.83±12.76	76.06±19.90	
t/p			t=0.358, p=0.722	t=0.154, p=0.878	t=0.246, p=0.806	
Education status						
Associate degree	18	24.7	29.88±8.28	46.17±10.63	76.05±18.02	
License	52	71.2	29.63±7.83	47.53±11.91	77.17±18.84	
Master's degree-doctorate	3	4.1	32.00±16.70	47.33±27.50	79.33±44.06	
F/p			F=0.736, p=0.534	F=0.196, p=0.898	F=0.362, p=0.781	
Income rate						
Equal to its income and expense	8	11.0	27.25±11.25	42.62±11.91	69.87±22.50	
Less than its income	48	65.8	29.85±7.39	48.00±10.12	77.85±16.51	
More than income	17	23.3	30.11±9.46	46.64±17.03	76.76±25.99	
F/p			F=0.371, P=0.692	F=0.678, p=0.511	F=0.562, p=0.572	
Living place						
Province	14	19.2	31.35±6.45	49.64±12.35	81.00±17.97	
District	59	80.8	29.22±8.65	46.49±12.14	75.71±19.95	
F/p			t=0.866, p=0.389	t=0.870, p=0.387	t=0.907, p=0.367	
Years of work in the profession						
1-5 years	22	30.1	29.90±6.74	45.72±12.72	75.63±18.65	
6-10 years	28	38.4	30.67±9.05	48.89±11.22	79.57±19.79	
11 years and above	23	31.5	28.08±8.74	46.21±12.97	74.30±20.60	
F/p			F=0.629, p=0.536	F=0.498, p=0.610	F=0.498, p=0.610	
Chronic illness condition						
Yes	8	11.0	32.37±7.50	49.00±10.71	81.37±17.36	
No	65	89.0	29.29±8.36	46.86±12.38	76.15±19.88	
t/p			t=0.993, p=0.324	t=0.467, p=0.642	t=0.709, p=0.48	
Smoking						
Yes	15	20.5	29.60±6.11	47.66±9.35	77.26±14.02	
No	58	79.5	29.63±8.80	46.94±12.85	76.58±20.88	
t/p			t=-0.019, p=0.985	t=-0.202, p=0.840	t=-0.119, p=0.906	
Drinking Alcohol						
Yes	2	2.7	32.00±0.00	54.00±0.00	86.00±0.00	
No	71	97.3	29.56±8.39	46.90±12.28	76.46±19.79	
t/p			t=2.447, p=0.017	t=4.870, p=0.000	t=4.058, p=0.000	

Independent sample t-test was used to compare the means of two independent groups, and a One-way ANOVA test was used to compare the means of more than two groups. PostHoc Bonferroni test was used in multi-group comparisons. P <0.05 was considered significant.

Table 2. Distribution of Compassion Fatigue Short Scale mean scores by COVID-19 disease characteristics (N = 73)

Specifications	Features of COVID-19 Disease				CFS/SF Total score X±SS
	N	%	CFS/SF Sub-Dimensions Secondary Trauma X±SS	Burnout X±SS	
COVID-19 positive status					
Yes	27	37.0	30.37±8.69	46.88±12.16	77.25±19.91
No	46	63.0	29.19±8.09	47.21±12.29	76.41±19.60
t/p			t=-0.582, p=0.562	t=-0.111, p=0.912	t=0.177, p=0.860
Your COVID-19 contact status					
Yes	57	78.1	29.59±8.09	45.87±12.14	75.47±19.51
No	16	21.9	29.75±9.20	51.43±11.55	81.18±19.78
t/p			t=-0.65, p=0.948	t=-1.634, p=0.105	t=0.538, p=0.306
Family members caught COVID-19					
Yes	40	54.8	30.60±7.88	47.50±11.60	78.10±18.59
No	33	45.2	28.45±8.72	46.60±12.98	75.06±20.88
t/p			t=0.456, p=0.274	t=0.762, p=0.757	t=0.657, p=0.513
Losing a relative due to COVID-19					
Yes	24	32.9	30.87±6.82	47.91±10.88	78.79±16.76
No	49	67.1	29.02±8.91	46.69±12.83	75.71±20.91
t/p			t=0.897, p=0.373	t=0.401, p=0.367	t=0.628, p=0.217
Treatment and care application status of the patient who is positive for COVID-19					
Yes	67	91.8	29.76±8.44	47.37±12.39	77.13±20.01
No	6	8.2	28.16±6.55	44.00±9.46	72.16±14.38
t/p			t=0.449, p=0.655	t=0.648, p=0.450	t=0.593, p=0.528
Emotions most intensely experienced during the COVID-19 pandemic process					
Fear	10	13.7	29.50±9.70	47.20±9.87	76.70±18.82
Worry	2	2.7	13.00±2.82	35.50±17.67	48.50±20.50
Unrest	4	5.5	32.00±5.35	49.75±5.05	81.75±9.42
Anxiety	10	13.7	33.40±3.53	51.90±5.68	85.30±8.59
Despair	3	4.1	28.66±6.50	43.33±19.50	72.00±25.11
Unhappiness	3	4.1	31.00±12.00	54.66±14.43	85.66±25.54
Sadness	7	9.6	30.00±5.25	46.14±7.24	76.14±11.90
Burnout	20	27.4	28.20±10.68	44.50±16.41	72.70±26.38
Insomnia	3	4.1	29.66±2.51	51.66±5.85	81.33±6.50
Fatigue	11	15.1	30.72±6.19	46.81±12.12	77.54±17.93
F/p			F=1.315, p=0.247	F=683, p=0.722	F=0.896, p=0.534

Independent sample t-test was used to compare the means of two independent groups, and a One-way ANOVA test was used to compare the means of more than two groups. PostHoc Bonferroni test was used in multi-group comparisons. P <0.05 was considered significant.

Table 3. Arithmetic Average, Standard Deviation And Cronbach's Alpha Values For Nurses' CFS/SF Scores

	Minimum	Maximum	X±SS	Cronbach Alpha
Compassion Fatigue Short Scale	29	122	76.72±19.58	0.866
Secondary Trauma	7	47	29.63±8.28	0.696
Professional Burnout	14	75	47.09±12.16	0.783

Table 4. Correlation Between Nurses' Compassion Fatigue Scale Scores

	1	2	3
¹ CFS/SF Secondary Trauma Sub-Dimension	1	.828**	.937**
² CFS/SF Occupational Burnout Sub-Dimension		1	.971**
³ CFS/SF Total Score			1

care and who work at emergency services are higher (Edmunds, 2010). However; in the study-findings, compassion fatigue levels could not be examined in relation to clinical services where nurses worked since all the services were changed into COVID-19 services due to the COVID pandemic. These results made us think that nurses' compassion fatigue levels differed in terms of their socio-demographic characteristics.

In the analysis done in terms of marital status; it was seen that those married participants had considerably higher average scores in CFS/SF-secondary trauma subscale as compared to the single participants ($p=0.044$). In the studies that examined the correlation between compassion fatigue and marital status; it was noted that no correlation existed between marital status and compassion fatigue (Ruiz-Fernández et al., 2020; Wu et al., 2020). The results of the current study made us conclude that since married nurses worked more intensively during an exhausting and stressful period like COVID-19 and since they did not take any day-offs and they got stuck between home and work place; their work burden may have increased more and the ambiguity that the pandemic period produced may have led to more tiredness and burnout among them.

In the study it was seen that those drinking alcohol demonstrated significantly higher average scores in CFS/SF-secondary trauma subscale, CFS/SF-professional burnout subscale and CFS/SF total average as compared to those not drinking alcohol ($p=0.017$, $p=0.000$, $p=0.000$; respectively). In the literature; unlike our study findings, it is seen that nurses used such positive coping strategies against compassion fatigue as listening to music, talking, talking on the phone, isolating themselves from the social environment, sleeping, walking around, going to cinema, being engaged with spirituality and religion, changing attitudes (Edmunds, 2010; Gök, 2015). These results underlined the importance that positive strategies developed by nurses against compassion fatigue should be supported and psychological support and assistance should be given them so that they can avoid negative coping strategies like drinking alcohol and smoking.

During COVID-19 pandemic period; the feelings that nurses felt most were found to be burnout (27.3%) and fatigue (15.1%). When the literature is investigated; it is stated that corona virus pandemic has elevated fatigue and burnout levels of health care workers further (Lai et al., 2020; Nolte et al., 2017; Wu et al., 2020). Our study was similar to these findings. This similarity may have resulted from the facts that health care professionals, who are in front line during the pandemic, have developed bigger control feeling and have got more knowledge about pandemic development, there is a bigger infection risk for themselves and those beloved

ones, care demand has increased and there is possibly lack of some basic personal protection materials.

In the study; a positive and strong correlation was found between CFS/SF total score and scores of CFS/SF-secondary trauma subscale and CFS/SF-burnout subscale. When the literature is looked at; there are studies that concur with our study findings and that demonstrate a positive correlation between compassion fatigue and burnout (Alkema et al., 2008; Slocum-Gori et al., 2013; Smart et al., 2014). Nurses work intensely at settings where they witness their patients' long term pains and when they feel insufficient in reducing the pain that patients experience, they suffer from compassion fatigue and burnout (Alharbi et al., 2020). It is pointed out that problems such as easier contraction of the disease, lack of immunity among global populations, delayed tests, limited medical equipments, ambiguity of pandemic and general anxiety level in society create an escalating stress in health and well-being systems during COVID-19 pandemic as in previous disasters and pandemic periods (Gök, 2015; Kang et al., 2015). Nurses who work under COVID-19 conditions are exposed to infection risk and feel that they may contract disease to others; which may result in an unwillingness to seek help from family or friends and may decrease the capacity of being compassionate (Wallace et al., 2020). In a study done; burnout and compassion fatigue was found to be higher among all the health care workers who worked with patients diagnosed with COVID-19 (Wallace et al., 2020). These results indicate that it is important that during COVID-19 period, nurses should psychologically be supported by considering compassion fatigue, burnout and trauma that they experience.

Limitations

The fact that the study was done at one hospital may be a limitation to generalize the findings and data.

CONCLUSIONS

In the study; it was found that nurses experienced compassion fatigue, trauma, and burnout which are subscales of compassion fatigue above the average level. To increase patient care quality and professional satisfaction; nurses' compassion fatigue should be prevented. In this sense, individual strategies should be developed for nurses. To prevent nurses' compassion fatigue; administrative and organizational innovative strategies should be developed. In this sense; a recreational site where nurses can get rid of their fatigue and a setting where they can express their feelings and thoughts should be created, they should be given caregiver support and awareness programs about compassion fatigue and positive coping strategies

should be held periodically. For prospective studies, it may be recommended that this study topic should be investigated with a bigger number of nurses and different variables.

Implications for Nursing Practice

To reduce compassion fatigue among nurses; programs for compassion skill training should be held. These programs may bring patient care quality, patient safety, and nurse satisfaction (Kim & Lee, 2020). Institutions should be strict and careful in terms of providing the necessary resources to nurses, health care workers, and patients so that evidence-based patient care services can be offered, a sufficient number of staff can be hired, psychological care and ethics can be prioritized for health care teams and a safe public health system can be strengthened.

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