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Does self-compassion mitigate the relationship between burnout and barriers to compassion? A cross-sectional quantitative study of 799 nurses

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ABSTRACT

Background: Burnout has numerous negative consequences for nurses, potentially impairing their ability to deliver compassionate patient care. However, the association between burnout and compassion and, more specifically, barriers to compassion in medicine is unclear. This article evaluates the associations between burnout and barriers to compassion and examines whether dispositional self-compassion might mitigate this association.

Hypothesis: Consistent with prior work, the authors expected greater burnout to predict greater barriers to compassion. We also expected self-compassion – the ability to be kind to the self during times of distress – to weaken the association between burnout and barriers to compassion among nurses.

Methods: Registered nurses working in New Zealand medical contexts were recruited using non-random convenience sampling. Following consent, 799 valid participants completed a cross-sectional survey including the Copenhagen Burnout Inventory, the Barriers to Physician Compassion scale, and a measure of dispositional self-compassion.

Results: As expected, greater burnout predicted greater barriers to compassion while self-compassion predicted fewer barriers. However, self-compassion mitigated the association between burnout and burnout related barriers to compassion (but not other barriers). The interaction suggested that suggested that the association was stronger (rather than weaker) among those with greater self-compassion.

Discussion: Understanding the lack of compassion and the effects of burnout in patient care are priorities in health. This report extends evidence on the association between burnout and compassion-fatigue to show that burnout also predicts the experience of specific barriers to compassion. While self-compassion predicted lower burnout and barriers, it may not necessarily reduce the extent to which burnout contributes to the experience of barriers to compassion in medicine. Implications for understanding how burnout manifests in barriers to clinical compassion, interventions and professional training, and future directions in nursing are discussed.

What is already known about the topic?

- Burnout is widespread among nurses and thought to have numerous negative correlates, including those related to their ability to deliver compassionate care.
- Prior researchers have typically linked burnout with other compassion-related forms of burnout (such as compassion fatigue) and have failed to illuminate factors that might buffer or attenuate this relationship.

What this paper adds

- The paper extends knowledge beyond compassion fatigue to consider how burnout may manifest in specific barriers to compassionate patient care.
- The development of self-compassion (the ability to care for the self in times of stress) may reduce the experience of carer, patient, environmental, and clinical barriers to compassion.

1. Introduction

Burnout is prevalent across a range of healthcare professions, including nursing (Beck, 1995; Poncet et al., 2007), and has serious consequences for both nurses (Parker and Kulik, 1995; Vahey et al., 2004) and patients (Aiken et al., 2002; McHugh et al., 2011). Burnout is generally defined as a set of symptoms relating to exhaustion, in the

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form of negative job attitudes, negative self-concepts, and a loss of concern and feeling for patients (Keidel, 2002). Given the central involvement of professional nurses in a variety of healthcare domains (Tingen et al., 2009), understanding the origins and consequences of burnout (Beck, 1995; McHugh et al., 2011; Poncet et al., 2007), particularly in terms of compassion-fatigue (Boyle, 2011; Coetzee and Klopper, 2010; Flarity et al., 2013, 2016a,b; Sabo, 2006; Yoder, 2010) and lower job satisfaction (Aiken et al., 2002; Hayes et al., 2010; Lu et al., 2012; Utriainen and Kyngäs, 2009) is increasingly important. The current report contributes to this area of study by examining the links between burnout and specific barriers to compassion in a large sample of registered nurses and testing the possibility that a key intrapersonal resource, self-compassion, might mitigate this relationship. Specially, the authors evaluate the possibility that burnout is less closely associated with barriers to compassion among more self-compassionate nurses.

Prior studies of burnout show consistent links to negative mental and physical health outcomes. Greater burnout has been linked to poorer immune functioning (Nakamura et al., 1999), lower social support (Constable and Russell, 1986; Duquette et al., 1994; Eastburg et al., 1994), and greater substance-use (Lee et al., 2003; Shanafelt et al., 2002). Burnout also varies among nurses with different demographic characteristics (Duquette et al., 1994; Keidel, 2002; Lee et al., 2003), those working with different patient populations (Aiken et al., 2002), and in different clinical settings (Aiken et al., 2002; Constable and Russell, 1986; Duquette et al., 1994; Lee et al., 2003).

However, despite the volume of research linking burnout with negative outcomes, the relations between burnout and compassion are unclear. Most prior work has focused on the association between burnout and a *lack of compassion* (compassion-fatigue), rather than seeking to identify specific factors that might be relevant. Compassion, along with the related constructs of empathy, kindness, and concern, are essential components of effective patient care (Attree, 2001; Bramley and Matiti, 2014; Frost, 2011; Heffernan et al., 2010; Irurita, 1999; McQueen, 2000) and are likely to be negatively impacted by burnout. Research shows a negative relationship between burnout and patient care-satisfaction (Leiter et al., 1998; McHugh et al., 2011; Shanafelt et al., 2002; Vahey et al., 2004) but the reasons for this link remains unclear.

Ironically then, the relationship between burnout and factors likely to influence caring remains understudied while the association between burnout and compassion-fatigue has been widely investigated (Craig and Sprang, 2010; Keidel, 2002; Killian, 2008), including among nurses (Hooper et al., 2010; Maytum et al., 2004; Sabo, 2008). Although compassion fatigue is a complex construct and, at least in trauma environments, includes elements of both secondary traumatisation and burnout (Adams et al., 2006), the fact that the experience of feeling "unable to care" is a highly salient aspect feeling burnt out (Chen and McMurray, 2001) makes this association unsurprising. However, because compassion-fatigue is a type of burnout specific to those in the caring professions (Figley, 2002; Keidel, 2002), associations with general measures of burnout are difficult to interpret. Put simply, a significant proportion of the co-variation between general measures of burnout and measures of compassion fatigue (which incorporates burnout) likely reflects their conceptual overlap and shared measurement characteristics. With this issue in mind, the primary aim of this report was to extend prior research by examining the associations between burnout and specific measures of caregiver, patient, clinical, and institutional and environmental barriers to compassion among nurses.

A second aim was to evaluate if personality factors in nurses might buffer or attenuate the association between burnout and barriers to compassionate care. Specifically, the authors evaluated whether self-compassion (the ability or tendency to respond to the self in times of failure or distress with kindness and understanding) (Neff, 2003a) might mitigate the association between burnout and barriers. Self-compassion can be viewed as a resilience type factor (Neff and McGehee, 2010) and early evidence denotes associations between burnout and lower self-compassion (Alkema et al., 2008; Barnard and Curry, 2012) as well as between self-compassion and lower compassion-fatigue (Alkema et al., 2008; Figley, 2002). In theory, these links reflect the notion that more self-compassionate individuals manage stress and burnout more effectively, letting demands exhaust less of their capacity to be caring (Alkema et al., 2008; Figley, 2002; Vigna et al., 2017).

More directly, several recent studies have shown that self-compassion buffers the association between negative psychological constructs and both mental (Denckla et al., 2017; Körner et al., 2015; Kyeong, 2013; Marshall et al., 2015; Phillips et al., 2017) and physical (Friis et al., 2015) health outcomes. Friis et al. (2015), for example, found that self-compassion weakened the association between greater diabetes distress and greater HbA1c among people with diabetes. Testing whether such "buffering" occurs in the association between burnout and barriers to compassion among nurses is the second aim of this report.

To summarise, while burnout is known to have numerous negative correlates among nurses, including those related to their ability to deliver compassionate care, most prior studies have linked burnout with other, compassion-related forms of burnout (i.e., compassion fatigue), and have failed to illuminate resiliency-type factors that might buffer this relationship. In contributing to work in this area, the current report documents the links between burnout and barriers to compassion and examines whether dispositional self-compassion might improve this association. Consistent with the above theory and research, the authors expected greater burnout to predict greater barriers to compassion among nurses (Hypothesis 1), and self-compassion to mitigate this association such that the association would be weaker among nurses with greater self-compassion (Hypothesis 2).

2. Method

2.1. Participants

Of the 799 registered nurses included in this report, 93.90% were female. The participants' average age was 45.47 years (SD = 11.81), average clinical experience was 26.12 years (SD = 12.77), and they predominantly identified as New Zealand European (65.30%), followed by British (12.80%) (see Table 1 for details). Nearly three quarters (73.8%) were New Zealand educated, the remainder being educated in the United Kingdom (14.30%) and elsewhere. Approximately half (54.80%) of the sample worked standard day shifts, 26.40% rostered shifts, and the remainder some combination. Most (59.3%) worked in large cities, with smaller numbers in small cities (17%) and large towns (10%). Most nurses (38.80%) worked 35–40 h per week.

2.2. Bias and sample size

Attempts to control bias include consultation with a senior academic nurse (A.L.) and colleagues to ensure study measurement addressed issues of relevance to practicing nurses, anonymous participation (reducing selection bias), and the use of validated measures that are known to have low correlations with demographics and clinical practice variables. The sample size was based on convenience sampling.

2.3. Procedure

Permission to conduct the study was obtained from the relevant human participants' ethics committee (University of Auckland Human Participants Ethics Committee Approval Number: 7640). Participants were recruited via non-random convenience sampling, specifically via a lecture series conducted by one of the authors (A.F.) at medical and nursing meetings and grand rounds, via contacts and referrals in hospitals and clinics in New Zealand, and through e-mails to various nursing organisations. Interested participants were sent an invitation email