

# Predictors of Compassion Fatigue in Mental Health Professionals: A Narrative Review

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Professionals who work in mental health settings are at risk of developing psychological distress themselves. The term “compassion fatigue” has been used to describe the negative effects of working in a psychologically distressing environment on a person’s ability to feel compassion for others. A number of studies have investigated predictors and correlates of compassion fatigue. However, as yet there is no consensus on which psychosocial factors are most commonly related to compassion fatigue. This review examines research on common correlates and predictors of compassion fatigue in mental health professionals. A literature search yielded 32 studies describing compassion fatigue in a range of mental health professionals and in relation to a variety of psychosocial factors. Quality of papers was variable. The review highlights several factors that were commonly associated with compassion fatigue (e.g., trauma history of mental health professionals, empathy). Some potential protective factors were also indicated, including certain behavioral and cognitive coping styles and mindfulness. Findings and implications are discussed, and directions for future studies are indicated. In particular, we highlight the need for longitudinal studies to investigate compassion fatigue’s development over time and to test models of the etiology of compassion fatigue.

*Keywords:* compassion fatigue, mental health professionals, ProQOL

Professionals who work with highly distressed clients, such as those who have experienced trauma, are at risk of developing compassion fatigue as a result of their work (Figley, 1995). Compassion fatigue has been described as the empathic strain and general exhaustion resulting from dealing with people in distress over time (Figley, 1995). It is characterized by physical and emotional exhaustion and a pronounced reduction in the ability to feel empathy and compassion for others (Elwood, Mott, Lohr, & Galovski, 2011; Mathieu, 2007).

The notion that helping professionals can, in turn, be adversely affected through their efforts to help others in distress, is longstanding. Indeed, since initial psychoanalytic ideas relating to transference and countertransference were acknowledged, different terms have been used to capture and understand these phenomena, such as burnout, vicarious traumatization, secondary traumatic stress, and compassion fatigue. There is considerable overlap between these constructs, and the use of different terms to describe these similar concepts, has hindered our ability to understand them and how they develop (Newell, Gardell, & MacNeil, 2016). A recent chronology of the development of these constructs has added clarity and distinguished each term (Newell et al., 2016). A brief overview is offered below.

The effects of delivering trauma-focused therapies on professionals were described by McCann and Pearlman (1990) as *vicarious traumatization*. This was defined as the negative effects of repeatedly engaging empathically with the trauma-related material of others, which could even bring about negative changes to the professional’s fundamental beliefs about themselves, the world, and others (McCann & Pearlman, 1990).

Around the same time, *secondary traumatic stress* was introduced and described as the psychological distress that can occur from hearing the details of another person’s trauma (Figley, 1995). Rather than the cognitive changes described as occurring with vicarious traumatization, characteristics of secondary traumatic stress mirror those of posttraumatic stress disorder (PTSD), including symptoms of hyperarousal, avoidance, and intrusive thoughts or memories relating to the trauma of another (Bride, 2004). Indeed, diagnostic criteria for PTSD now acknowledge the potentially traumatizing effect of “repeated or extreme exposure to details of the traumatic events” (American Psychiatric Association, 2013, p. 271).

Compassion fatigue has also been distinguished from *burnout*, which is psychological and emotional exhaustion, associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively, sometimes in the context of high workloads or a nonsupportive work environment (Stamm, 2010). It is also associated with a reduction in a sense of professional accomplishment (Maslach, 1982). The main distinguishing feature of burnout is the emphasis on environmental and organizational stressors as opposed to psychological and emotional processes within the individual resulting from interactions with another.

In contrast to compassion fatigue, the term *compassion satisfaction* has been used to describe the positive aspects of working in helping professions. Compassion satisfaction is defined as the

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pleasure derived from helping, affection for colleagues, and a good feeling resulting from the ability to help and make a contribution (Figley & Stamm, 1996).

The current review focuses on compassion fatigue as, in comparison to the other constructs described above, it is a useful and more general term to describe the emotional and physical fatigue experienced by professionals due to their chronic use of empathy in helping others in distress (Figley, 1995; Newell et al., 2016; Stamm, 2010). Compassion fatigue is prevalent in helping professionals more generally, and is not specific to those who work with trauma. For example, studies have investigated the prevalence of compassion fatigue in mental health professionals (Zeidner, Hadar, Matthews, & Roberts, 2013), nurses (Hegney et al., 2014), doctors (Gleichgerricht & Decety, 2014), social workers (Simon, Pryce, Roff, & Klemmack, 2005), chaplains (Yan & Beder, 2013), and various emergency services workers (Cicognani, Pietrantonio, Palestini, & Prati, 2009).

Consistent throughout the literature is the notion that compassion fatigue can make it harder for professionals to carry out their roles with empathy and compassion. It is a concept that is widely researched and becoming a topic of interest in different helping professions (see Yang & Kim, 2012 for a review of compassion fatigue in nurses), and will be the central focus of this review. Although findings suggest that certain factors are related to compassion fatigue, research in this area is still relatively recent and a coherent picture is yet to develop.

### Compassion Fatigue in Mental Health Professionals

The compassion of health care professionals in the United Kingdom was under scrutiny following serious incidents in Mid-Staffordshire National Health Service (NHS) hospital in 2008. A resulting investigation and report highlighted how a lack of compassion had led to serious failings (Francis, 2013). In response to this investigation, the government recommended that compassion should be at the forefront of effective health care (Department of Health, 2013). However, studies have suggested that compassion fatigue can occur in a range of mental health professionals and settings, such as psychologists (Aukštinaitytė & Zajackauskaitė-Staskevičienė, 2010), psychiatric nurses in forensic units (Laurud, Nonstad, & Palmstierna, 2009), trauma therapists (Killian, 2008), mental health counselors (Thompson, Amatea, & Thompson, 2014), and telephone counselors (O'Sullivan & Whelan, 2011). Clinical social workers in the United States, who often carry out therapy, can also be at risk of compassion fatigue (Thomas & Otis, 2010).

In his etiological model of compassion fatigue in psychotherapists, Figley (2002) proposes that empathy plays a key role in the development of compassion fatigue. The model is based on the assumption that empathy is an important factor in developing a good therapeutic relationship and delivering an effective intervention (Figley, 1995). It suggests that through their empathic response, therapists experience the emotional distress of a client, but that this also contributes directly to the development of compassion fatigue.

The notion of empathy being regarded as crucial in the therapeutic process is longstanding. Carl Rogers outlined six "necessary and sufficient conditions of therapeutic personality change" (Rogers, 1957), which he suggested were essential for psychotherapeu-

tic change. Two of these conditions regarded empathy, in that the therapist must both experience and communicate to the client an empathic understanding of their problem. The importance of empathy has also been detailed in more recent models of psychological treatment, such as the role of "empathic listening" within the Socratic questioning techniques in cognitive behavioral therapy (Padesky & Greenberger, 1995). Given the importance of empathy in mental health work, and the potential for compassion fatigue to reduce empathy in professionals, it is important to understand what psychosocial factors might be associated with compassion fatigue.

### Aim of the Current Review

There are currently no reviews of compassion fatigue in mental health professionals. There have been past reviews involving other health professionals. For example, one review of compassion fatigue in nurses, including psychiatric nurses, found that compassion fatigue was associated with factors such as age, educational background, work hours, stress, burnout, and organizational support (Yang & Kim, 2012). Another paper has reviewed the literature on secondary traumatic stress, vicarious traumatization, traumatic countertransference, burnout, and compassion fatigue, but specifically relating to professionals who work with individuals who have experienced trauma (Collins & Long, 2003). A search of the Cochrane Library yielded no results for "compassion fatigue."

Given the significant role of empathy and compassion in the work of mental health professionals, it seems important to understand what psychosocial factors are associated with compassion fatigue. The current review addresses the following question:

What factors are associated with compassion fatigue in mental health professionals?

### Method

Relevant studies were identified via a systematic search of four databases (PsycINFO, PubMed, CINAHL, and PILOTS) for using the following search criteria: *compassion fatigue AND (predict\* OR risk factor\* OR risk OR cause\* OR correlate\* OR susceptible OR susceptibility OR protect\* OR resilience OR vulnerable OR vulnerability) AND (mental health nurse\* OR psychiatric nurse\* OR mental health professional\* OR therapist\* OR psychologist\* OR counselor\* OR mental health physician\* OR mental health professional\* OR psychiatrist\* OR social worker\* OR psychotherapist\*)*.

Studies were included if they used quantitative analyses to investigate predictor or correlational variables of compassion fatigue; used validated measures of compassion fatigue; included participants who were in a mental health-related profession (studies that investigated compassion fatigue in the general public were excluded); had a cross-sectional, correlational, longitudinal, experimental, or quasi-experimental design; were published in peer-reviewed journals, and were published in English or where a translation into English was available. Studies published up until the end of August 2014 were considered for review. In addition to the electronic database search, a "hand search" of two relevant journals, *The Journal of Traumatic Stress* and *Traumatology* was carried out, which identified a further two studies that warranted examination. These particular journals were chosen as they were the most commonly occurring journals within the original search.

The initial search yielded a total of 477 studies, the titles and abstracts of which were screened to determine which were potentially eligible for inclusion. At this point, 439 studies were found to be duplicates or not relevant, leaving 40 (including those found in the hand searches), the full texts of which were examined in detail. Initial screening for inclusion eligibility was completed by the first author, while the second author completed reliability checks.

Following this process, eight studies were removed as they did not meet inclusion criteria. Including the two studies found in the journal hand search, a total of 32 studies met all inclusion criteria (refer to Figure A1 in the Appendix for a breakdown of the study selection process). Of those that did not meet criteria, a number of them did use compassion fatigue measures (e.g., Professional Quality of Life Scale (ProQOL; Stamm, 2010), which also includes subscales of burnout and compassion satisfaction, but did not report any findings relating to compassion fatigue (e.g., Lambert & Lawson, 2013); two were not available in English; and one used a measure of compassion fatigue to predict working alliance, rather than reporting correlates or predictors of compassion fatigue (Carmel & Friedlander, 2009).

The quality of each study was assessed using the Quality Assurance Checklist (Kmet, Lee, & Cook, 2004). The checklist comprises 14 items. Three items were not used in the present review as they are relevant only to studies that used an intervention. Each study was rated against the items on the checklist and achieved an overall score between 0 and 42 which was then converted to give a percentage score (0–100).

## Design and Demographic Information

Thirty-two studies were included in the review, all of which were cross-sectional in design. While 23 studies used the ProQOL to measure compassion fatigue, different versions of the measure were used, including the third, fourth, and fifth editions (Stamm, 2010). Nine studies used versions of the Compassion Fatigue Self-Test (CFST) which, as an earlier version of the ProQOL, shares the subscales of Compassion Fatigue, Compassion Satisfaction, and Burnout. In terms of location, most (18) studies were conducted in the United States, with three from Israel, two each from Germany and Canada, and one study each from Lithuania, United Kingdom, Austria, Australia, Switzerland, Norway, South Africa, and Italy (some studies used participants from more than one country). Table 1 provides an overview of each study in the review.

Most studies used correlation and regression analyses to test relationships between compassion fatigue and other variables. Group differences analyses such as *t* tests and analyses of variance were also used, as was a chi-square analysis in one study to investigate risk of compassion fatigue. Sample sizes ranged from 13 to 1,121, with a median of 135. All studies were published in 2002 or later. The literature search was conducted in August 2014 so any relevant studies that may have been published since this date are not included.

While the focus of the present review was on mental health professionals, there was some variation in the specific job roles of participants. Sample populations included psychologists, trauma therapists, psychiatrists, telephone counselors, genetic counselors, child welfare workers, mental health social workers, employee

assistance professionals, community mental health clinicians, forensic mental health nurses, psychotherapists, family therapists, and volunteer bereavement counselors.

## Overview of Study Quality

Each study was assessed using the Quality Assurance Checklist (Kmet et al., 2004), compared against the criteria in the checklist and given an overall quality rating as a percentage. The studies varied widely in terms of sample size, but each study scored at least reasonably highly for quality on the checklist, with ratings ranging from 60% to 95%, with a median of 80%.

It is noted that the way in which samples were recruited may have been open to bias. For example, many studies sent invitations to participants at random, often on a large scale, and relied on data being voluntarily returned. It is possible that participants who were experiencing higher levels of compassion fatigue may not have been as likely to take extra time to complete a battery of measures if they were already having some difficulties coping with the demands of their work. Alternatively, those who had higher levels of compassion fatigue may have been more willing to participate, driven by a need to increase awareness of the issue. Few studies discussed the impact of their recruitment strategies and the potential for bias in this way.

In addition, the studies were cross-sectional in nature and rarely did group comparisons. It is therefore possible that factors other than those being measured were influencing the amount of compassion fatigue being reported by participants. While some studies do acknowledge the limitations of cross-sectional designs, few studies discuss the possibility of extraneous variables influencing compassion fatigue. Yet it is possible that factors specific to that time were affecting levels of compassion fatigue, such as team dynamics, organizational support, or wider social or political influences on health services.

## Results

A wide range of factors were investigated in relation to compassion fatigue. For example, many studies reported on the association between compassion fatigue and demographic variables such as sex (e.g., Zeidner et al., 2013), age (e.g., Connally, 2012), and ethnicity (e.g., Sprang, Craig, & Clark, 2011). Other factors related to the clinician were also investigated, such as years of work experience (e.g., Sprang, Clark, & Whitt-Woosley, 2007), caseload (e.g., Simon et al., 2006), trauma history (e.g., Killian, 2008), empathy (e.g., MacRitchie & Leibowitz, 2010), mindfulness traits (e.g., Thielemann & Cacciatore, 2014), religion (e.g., Injeyan et al., 2011), and coping methods (e.g., Jacobson, 2012). Many studies that used the ProQOL to measure compassion fatigue also reported associations with other ProQOL variables (e.g., Collins & Long, 2003), namely, burnout and compassion satisfaction. The main findings are summarized and discussed below.

## Trauma History

The factor most commonly associated with compassion fatigue was participants' own experiences of traumatic life events, with six studies reporting that higher compassion fatigue was related to previous trauma (Deighton, Gurriss, & Traue, 2007; Killian, 2008;

Table 1  
*Overview of Study Characteristics, Findings, and Quality Ratings*

Study	Sample	Country	N	CF measure	Quality (%)	Main findings
Aukštinaitytė & Zajančkauskaitė-Staskevičienė, 2010	Psychologists	Lithuania	103	ProQOL	85	CF was negatively correlated with self-care, the ability to leave working strain behind, hearing the signals of one's own body, preservation of healthy work limits, not allowing others to exhaust you, and setting and reaching life goals.
Birck (2001)	Professionals working with torture survivors	Germany	25	CFST	68	CF was positively correlated with disruptions of other safety, self-trust, and self-esteem. Therapists showed higher CF than interpreters. There was no association between CF and supervision hours.
Boscarino et al. (2004)	Social workers	USA	236	CFST	70	CF was positively predicted by the level of World Trade Center counseling involvement and negatively by a supportive work environment.
Buchanan et al. (2006)	Mental health trauma professionals	Canada	280	CFST	60	CF was positively correlated with perceived signs of STS.
Cohen et al. (2006)	Hospital social workers	Israel	53	CFST	68	CF was not significantly correlated with the number of terror incidents attended, nor with any of the demographic variables. No differences in CF were found between participants who received supervision and debriefing and those who did not.
Collins & Long (2003)	Trauma recovery workers	UK	13	CFST	70	Levels of CF increased over the first year in post.
Connally (2012)	Community mental health clinicians	USA	36	ProQOL	80	There were no statistically significant differences among variables such as age, sex, ethnicity, and sexual orientation with CF.
Craig & Sprang (2010)	Trauma therapists	USA	532	ProQOL	90	CF was higher in therapists in inpatient care settings than community mental health centers and significantly more than those in private practice. CF was positively predicted by the percentage of PTSD cases on caseloads and negatively predicted by the use of evidence-based practice.
Deighton et al. (2007)	Psychotherapists treating torture survivors	Germany, Austria, and Switzerland	100	ProQOL	73	CF positively correlated with number of clients seen per week. A combination of high advocacy and low degree of working through traumatic events was related to higher levels of CF.
Hatcher & Noakes (2010)	Clinicians treating sex offenders	Australia	48	ProQOL	85	CF was positively correlated with and predicted by role problems.
Injeyan et al. (2011)	Genetic counselors	Canada	355	ProQOL	85	Counselors were more at risk of CF if they had low dispositional optimism, and external locus of control. Using religion/spirituality as a coping mechanism positively predicted CF.
Jacobson (2012)	Employee assistance professionals	USA	325	ProQOL	85	CF was positively predicted by negative coping style.
Killian (2008)	Trauma therapists	USA	104	ProQOL	75	CF was positively predicted by work drain, sense of powerlessness regarding social welfare or judicial systems that are failing their clients, lack of emotional self-awareness, and therapists' history of trauma.
Lauvrud et al. (2009)	Forensic mental health nurses	Norway	70	ProQOL	77	No association was found between CF and prevalence of PTSD symptoms.
Lawson & Myers (2011)	Counselors	USA	506	ProQOL	90	CF was negatively correlated with total wellness scores.

(table continues)

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Table 1 (continued)

Study	Sample	Country	N	CF measure	Quality (%)	Main findings
MacRitchie & Leibowitz (2010)	Trauma workers (counselors)	South Africa	64	CFST	75	CF was negatively correlated with social support, and positively correlated with empathy. CF was not correlated with level of exposure to violent crime. Empathy moderated the relationship between CF and previous trauma. Participants who had previously been victims of crime and had higher empathy scores scored more highly on CF.
Nelson-Gardell & Harris (2003)	Child welfare workers	USA	166	CFST	77	CF significantly correlated with all five scales of the Childhood Trauma Questionnaire, which were also significant predictors.
Newmeyer et al. (2014)	Mental health trauma workers	USA	22	ProQOL	82	CF was not associated with spirituality, ego resilience, or stress vulnerability.
O'Sullivan & Whelan (2011)	Telephone counselors	Australia	64	ProQOL	90	CF was positively correlated with posttraumatic growth, relating to others and personal strength.
Racanelli (2005)	Mental health clinicians	Israel and USA	66	ProQOL	86	CF was not significantly correlated with or predicted by attachment style, country of practice, years' experience, experience of terrorism, hours worked per week, family experience of terrorism, or gender.
Ray et al. (2013)	Mental health clinicians	Canada	169	ProQOL	90	CF was associated with several areas of work life quality and all three subscales of burnout.
Robins et al. (2009)	Medical, nursing, social work, and allied health professionals	USA	314	CFST	73	CF was positively predicted by years in direct care, internal coping, and three empathy subscales (perspective taking, fantasy, and personal distress). Trauma workers were more likely to report high CF than those working in a children's hospital.
Rossi et al. (2012)	Community mental health workers	Italy	260	ProQOL	85	CF was positively correlated with negative life events, lifetime traumatic events, and distress. CF was positively predicted by being female, having a professional qualification, having a fixed-term contract, being employed full-time, suffering a negative life event in the past 12 months, and years working in the service.
Simon et al. (2005)	Oncology social workers	USA	21	CFST	80	CF was not significantly associated with age, length of time in oncology, number of clients seen each month, emotional involvement with clients, ability to separate work from home, and level of social work licensure.
Sprang et al. (2007)	Behavioral health providers	USA	1,121	ProQOL	75	CF was associated with being female, being a medical provider (i.e., psychiatrist), and a lack of specialist training. CF was predicted by being female, young in age, having a higher educational degree, having less clinical experience, and a higher percentage of clients with PTSD.
Sprang et al. (2011)	Mental health workers	USA	668	ProQOL	70	Males reported significantly higher levels of CF than females. Hispanic workers, those in rural areas and those who had no religious activity also reported higher CF. Child welfare workers reported higher CF.

Table 1 (continued)

Study	Sample	Country	N	CF measure	Quality (%)	Main findings
Thieleman & Cacciatore (2014)	Bereavement counsellors	USA	41	ProQOL	80	CF was negatively correlated with mindfulness attention awareness. No significant relationship was found between the bereavement status of the participant and CF.
Thompson et al. (2014)	Mental health counselors	USA	213	ProQOL	80	CF was negatively correlated with and was predicted by counselor perceptions of positive working conditions and mindfulness. Females reported higher CF than males. CF was positively predicted by maladaptive coping styles.
Thomas & Otis (2010)	Clinical social workers	USA	171	ProQOL	95	CF was positively correlated with fantasy and personal distress subscales of empathy, and adult trauma history (also a predictor). CF was negatively correlated with emotional separation (also a predictor) and mindfulness.
Tosone et al. (2010)	New York social workers following 9/11	USA	481	ProQOL	85	CF was predicted by avoidant and ambivalent attachment styles, and the amount of time spent working with trauma victims.
Udipi et al. (2008)	Genetic counselors	USA	222	ProQOL	95	CF was positively predicted by use of self-criticism and giving up as coping strategies, the number of different types of distressing events experienced, number of patients seen per week, religion, parental status, and seeking support.
Zeidner et al. (2013)	Mental health professionals	Israel	89	ProQOL	80	Females reported higher levels of CF than males. CF was negatively correlated with trait emotional intelligence, emotion management, and negative affect. Problem-focused coping was negatively correlated with CF.

Note. CF = compassion fatigue; STS = secondary traumatic stress; ProQOL = Professional Quality of Life Scale; CFST = Compassion Fatigue Self-Test; PTSD = posttraumatic stress disorder.

MacRitchie & Leibowitz, 2010; Nelson-Gardell & Harris, 2003; Rossi et al., 2012; Thomas & Otis, 2010). One study reported higher compassion fatigue in participants who had previously been exposed to violent crime (MacRitchie & Leibowitz, 2010). Nelson-Gardell and Harris (2003) used the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) to assess past trauma experience. The CTQ comprises five subscales of childhood trauma: Emotional Abuse, Physical Abuse, Sexual Abuse, Emotional Neglect, and Physical Neglect. All CTQ subscales were associated with higher compassion fatigue. An additional study found that a measure of stressful life experiences was not related to compassion fatigue (Jacobson, 2012). The fact that this study reported that number of stressful life experiences was not related to compassion fatigue suggests that there is something specific about traumatic events that leave clinicians more vulnerable to compassion fatigue.

**Mindfulness**

Three studies assessed the link between mindfulness and compassion fatigue (Thieleman & Cacciatore, 2014; Thomas & Otis, 2010; Thompson et al., 2014), and all found that greater

levels of dispositional mindfulness were associated with lower levels of compassion fatigue. Two studies (Thieleman & Cacciatore, 2014; Thompson et al., 2014) used the Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003) while the third (Thomas & Otis, 2010) used the Five-Facet Mindfulness Questionnaire (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006), both of which measure dispositional mindfulness and mindfulness attitudes. It was noticeable that the relationships reported in each of these studies were relatively strong, suggesting that mindfulness might play an important protective role against compassion fatigue.

This suggests that there is emerging evidence for mindfulness being a protective factor for compassion fatigue. The two measures of mindfulness used in these studies: The MAAS and the Five-Facet Mindfulness Questionnaire, both measure dispositional mindfulness, such as the tendency to be receptive to what is happening around you. Neither measure captures whether clinicians were actually practicing mindfulness as a coping strategy or lifestyle choice. This would be a useful avenue for future research to further determine how useful mindfulness can be in building resilience against compassion fatigue.

## Empathy

Five studies reported findings related to empathy and compassion fatigue (MacRitchie & Leibowitz, 2010; O'Sullivan & Whelan, 2011; Robins, Meltzer, & Zelikovsky, 2009; Simon et al., 2006; Thomas & Otis, 2010), with three reporting significant results. MacRitchie and Leibowitz (2010) found not only that participants' level of compassion fatigue increased as level of empathy increased, but that empathy also moderated the relationship between compassion fatigue and previous trauma. In other words, for those trauma workers who had previously been victims of violent crime, the higher their level of empathy, the higher their compassion fatigue scores. While this is an interesting finding, and one which is consistent with Figley's initial theoretical model, this study scored below the median score for study quality, mainly due to a lack estimates of variance in its results statistics, and due to having a relatively small sample size ( $N = 64$ ).

Two further studies used the subscales of the Interpersonal Reactivity Index (IRI; Davis, 1983) measure of empathy to look more closely at the relationship between empathy and compassion fatigue (Robins et al., 2009; Thomas & Otis, 2010). Scores for compassion fatigue were higher as scores on three empathy subscales increased: Fantasy (the tendency to transpose oneself imaginatively into the feelings and actions of fictitious characters), Perspective Taking (the tendency to spontaneously adopt the psychological point of view of others), and Personal Distress ("self-oriented" feelings of personal anxiety in tense interpersonal settings). However, in both studies the statistics suggested that Personal Distress was most strongly related to compassion fatigue, compared with the other two subscales. The Thomas and Otis (2010) study reported the slightly stronger correlation here and was methodologically the stronger of the two studies. This finding might suggest that it is the tendency to feel distress in response to that of others that is important to the development of compassion fatigue, as opposed to other facets of empathy such as the tendency to adopt the point of view of another spontaneously.

While Simon et al. (2006) reported nonsignificant findings, the correlation coefficient was relatively large ( $-.40$ ) and suggested that as empathy increased, compassion fatigue decreased. While this trend contradicts those above, it should be treated with caution, not just because it is not statistically significant but because the empathy measure was not standardized (participants were asked to rate themselves on the single item: "empathetic response to clients").

## Caseload

Four studies reported on the relationship between caseload and compassion fatigue (Deighton et al., 2007; MacRitchie & Leibowitz, 2010; Tosone, Bettmann, Minami, & Jaspersen, 2010; Udipi, Veach, Kao, & LeRoy, 2008). While one study found that the two variables were not related (MacRitchie & Leibowitz, 2010), the number of patients seen per week by genetic counselors was related to higher compassion fatigue in another (Udipi et al., 2008). In professionals working with trauma victims, a high number of cases seen per week was related to higher compassion fatigue (Deighton et al., 2007) as was time spent working with victims (Tosone et al., 2010). This finding perhaps makes intuitive sense insofar as one might expect clinicians to be more prone to com-

passion fatigue the more they are exposed to the challenges of working with clients.

## Experience and Age

Ten studies examined the relationship between amount of clinical experience and compassion fatigue (Birck, 2001; Cohen, Gagin, & Peled-Avram, 2006; Craig & Sprang, 2010; Deighton et al., 2007; Nelson-Gardell & Harris, 2003; Robins et al., 2009; Rossi et al., 2012; Thompson et al., 2014; Thomas & Otis, 2010; Udipi et al., 2008). This was typically measured by asking participants how long they had worked in the mental health field (e.g., Thompson et al., 2014), although in some studies participants were asked about how long they had worked in direct care (Robins et al., 2009), or for how long they had worked in that particular role (e.g., Rossi et al., 2012). Of these 10 studies, only three reported that experience was related to compassion fatigue. Compassion fatigue increased with years spent working in the field of trauma counseling (Birck, 2001), with a strong correlation reported, although this particular study had a very small sample size ( $N = 25$ ). Participants who had worked for longer as a mental health practitioner in a children's hospital were also more likely to report high compassion fatigue (Robins et al., 2009). However, one study found that as years spent in the mental health field increased, compassion fatigue decreased (Thompson et al., 2014), although the strength of the correlation here was small.

In terms of nonsignificant trends, three studies did report that compassion fatigue decreased as level of experience increased, although the correlations here were small (Nelson-Gardell & Harris, 2003; Thomas & Otis, 2010; Udipi et al., 2008). Similar variation was found in the association between compassion fatigue and age.

It is likely that those with more experience are assigned the most challenging cases, or expected to cope with larger caseloads than those less experienced. At the same time, it is possible that with their experience these clinicians have learned more effective ways of coping and are then not as likely to develop compassion fatigue.

Eight studies reported statistics relating age to compassion fatigue (Birck, 2001; Cohen et al., 2006; Craig & Sprang, 2010; Hatcher & Noakes, 2010; Nelson-Gardell & Harris, 2003; Rossi et al., 2012; Sprang et al., 2011; Thomas & Otis, 2010). Only one reported a significant finding, with younger participants having higher levels of compassion fatigue (Sprang et al., 2011). In those that found no relationship, three found very small trends toward compassion fatigue decreasing with age (Cohen et al., 2006; Nelson-Gardell & Harris, 2003; Thomas & Otis, 2010). Two studies reported mean compassion fatigue scores, with participants in the youngest categories (20–24 and 18–30) reporting lower compassion fatigue scores than the oldest (45+ and 50+; Hatcher & Noakes, 2010; Rossi et al., 2012), so the overall picture is very mixed.

One study in the review found that younger professionals were more likely to report compassion fatigue (Sprang et al., 2011) and we can reasonably assume that because they were younger they were therefore less experienced. Thompson et al. (2014) found that experience was associated with lower compassion fatigue. They suggested that those with more experience may be more likely to find themselves in supervisory roles and therefore less directly exposed to clients' trauma. But many clinicians in supervisory

roles still continue to see clients and, in addition, are required to hold in mind the clients of their supervisees, as well as bear any distress that those clinicians may bring to supervision, so may, in fact, be more exposed.

### Sex Differences

Of the 32 studies reviewed, 12 reported data on the relationship between a person's sex and compassion fatigue (Birck, 2001; Connally, 2012; Craig & Sprang, 2010; Deighton et al., 2007; Hatcher & Noakes, 2010; Robins et al., 2009; Rossi et al., 2012; Sprang et al., 2007, 2011; Thomas & Otis, 2010; Thompson et al., 2014; Zeidner et al., 2013).

Three studies found that being female was associated with higher levels of compassion fatigue (Sprang et al., 2007; Thompson et al., 2014; Zeidner et al., 2013), whereas another found that males reported higher compassion fatigue than females (Sprang et al., 2011). These authors found that the main predictor of compassion fatigue in their sample was job role, namely, child welfare workers. They attributed the anomaly regarding males to the fact that in their population most males were also child welfare workers.

### Coping Style

Four studies used formal measures of coping style and assessed its association with compassion fatigue (Jacobson, 2012; Thompson et al., 2014; Udipi et al., 2008; Zeidner et al., 2013). Three used the Brief COPE measure (Carver, 1997) which breaks down coping style into three subscales: problem-focused, emotion-focused, and maladaptive coping (Meyer, 2001). Two studies found that the use of maladaptive coping styles was associated with higher levels of compassion fatigue (Jacobson, 2012; Thompson et al., 2014). One study, which scored highly on the quality rating, found that two of the Brief COPE items in particular, use of self-criticism and giving up, were related to higher compassion fatigue (Udipi et al., 2008). The Coping Inventory for Stressful Situations—Situation Specific Coping (Endler & Parker, 1990) was used in one study which found that task-focused coping was weakly associated with lower levels of compassion fatigue, while emotion-focused coping more strongly predicted high compassion fatigue (Zeidner et al., 2013). Some studies included variables that might be interpreted as coping methods but were not measured by formal questionnaires as above, such as social support, which was found to be related to lower compassion fatigue (MacRitchie & Leibowitz, 2010) and use of religion, which is discussed below.

Having a positive perception of one's work environment was associated with lower compassion fatigue (Thompson et al., 2014). This includes factors such as coworker support and perceptions of fairness and support in the work organization. High emotional intelligence, as measured by the Schutte Self-Report Inventory (Schutte et al., 1998) predicted higher compassion fatigue (Zeidner et al., 2013), as did emotional separation (Thomas & Otis, 2010), measured by the Maintenance of Emotional Separation Scale (Corcoran, 1982). The ability to identify one's own emotional states (as measured by emotional self-awareness—Emotional Self-Awareness Questionnaire; Killian, 2007) however was related to lower compassion fatigue (Killian, 2008). Being emotionally self-aware is posited as being beneficial due to allowing professionals

to detect early signs of being affected by the role, and therefore in a better position to tackle it (Killian, 2008).

### Religion

Participant religion and religious practices were investigated in three studies with mixed findings in relation to compassion fatigue (Sprang et al., 2011; Injeyan et al., 2011; Udipi et al., 2008) One study found that participants who took no part in religious activities were more likely to report compassion fatigue compared with those who had sporadic, active, or very active religious participation (Sprang et al., 2011). However, two studies found that the use of religion as a coping strategy was related to higher levels of compassion fatigue (Injeyan et al., 2011; Udipi et al., 2008).

### Other ProQOL Variables—Burnout

Eleven studies reported on the relationship between compassion fatigue and burnout (Aukštinaitytė & Zajančauskaitė-Staskevičienė, 2010; Birck, 2001; Collins & Long, 2003; Ray, Wong, White, & Heaslip, 2013; Robins et al., 2009; Rossi et al., 2012; Simon et al., 2006; Thomas & Otis, 2010; Thompson et al., 2014; Udipi et al., 2008; Zeidner et al., 2013). All studies found significant positive correlations between the two variables, and these relationships tended to be strong. While a commonly used measure of burnout is the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981), most studies in this review used the ProQOL to measure burnout.

Of all the variables measured alongside compassion fatigue, burnout was one of those most strongly related. Given that the ProQOL contains measures of both compassion fatigue and burnout, it is quite possible that conceptual overlap between the two constructs explains the high association. It is also possible that individuals begin to develop signs of compassion fatigue once they begin to feel burnt out, or vice versa. In one study, compassion fatigue was related to all three subscales of the MBI, and particularly strongly with *emotional exhaustion* (Ray et al., 2013). Potentially useful further research might involve combining the research literature on predictors of both burnout and compassion fatigue to see whether they share common predictors.

### Compassion Satisfaction

In addition, eight studies investigated the relationship between compassion fatigue and compassion satisfaction (Birck, 2001; Collins & Long, 2003; Robins et al., 2009; Rossi et al., 2012; Simon et al., 2006; Thomas & Otis, 2010; Thompson et al., 2014; Udipi et al., 2008). Of these studies, six found that higher levels of compassion satisfaction were associated with lower levels of compassion fatigue, while the remaining two found nonsignificant results. As with burnout, compassion satisfaction was measured using either the ProQOL or CFST. Given that compassion satisfaction describes the potential for positive aspects of helping professions to develop, it is perhaps not surprising that it is associated with lower compassion fatigue. Professionals who are experiencing psychological distress and fatigue are less likely, it seems, to report feeling satisfaction in their role. Some studies suggested that compassion satisfaction can act as a protective factor against compassion fatigue.



## Discussion

The current review aimed to determine factors most commonly associated with compassion fatigue in mental health professionals. In total, 32 studies were reviewed, with a large number and variety of variables being investigated. Despite the variation in studies, some factors were commonly reported to be related to compassion fatigue. The main factors included the professionals' own trauma history, mindfulness, empathy, and caseload, as well as other ProQOL variables: burnout and compassion satisfaction. Other variables that were investigated report very mixed results and as such do not appear to consistently influence compassion fatigue, such as age, sex, religion, and work experience.

Those factors where a high proportion of studies found significant relationships include trauma history, certain types of empathy, and a high caseload. These could therefore be considered as the main "risk factors" for compassion fatigue in mental health professionals. Some factors, such as mindfulness, while not extensively researched, were associated with lower compassion fatigue which might indicate them as potential protective factors.

The findings seem to corroborate Figley's theory which implicates empathy in the development of compassion fatigue (Figley, 2002). Empathy is well recognized as playing an important role in mental health care yet seems to pose a risk to the well-being of clinicians. The relationship between empathy and compassion fatigue is not made clear by cross-sectional studies, however. Empathy's apparent role in the development of compassion fatigue suggests that those with higher empathy levels might be more vulnerable to compassion fatigue in the first instance. However, one of the effects of compassion fatigue is a reduction in an individual's ability to feel and display empathy (Mathieu, 2007). It is therefore not necessarily clear whether we would expect empathy to correlate positively or negatively with compassion fatigue. A clinician may have developed compassion fatigue because they are highly empathic, for example, but have a low empathy score due to the effects of compassion fatigue. In order to investigate this relationship more thoroughly, longitudinal research is required.

Results from the current review, however, shed some further light on the relationship between empathy, compassion fatigue, and trauma history. It has previously been suggested that professionals with a personal history of trauma may be more vulnerable to secondary traumatic stress reactions because of the potential reactivation of traumatic memories and elicitation of intense empathic responses (Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The finding that empathy moderates the relationship between compassion fatigue and trauma history (MacRitchie & Leibowitz, 2010), suggests that clinicians who were more empathic were more likely to experience compassion fatigue, if they had a history of trauma. It is possible that empathy in and of itself does not necessarily increase a clinician's risk of compassion fatigue, but that it does so via its relationship with their previous experience of traumatic events, and how this plays out in their interactions with clients and patients.

Given the relationship between compassion fatigue and compassion satisfaction, it may be of interest to investigate what factors are associated with higher levels of compassion satisfaction in helping professionals. Some studies have suggested that trainee professionals have lower compassion satisfaction, whereas part-time workers reported higher (Robins et al.,

2009). The relationship between compassion satisfaction and empathy may also warrant further investigation. Some research has reported that compassion satisfaction is related to empathic concern as measured by the IRI (Thomas & Otis, 2010). Further research might look more closely at the relationship between different facets of empathy in relation to both compassion satisfaction and compassion fatigue.

The findings relating to trauma history have led some authors to suggest that the relationship between personal trauma history and reactions to working with traumatized others, has implications for the validity of secondary traumatic stress reactions (Elwood et al., 2011), such as compassion fatigue. If what is being conceptualized as a secondary trauma reaction can be explained by some pre-existing psychological difficulty, such as PTSD from a previous trauma, then individuals' reactions to trauma rather than their level of exposure may be more predictive of difficulties like compassion fatigue (Elwood et al., 2011).

One thing that is not reported in these studies is whether or not clinicians had subsequent difficulties relating to their traumas or if they had received appropriate help to resolve any difficulties. It has been suggested that if previous exposure to trauma goes unacknowledged or unresolved it may intensify and increase symptoms of secondary trauma (Munroe et al., 1995; Solomon, 1993). Indeed, previous research that measured secondary trauma using a PTSD scale (Impact of Events Scale; Weiss, 2007) has suggested that participants who considered their reactions to trauma to be unresolved, or who had had previous trauma therapy themselves, were more likely to have high secondary trauma (Creamer & Liddle, 2005; Hargrave, Scott, & McDowall, 2006).

A large number of studies found an association between burnout and compassion fatigue. The relationship between these two factors could be explained by some conceptual overlap. As constructs, they both purport to describe psychological and physical effects of mentally and emotionally demanding work that develop over time. Conclusive findings in research of this type might be hindered by conceptual overlap between the two constructs, which could essentially be "tapping into" a shared characteristic, such as emotional exhaustion. As such, a broader challenge for research in this area perhaps is to develop clearer distinctions between compassion fatigue and burnout.

Other similar constructs might also be investigated in future work. For example, moral distress has been reported in health professionals such as nurses and found to be related to higher compassion fatigue (Maiden, Georges, & Connelly, 2011). Moral distress has been found to exist in mental health practitioners too (Austin, Bergum, & Goldberg, 2003), suggesting it is certainly an area worth exploring in furthering our understanding of compassion fatigue in mental health professionals.

## Implications

One of the most exciting implications from this review is the emergence of mindfulness playing a potentially protective role against compassion fatigue. The relationship between mindfulness and compassion fatigue could have implications for the way in which clinicians manage the stresses of their work. The findings in this review suggest the need for further, more experimental, research that would develop our understanding, such as investigating the effectiveness of mindfulness over time as an intervention in the

workplace, or testing differences between groups of clinicians who use mindfulness and those who do not. Indeed, recent research has suggested that meditation practices might be effective in reducing stress and promoting resilience (Seppala, Hutcherson, Nguyen, Doty, & Gross, 2014), although this was in an undergraduate student population. An older study found that an 8-week meditation-based stress reduction program helped reduce anxiety and psychological distress in medical students, as well as increase overall empathy scores (Shapiro, Schwartz, & Bonner, 1998). In addition, further exploration of other cognitive and behavioral coping mechanisms and their impact on compassion fatigue over time would be a useful area of research.

Because professionals' own trauma history is associated with compassion fatigue, it has been suggested that organizations should make available services that provide helping professionals with opportunities to process personal traumas (Killian, 2008). This is a potentially important finding when considering what might motivate an individual to seek a career as a mental health clinician. It is possible that some clinicians may have had significant difficulties or trauma in their past and that this motivated them to help others in similar situations. However, they may be more prone to compassion fatigue as a result. Knowing that previous trauma history is related to higher compassion fatigue, clinicians or the organizations in which they work could be more proactive in providing necessary support to protect against compassion fatigue. This might have additional implications for training organizations, who may wish to consider training health care professionals in understanding and recognition of compassion fatigue and potential risk factors, during their core training.

While most studies in the review measured and reported on a number of different variables, few conducted further analyses to look at how the different variables might interact in relation to compassion fatigue. One example to the contrary is that of MacRitchie and Leibowitz (2010) who found overall level of empathy moderated the relationship between compassion fatigue and previous trauma. It would be interesting to investigate relationships between variables that are most strongly or regularly associated with compassion fatigue. For example, it may be that clinicians with a history of trauma are more likely to engage in less effective coping strategies.

### Limitations and Future Directions

The studies included in this review were cross-sectional in design, and therefore unable to clearly determine any causal relationships. This leaves many questions unanswered. For example, are clinicians more likely to develop signs of compassion fatigue because they employ maladaptive coping strategies, or do the effects of compassion fatigue lead clinicians to change the way they cope with the demands of the work? Clinicians' own trauma history was a common predictor of compassion fatigue, but the nature of the studies does not allow us to understand what mechanisms might occur following a traumatic event that make the development of compassion fatigue more likely. As mentioned above, the extent of the impact of these traumatic events and whether or not clinicians received or indeed required support following the events is not known.

The fact that the review only included quantitative findings also limited its scope. By definition, only those variables that

researchers decided to measure could be analyzed in relation to compassion fatigue, which, in turn, is limited by the availability of suitable measures. One way to broaden the scope of the review would be to include qualitative studies. Within the current review, four of the 32 studies included qualitative methods alongside quantitative (Collins & Long, 2003; Hatcher & Noakes, 2010; Killian, 2008; Udipi et al., 2008). The findings from these studies revealed further information about the use of coping strategies that clinicians described as being useful in preventing compassion fatigue. For example, using supervision as a space to debrief and share experiences of work was found to be helpful, or indeed "crucial" in dealing with the impact of working with clients (Hatcher & Noakes, 2010; Killian, 2008). Also, the study by Udipi and colleagues (2008) could potentially provide more insight into clinicians' empathy and the emotional impact of counseling. Participants here described the draining effect of being emotionally invested in clients, and the power of emotional countertransference in provoking reactions about their own personal situations.

There are distinct overlaps between compassion fatigue and other constructs related to the deleterious effect of certain professions, namely, secondary traumatic stress and burnout. Future research might look more closely at these relationships, and consider how burnout and compassion fatigue might interact not just with each other, but with other variables such as coping styles. For example, it may be that some health professionals engage in adaptive coping styles and successfully protect against compassion fatigue. However, over time the effects of burnout might leave them less able to engage in protective activities, leaving them, in turn, more vulnerable to compassion fatigue. These are the kinds of questions that could be crucial in understanding the subtleties of how compassion fatigue develops but, as previously mentioned, can only be properly investigated through longitudinal work. Furthermore, there appears to be a scarcity of large-scale studies within this literature, with many of the reviewed articles reporting on relatively small sample sizes.

While the present review chose specifically to focus on compassion fatigue as a stand-alone construct, there is a lack of clarity about how distinct it is from other concepts, particularly secondary traumatic stress. Compassion fatigue is different from secondary traumatic stress in that it is characterized by exhaustion and a reduction in empathy; effects that accumulate over time, whereas secondary traumatic stress is more an anxiety, PTSD-like reaction to hearing about traumatic events. Nevertheless, the measures used to quantify compassion fatigue, for example, the ProQOL, are subjectively similar to those used to measure secondary traumatic stress (e.g., Secondary Traumatic Stress Scale; Bride, Robinson, Yegidis, & Figley, 2004). Because the two terms are often used interchangeably, it is possible that the current review did not detect papers that used the ProQOL measure; for example, if such studies did not specifically use the term compassion fatigue. Further research is required to clarify the conceptualizations and measurements of these constructs.

### Conclusions

The findings from this review have shed light on possible risk factors for mental health professionals in the development of compassion fatigue which can make it harder for them to carry out

their work. In particular, past traumas in professionals, empathy and exposure to trauma, and distress of clients (e.g., high caseload) are factors commonly associated with higher compassion fatigue. Despite this, possible protective factors, such as mindfulness, have emerged in the literature which has been associated with lower compassion fatigue and provide a possible avenue for future research.

Clearly, the factors influencing the development of compassion fatigue are numerous and the relationships between them complex. Nevertheless, this review has examined the literature and a wide range of studies in order to provide a current understanding of psychosocial factors influencing the development of compassion fatigue. The field would clearly benefit from more longitudinal research, to more accurately determine which factors make the onset of compassion fatigue more likely. This review indicates several clear gaps for future research into compassion fatigue in the mental health care professions.

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**Appendix**  
**Study Selection Process**

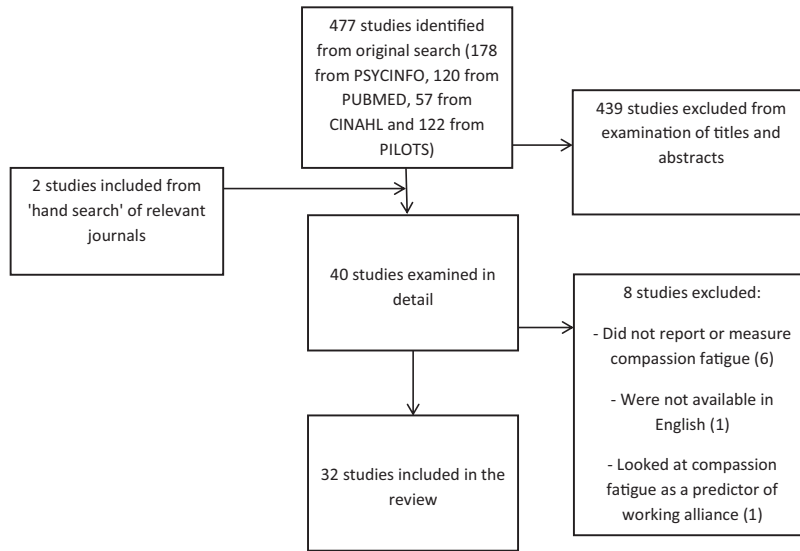


Figure A1. Study selection flowchart.

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