Encyclopedia of Trauma: An Interdisciplinary Guide

Compassion Fatigue

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Compassion fatigue is a recent concept that refers to the emotional and physical exhaustion that can affect helping professionals and caregivers over time. It has been associated with a gradual desensitization to patient stories, a decrease in quality care for patients and clients (sometimes described as “poor bedside manners”), an increase in clinical errors, higher rates of depression and anxiety disorders among helpers, and rising rates of stress leave and degradation in workplace climate. Helping professionals have also found that their empathy and ability to connect with their loved ones and friends is impacted by compassion fatigue. In turn, this can lead to increased rates of stress in the household, divorce, and social isolation. The most insidious aspect of compassion fatigue is that it attacks the very core of what brings helpers into this work: their empathy and compassion for others.

The term helping professional is a broad term used to describe anyone who works in a professional helping capacity with other individuals: nurses, doctors, allied health professionals, mental health counselors, teachers, police officers, victim service workers, personal support workers, lawyers, animal care workers, paramedics, firefighters, and aid workers, to name a few.

Caregivers

Caregivers can also develop compassion fatigue: having to care for a spouse with Alzheimer's disease at home for many years, caring for a child with pervasive developmental delay or complex health care needs—these can take their toll on caregivers' emotional and physical health and lead to a reduction in their compassion and ability to care for their charges. Helping professionals are often initially attracted to this field for personal reasons: Some research indicates that around 60% of individuals who choose to become helping professionals have their own history of trauma or loss (or witnessed someone close to them struggle with mental health, addiction or a traumatic event). This means that many helpers have an increased vulnerability to developing a mental illness and can find themselves triggered by the traumatic stories of their clients, particularly if they have not sought treatment for their own emotional injuries.

In addition to prior life history, which creates vulnerability, research shows that some helping professionals are at an increased risk of developing compassion fatigue: those who work full-time in direct client service, such as child protection; those who work with inadequate resources (insufficient referral sources, poor pay, dysfunctional organizations); helpers who are exposed to a great deal of traumatic material; and those with inadequate training.

History of the Term

Compassion fatigue was not a well-known concept until the late 1990s. The term “burnout” had been popular since it was first coined in the 1970s, and it was often used as a catch-all term to refer to work-related exhaustion, frustration with work, low levels of engagement, dissatisfaction with inadequate pay, excessive workload and poor supervision for employees in any field of work. In the 1990s, however, researchers started finding clear evidence that helping professionals were experiencing something more complex than regular burnout: Social workers, nurses, crisis workers and other helpers were exhibiting signs of marked emotional and physical exhaustion with a deep shift in their ability to connect with feelings of compassion for others (clients, colleagues, and loved ones). Many confessed that they were becoming desensitized to their patients' stories. In addition, research found that exposure to traumatic material was negatively impacting helping professionals: Helpers were experiencing intrusive images, nightmares, and difficulty getting rid of traumatic stories recounted by their clients. They were also noticing that the stories they heard were profoundly changing their view of the world; some helpers who were parents described feeling a loss of a sense of safety for their children, being unable to hire babysitters for fear of molestation, for example. Some cancer workers noticed an increased hypervigilance about any physical symptom that may indicate warning signs of cancer (a headache becoming a sure sign of a brain tumor). In addition to this shift in worldview, some helpers were experiencing symptoms similar to posttraumatic stress disorder, without having experienced primary trauma themselves.

In 1995, trauma specialist Charles Figley published an important edited book on compassion fatigue titled

Compassion Fatigue: Coping With Secondary Traumatic Stress Disorder, in which researchers put forward compelling evidence demonstrating that helpers from many different walks of life were being deeply impacted by their work with patients and clients. Most of the early research was carried out among crisis workers in various fields (AIDS, emergency response, child protection, etc.), and evidence was clear that helpers were being profoundly affected by the repeated exposure to traumatic stories, intractable problems, lack of resources, and a demand that far outweighed what the helpers could provide.

Following the release of Figley's foundational book, several others were published which explored incidence rates in further depth and also began exploring therapeutic approaches to reducing and treating compassion fatigue.

Problems with Terminology

The field of compassion fatigue research has made tremendous strides in the past two decades. However, lack of agreement on terminology has clouded scholars' ability to carry out effective literature reviews as many different terms are used interchangeably to refer to compassion fatigue: burnout, vicarious trauma, compassion stress, and secondary traumatic stress to name a few. A proper literature search is made extremely difficult by this lack of agreement in terminology. In the early literature, the term secondary stress and compassion fatigue were used interchangeably. Even leaders in the field do not always use the terms with consistency: some of them argue that compassion fatigue is defined as a combination of work-related burnout and secondary traumatic stress. Others advocate for the inclusion of vicarious trauma in this definition, and believe that secondary traumatic stress and vicarious trauma are not one and the same but that vicarious trauma is the cumulative result of many secondary traumatic events.

Newer work on the topic suggests that compassion fatigue, burnout, secondary traumatic stress, and vicarious trauma are complementary terms that can affect a helper simultaneously, but that it is also possible for a caregiver or helping professional to experience one without the others. A nurse working in a long-term care facility with little trauma exposure, for example, may not experience any secondary traumatic stress or vicarious trauma, but may feel deep compassion fatigue. A police officer working in a very healthy work environment but with high trauma exposure (investigating child pornography, for example) may have low levels of burnout and compassion fatigue, but may be struggling with extremely high levels of vicarious and secondary trauma.

This lack of agreement on definitions is a problem that needs to be addressed in order to ensure that the correct symptoms and incidence rates are being studied and reported.

Incidence Rates

It is difficult to provide a definitive number on the incidence of compassion fatigue among helpers partly because of the terminological confusion described above. Some studies have reported that between 40% and 85% of helping professionals have compassion fatigue and/or high rates of secondary trauma. Research among child protection workers, oncology nurses, physicians, medical students, and lawyers show similar results: A large percentage of these helping professionals experienced compassion fatigue at some point in their career. Helpers with a higher rate of trauma exposure logically experienced higher rates of secondary traumatic stress. A study of hospice nurses in Florida indicated that not having access to timely debriefing after a patient's death increased the rates of compassion fatigue among staff.

The Continuum of Compassion Fatigue

Compassion fatigue can affect helping professionals throughout their career. It exists on a continuum and can ebb and flow depending on several factors such as self-care, workload, nature of the work (is the helper doing a lot of trauma work or helping many clients in difficulty), availability of referral resources, and other related factors. A helper with a high level of compassion fatigue may find himself or herself temporarily restored after a 2-week break, only to find himself or herself flooded with emotional and physical exhaustion upon returning

to work.

More Education Needed

Unfortunately, in spite of advances in the field of compassion fatigue education over the past decades, it remains a poorly understood concept in some helping fields. Few health care workers receive training about compassion fatigue and related concepts during their professional training. Therefore, physicians and mental health counselors, who are often the first point of contact for helpers struggling with symptoms of compassion fatigue, may not think to ask clients whether they feel that some of their symptoms are being caused by the nature of their work. Helping professionals may end up receiving a diagnosis of clinical depression or anxiety disorder without receiving any treatment for the underlying work-related causes.

The Stigma of Compassion Fatigue

There is still a powerful stigma associated with suffering from compassion fatigue. The diagnosis of posttraumatic stress disorder (PTSD) has faced a similar struggle among law enforcement and the military. Although it is considered to be a more acceptable diagnosis than it used to be, the stigma remains in some circles—that one is not “tough enough” to handle the work or that the compassion fatigue or PTSD is caused by poor self-care or inadequate work-life balance. In fact, the data show that helping professionals who are most deeply affected by their work are often the best and the brightest in the field—the most caring of individuals. Negative labels only further their isolation and self-blame.

Treating Compassion Fatigue

Specialists in the field are clear in stating that compassion fatigue is a normal consequence of the work, an occupational hazard, and not a failing on the part of the helping professional. There is no clear evidence that compassion fatigue can be entirely prevented. However, recent research highlights several key elements that contribute to reducing compassion fatigue and, hopefully, to preventing a relapse in the helper: improved training, working part-time or having an improved workload, flexibility and control over work schedule, access to timely professional debriefing, social support, and regular professional development. In addition to this, learning grounding techniques can be highly protective for staff working in high trauma environments. Two compassion fatigue researchers have developed a five-session treatment protocol to treat helpers with compassion fatigue, and this approach has been very well received in the treatment field.

New Directions for Research

Researchers are now turning attention to issues of prevention and resiliency: can we prevent compassion fatigue in helpers, and if so, how can this be done? What are the key resiliency factors that protect some helpers more than others? What can organizations do to improve conditions for staff? Some recent Canadian studies have demonstrated that organizational changes are in fact far more effective than individual strategies in mitigating the effects of compassion fatigue in helpers.

Clients and patients will not stop needing help and support. Disasters will continue to arise. Children will get sick; trauma will occur. Helping professionals need to continue to explore ways to remain healthy while doing this deeply challenging and rewarding work.

- compassion fatigue
- compassion
- trauma
- burnout
- child protection
- workload
- stigma

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See Also

- Secondary Trauma Among Behavioral Health Professionals
- Secondary Trauma Among Chaplains
- Secondary Trauma Among First Responders
- Secondary Trauma Among Judges, Jurors, Attorneys, and Courtroom Personnel
- Secondary Trauma Among Medical Professionals
- Secondary Trauma Among Medics and Corpsmen
- Secondary Traumatic Stress
- Self-Regulation
- Vicarious Trauma

Further Readings

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