

Compassion Fatigue, Burnout, and Neonatal Abstinence Syndrome

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ABSTRACT

NICU nurses have seen a dramatic increase in cases of neonatal abstinence syndrome (NAS). The care needs of infants with NAS are highly demanding and can lead to feelings of frustration and emotional exhaustion among NICU nurses. Although studies have examined the experiences of nurses caring for NAS patients, none have specifically addressed the risk for compassion fatigue and burnout. Nurses need practical strategies to reduce their risk for compassion fatigue and burnout when caring for these patients. Improved education and implementation of self-care measures can help nurses more effectively manage stress and positively impact care of these infants and their families.

Keywords: neonatal abstinence syndrome; burnout; compassion fatigue; self-care; nurses

NURSES WORKING IN THE NICU FACE stressful and emotionally exhausting situations every day when caring for critically ill infants and their families. Caring for infants with neonatal abstinence syndrome (NAS) presents a uniquely challenging situation in which nurses are at risk for compassion fatigue and burnout. NAS is composed of symptoms that reflect physiologic dependence on opioids, resulting in central nervous system hyperirritability, respiratory distress, and gastrointestinal dysfunction.¹ Infants with NAS often require continuous care and are sometimes inconsolable. Consider the following scenario, which illustrates the risk for compassion fatigue and burnout among nurses caring for infants with NAS:

Nurse Karen is taking care of baby Jack in the NICU. Jack is a full-term infant being treated for NAS. He is receiving morphine and clonidine every four hours. Jack is on room air and bottle feeding ad lib on demand. Karen was told in report that Jack's morphine was weaned yesterday afternoon, and his NAS scores have started to increase. Jack wakes shortly after his last feeding and is difficult to console. Karen swaddles

Jack, offers a pacifier, and rocks him, but he continues to cry. Finally, Karen is able to rock Jack back to sleep. Karen goes to check in on her other patient but soon hears Jack crying frantically. Karen notifies the neonatologist that Jack's last NAS score was 12, describes his increased symptoms, and subsequently receives an order for an increased morphine dose. Karen tries to calm Jack but feels herself becoming frustrated. Jack's cry is incessant and sounds painful. Karen feels a sense of uselessness, thinking "nothing works" to calm him. Karen's thoughts also ruminate on her perception that there are more and more NAS infants in the NICU, and she always seems to be assigned to them. Karen thinks, "I'd much rather care for a 23-week infant on multiple drips and high-frequency oscillating ventilation than sit and rock an infant who cries continuously. I am a critical care nurse, not a baby rocker."

Later in the day, Jack is finally asleep when his mother comes to visit. Karen updates Jack's mother on Jack's increased NAS scores and need for a higher morphine dose. Karen encourages Jack's mother to let him sleep

because sleep will help him with the withdrawal process. Jack's mother turns to Karen and says, "So you mean I can't hold my own baby? I didn't come all the way in here to not hold him." Jack's mother unwraps Jack, holds him briefly, and then complains to Karen that he must be hungry because he is crying. Jack is so disorganized and frantic that he cannot eat. Jack's mother leaves the unit while Karen is in with her other patient. When Karen realizes what has happened, her frustration turns to anger and despair. "I cannot believe we send babies home to parents who can hardly take care of themselves, let alone their baby."

Karen looks around for help, but the unit is busy, and her coworkers are occupied with their own assignments. During the week, there is a volunteer who will hold and rock crying infants but not on the weekend. Karen attempts to calm Jack but feels detached, as though she is just going through the motions. During this time, the charge nurse informs Karen that she is getting an admission. Karen explains that her assignment is really busy already, but the charge nurse replies that Karen's patients are currently the most stable in the unit. Although Jack is considered stable because he is on room air, the charge nurse fails to consider his intensive needs or recognize the stress Karen is experiencing. As Karen's admission arrives, she hears Jack's frantic crying. Despite working as efficiently as possible, Karen cannot meet all the needs of her patient. Adding to her stress, Karen finds out that her other patient's mother has complained to the charge nurse stating that Karen was inattentive to her baby. She leaves work feeling physically and emotionally exhausted, dreading her return tomorrow morning.

Although NAS patients may be considered low acuity, requiring interventions not reliant on a high level of technical expertise, they often exhibit highly demanding care needs.²⁻⁴ A combination of several factors, including staffing constraints, inadequate supportive services, the need for improved education of nurses regarding addiction, and an incongruence between nurse expectations and actual care needs of this population can lead to burnout.^{3,5} The purpose of this article is to discuss the potential for compassion fatigue and burnout among nurses in the NICU when caring for infants being treated for NAS. Although not all nurses who care for infants with NAS will develop compassion fatigue or burnout, recognition of the risk factors and signs of compassion fatigue and burnout is vital to implementing preventative measures. The secondary purpose of this article is to identify potential, practical support strategies for nurses at risk for compassion fatigue and burnout when caring for infants with NAS.

NEONATAL ABSTINENCE SYNDROME

The NAS has received increased attention in recent years. The incidence of drug abuse among pregnant women has

increased, and consequently, NICUs are seeing a dramatic rise in cases of NAS.⁶ In addition, several calls for improved care of the mother and infant highlight the need for a critical assessment of care activities.^{2,3,7,8} Although many important aspects of NAS have been addressed, literature on the potential for compassion fatigue and burnout when caring for this challenging patient population is lacking. An overview of NAS, including signs and symptoms, pharmacologic management, and nonpharmacologic interventions, is described in the literature. Three studies have examined the experiences of nurses caring for infants with NAS, revealing themes of moral distress, exhaustion, frustration, and burnout.²⁻⁴

Fraser and colleagues⁴ identified five themes of nurses' experiences caring for infants with NAS, including (1) the relationship with the infant, (2) response to the family, (3) tensions within the care environment, (4) nurses' needs, and (5) making a difference. The relationship with the infant was described as time consuming and difficult, and nurses felt that the acuity and workload of caring for NAS infants was not acknowledged. Nurses perceived families as highly demanding, exhibiting a wide range of emotional, social, and practical support needs. When families did not visit, nurses expressed frustration. Tensions within the care environment included the perception that medical staff did not recognize or respect nurses' assessment skills, the perception that infants were being discharged to an unsafe environment, and questioning if the special care nursery is the optimal environment for these babies to receive care. Nurses' needs related to the emotional work of caring for NAS infants and lack of skills in developing a therapeutic relationship with the families. Nurses identified the need for more organizational support and education as barriers to effectively making a difference for these high-risk families.⁴

Murphy-Oikonen and associates³ identified two primary themes in their study of nurses' experiences in caring for infants with NAS including (1) commitment to infants and (2) a contrast between technical competencies of the NICU nurse and expected maternal care required for NAS infants. Three additional themes identified in the study include (1) a disconnect between expectations of nurses and families; (2) stress, frustration, and burnout; and (3) an increased awareness of drugs that impacts nurses' home and work life.³ The authors suggest improved education to change nurse perceptions of this population, organizational support and validation, and recognition of the strain that caring for NAS infants puts on nurses.

Maguire and colleagues² examined the lived experience of nurses caring for infants with NAS, revealing three areas of concern, including (1) caring for the infants, (2) coping with the families, and (3) discharging infants home. Nurses expressed distress and frustration, especially related to the inability to console the painful crying of NAS infants. When unable to comfort these infants, nurses felt that their skills and efforts were useless. Nurses also underrated the skills required to care for NAS infants, suggesting that they had

been trained to care for a different population and questioning whether the NICU was the best setting for these infants.² Coping with the families was described as adding to nurse distress because these families could be verbally abusive, aggressive, or threatening. Nurses perceived that some mothers blamed nurses for the infant's problems or showed little interest in caring for their infant. The authors note that nurses continued to show a strong attachment and dedication to these infants despite the challenges in coping with families. Discharging infants home was another source of distress for nurses as they expressed concerns about the home environment, fears of abuse, perceived inability of the mother to provide infant care, and long-term issues for the infant.²

COMPASSION FATIGUE AND BURNOUT

Burnout and compassion fatigue of nurses has also received significant attention in the literature. Compassion fatigue and burnout are interrelated yet distinctly different phenomena. Burnout is a "psychological syndrome that involves a prolonged response to chronic interpersonal stressors on the job."^{9(p332)} Three dimensions of burnout include (1) overwhelming exhaustion, (2) feelings of cynicism and detachment from the job, and (3) a sense of ineffectiveness and lack of accomplishment.⁹ Burnout results from interacting with the work environment and reflects feelings of powerlessness, excessive workload, or a sense of inadequate achievement which can lead to disengagement. Compassion fatigue, though, is a unique form of burnout that results from interactions and relationships with people in need of help rather than the work environment.⁵

The term *compassion fatigue* was first described by Joinson¹⁰ in 1992 as a form of burnout that is linked to people in caring professions. Later, Figley¹¹ adopted compassion fatigue as a user-friendly term for secondary traumatic stress, which impacts those who are exposed to a traumatized or suffering person. Coetzee and Klopper,⁵ through their concept analysis, define compassion fatigue in nursing practice as "the final result 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."^(p237) When the three primary risk factors for compassion fatigue, (1) contact with patients, (2) use of self, and (3) stress, are combined with prolonged, continuous, and intense exposure, nurses are at risk for exhausting their compassionate energy. If compassionate energy expenditure exceeds restorative processes, symptoms can progress along a continuum from compassion discomfort, to compassion stress, to compassion fatigue.⁵ The potential for compassion fatigue is related to the emotional investment and empathetic caring practices of nurses.^{5,12}

Compassion fatigue and burnout have been studied in various health care settings and patient populations, including pediatrics.¹³⁻¹⁶ Sacco and colleagues¹³ evaluated the

prevalence of compassion fatigue and compassion satisfaction among adult and pediatric critical care units, finding that mixed acuity units had higher burnout and secondary traumatic stress scores and lower compassion satisfaction. This finding is interesting in light of NAS infants' nurses' reports of frustration which related the contrast between technical competencies of the critical care nurse and the maternal care required of NAS infants.³

Research on nurses' experiences caring for infants with NAS raises concerns regarding the potential for compassion fatigue and burnout. Nurses described many aspects of compassion fatigue and burnout in their interviews. For example, stress from wanting to soothe the infant's painful cries led to feelings of ineffectiveness.² Challenging family dynamics and concerns regarding infants' safety after discharge added to nurses' stress and feelings of cynicism.²⁻⁴ The almost-continuous care required by NAS infants that is illustrated by the case study presented in the beginning of this article suggests that nurses are in a situation that corresponds with risk for compassion fatigue: contact with patients; use of self; and stress that is prolonged, continuous, and intense.⁵

Consequences of compassion fatigue and burnout impact the patient, family, and individual nurse. Nurses experiencing symptoms of compassion fatigue or burnout are less likely to effectively support the mother-infant dyad, which is of particular importance for mothers with addiction.^{17,18} Promoting a healthy parent-infant relationship by engaging mothers with addiction in the care of their infants is one of the most effective ways to improve outcomes for the mother and infant.¹⁸ Recent literature also focuses on the need for increased understanding of addiction as a complex biopsychosocial issue and the potential for a maternal history of trauma.⁸

RECOGNITION AND PREVENTION OF COMPASSION FATIGUE AND BURNOUT

Delivery of safe, quality care with high levels of patient satisfaction is unlikely to be achieved if nurses are experiencing burnout.¹³ Burnout and compassion fatigue are associated with increased turnover, nurse attrition, and decreased engagement.^{9,19,20} Lack of awareness of compassion fatigue symptoms and strategies for prevention impact the individual nurse, workplace, and patient care, leading to disengagement, decreased productivity, safety concerns, and stress in personal relationships.¹⁹ Consequently, leaders in health care are motivated to address mitigating factors related to these issues. Although compassion is an essential component of effective nursing care, self-care and self-compassion are needed to maintain nurse well-being.¹³

Given the amount of attention focused on patient satisfaction, family-centered care, and productivity, needed support for nurses could easily be overlooked.^{13,16} According to Potter and colleagues,²¹ the first step to compassion fatigue prevention is to establish prevalence and create a positive work

environment. In the case of caring for infants with NAS, organizational support to establish a positive work environment may include involvement from ancillary services, such as social work and lactation consultants, scheduling and staffing considerations that acknowledge workload, and utilization of volunteers. Involvement of ancillary services is especially important on off-shifts when parents often visit. Seeking help from coworkers, supportive staff, volunteers, and parents may seem obvious, but barriers to effective teamwork can limit nurses' use of these strategies. Strong teamwork skills have been shown to increase staff satisfaction, lower nurse burnout rates, and reduce turnover.²² Creating a culture of teamwork, where asking for help is not viewed as a weakness and nurses spontaneously help one another, promotes a healthier work environment, reduces stress, improves patient safety, and promotes optimal patient care.^{22,23}

In the case of infants with NAS, optimizing nonpharmacologic interventions is critical to supporting infants through the withdrawal process. Optimization of nonpharmacologic interventions requires teamwork to minimize stress on the infant. Examples include using two-person caregiving, with one nurse providing comfort measures and the other completing caregiving activities; the expectation being, infant cries are responded to promptly by the first available caregiver. Nurses must develop clear, assertive communication skills to ask for help in providing optimal care. Although some evidence suggests that formal teamwork training is required to achieve measurable benefits, other theories suggest that individually improving key interpersonal skills can impact the overall culture and eventually establish a new norm.^{22,23} In addition to the organizational support described earlier, nurses need practical strategies to manage the frustration, stress, and emotional fatigue associated with caring for infants with NAS.

Achieving balance between the challenges and rewards of caring for difficult patients is an ongoing struggle for nurses in critical care.¹³ Compassion fatigue and burnout prevention strategies have been shown to benefit nurses working with pediatric patients.^{15,16,24} Educational seminars on compassion fatigue can improve awareness of symptoms and self-care strategies for prevention of compassion fatigue.^{15,16} Self-care strategies include regular exercise, healthy eating habits, and time devoted to recharging.^{15,16} It is notable that nurses who are experiencing a high level of personal stress are at greater risk for developing symptoms.¹⁶ Nurses who repeatedly care for the same patient, a practice promoted in the NICU to provide continuity of care, are also at increased risk for developing these issues.¹³ Because caring for infants with NAS may put nurses at risk for compassion fatigue, finding ways to regularly renew one's emotional reserves is important, using strategies that are personalized for optimal effectiveness.^{5,13}

Preliminary research on the use of resiliency programs to combat compassion fatigue is encouraging.^{15,21} Resiliency strategies include self-regulation, intentionality, self-validation,

social connection, and self-care.^{15,21} Kabat-Zinn's mindfulness-based stress reduction (MBSR) which promotes mindfulness, the practice of focusing on the present moment without judgment, has also gained popularity as a strategy to improve well-being and reduce stress.²⁵ Mealer and colleagues¹⁴ describe improvement in nurses' coping skills through the implementation of a resilience training program for intensive care unit (ICU) nurses that included education on self-care behaviors, MBSR, expressive writing, and exercise. Resilience training and MBSR could be offered to nurses as part of orientation to the NICU or as part of an education program on addiction and NAS. Research is needed to validate the effectiveness of resiliency programs and MBSR interventions within the context of caring for NAS patients in the NICU.

CHALLENGES

The need for prevention of compassion fatigue and burnout is clear, and multiple strategies are suggested in the literature. Limitations to implementing these strategies exist. Formal training programs require significant time, resources, and managerial support and are not practical for all units. Nurses who are motivated to learn self-regulation, self-care, mindfulness, and teamwork skills may achieve some benefit through personal development activities. But pressure to learn additional skills on personal time may contribute to feelings of being overwhelmed and actually worsen symptoms. Resiliency training and MBSR are not an instant solution and require dedication of participants over several weeks. Research is needed to assess the effectiveness of specific interventions within the context of caring for infants with NAS and to establish a threshold for minimally required training for nurses to benefit from prevention strategies.

SUMMARY

Caring for infants with NAS requires an immense amount of patience and can be emotionally, physically, and mentally taxing on NICU nurses. The dramatic increase in NAS cases in combination with economic factors requires nurses to care for these highly demanding patients while coping with limited resources. Evidence suggests that nurses are at risk for compassion fatigue and burnout and can benefit from increased awareness and prevention strategies.

Compassion fatigue and burnout prevention self-care strategies have been studied in the intensive care setting and provide insight into managing symptoms among NICU nurses. NICU nurses may benefit from educational seminars that teach self-care skills and mindfulness, improve self-awareness, and promote effective teamwork. In addition, nurses can initiate some of these interventions on their own. Compassion fatigue and burnout prevention, improved education on addiction, and increased organizational support can help nurses remain engaged with NAS patients, resulting in improved care outcomes.

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Erin Sweigart, MSN, RN, RNC-NIC, has been a nurse for ten years, specializing in neonatal intensive care. In 2005, she graduated from Case Western Reserve University with a Bachelor of Science in Nursing, after which she began working at a Level III NICU. Erin also gained two years' experience working at a Level I facility providing postpartum mother-baby couplet care before returning to the neonatal intensive care setting. Currently, she works at a 34-bed Level III NICU within the Cleveland Clinic Health System. In 2013, Erin obtained specialty certification in neonatal intensive care. In December 2015, she graduated from Kent State University with a Master of Science in Nursing Education.

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