An Investigation into Burnout and Compassion Fatigue in Personnel Support Occupations

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Abstract

In 2007, the Chief of Military Personnel (CMP) requested that a benchmark study be conducted on chaplains in the military, examining current issues and practices in each of The Technical Cooperation Program (TTCP) countries - Canada, Australia, New Zealand, the United Kingdom, and the United States. The report made several recommendations for future research that would address some of the more pressing concerns and issues regarding chaplains in the Canadian Forces (CF). One of those suggestions was to investigate the extent to which CF chaplains experience stress and burnout in their profession and the possible strategies for prevention. Preliminary review of the literature has indicated that the challenges and issues experienced by chaplains in the CF are reflective of their working in a helping profession and thus, are likely to also be experienced by others who are similarly engaged in caring work. As such, it was thereby determined that the analysis should be extended to include all personnel in the CF who are engaged in personnel support occupations. Thus, this paper is an investigation into burnout and compassion fatigue in what will be referred to as personnel support providers in the military or human service providers in the civilian sector. The paper first provides definitions of the key constructs of burnout and compassion fatigue. Following this discussion, the standard measurement instruments employed in the research for both constructs are detailed. A review of the research in both the areas of burnout and compassion fatigue is then discussed, providing a theoretical overview of each, their impact, and the applicable strategies for prevention and treatment. This review of relevant research provides the foundation for the development of two conceptual models – one for burnout and one for compassion fatigue. The paper then concludes with a discussion of the potential implications for the CF, followed by recommendations for future research and analysis.

Résumé

En 2007, le Chef du personnel militaire (CPM) demandait la réalisation d'une étude comparative sur les aumôniers dans les organisations militaires, portant sur les questions et pratiques actuelles dans chaque pays membre du Programme de coopération technique (TTCP) – le Canada, l'Australie, la Nouvelle-Zélande, le Royaume-Uni et les États-Unis. Le rapport contenait plusieurs recommandations de faire des recherches sur certaines questions et préoccupations parmi les plus pressantes concernant les aumôniers des Forces canadiennes (FC). Une de ces recommandations conseillait d'enquêter sur la gravité du stress et du burnout qu'éprouvent les aumôniers des FC dans l'exercice de leur profession et sur les stratégies de prévention possibles. Une revue préliminaire de la littérature a indiqué que les défis et difficultés auxquels les aumôniers des FC devaient faire face résultaient des impératifs d'une profession axée sur la relation d'aide et qu'en conséquence, les autres professionnels oeuvrant dans un domaine similaire avaient probablement à faire face aux mêmes problèmes. Ainsi, on a décidé d'étendre l'analyse à l'ensemble du personnel des FC qui travaille dans les services de soutien au personnel. Le présent article est donc une enquête sur le burnout et l'usure de compassion chez ceux qu'on appelle les fournisseurs de services de soutien au personnel dans la sphère militaire et les fournisseurs de services à la personne dans le domaine civil. L'auteur entame son article par une définition et une discussion des concepts-clés de burnout et d'usure de compassion. Elle décrit en détail les instruments de mesure normalisés qui sont utilisés dans les recherches portant sur ces deux concepts. L'auteur passe ensuite en revue les travaux de recherche qui ont été effectués dans les domaines du burnout et de l'usure de compassion. Elle expose la théorie derrière ces concepts, souligne l'incidence de ces maladies et propose des stratégies de prévention et de traitement. Cette revue de la littérature pertinente pose les fondements nécessaires à l'élaboration de deux modèles conceptuels – un pour le burnout et un autre pour l'usure de compassion. L'auteur conclut son article par une discussion des implications potentielles pour les FC, suivie de recommandations applicables à de futures recherches et analyses.

Executive Summary

In 2007, the Chief of Military Personnel (CMP) requested that a benchmark study be conducted on chaplains in the military, examining current issues and practices in each of The Technical Cooperation Program (TTCP) countries - Canada, Australia, New Zealand, the United Kingdom, and the United States. The report made several recommendations for future research that would address some of the more pressing concerns and issues regarding chaplains in the Canadian Forces (CF). One of those suggestions was to investigate the extent to which CF chaplains experience stress and burnout in their profession and the possible strategies for prevention. Preliminary review of the literature has indicated that the challenges and issues experienced by chaplains in the CF are reflective of their working in a helping profession and thus, are likely to also be experienced by others who are similarly engaged in caring work. As such, it was thereby determined that the analysis should be extended to include all personnel in the CF who are engaged in personnel support occupations. Thus, this paper is an investigation into burnout and compassion fatigue in what will be referred to as personnel support providers in the military or human service providers in the civilian sector.

A definition of the key constructs, namely burnout and compassion fatigue, is first provided. Burnout is often found among human service providers who are engaged in the helping profession, whereby their primary professional responsibility is to provide care for others. It is understood to be a response to the chronic strain of continually being engaged in extensive interactions with others, particularly when they are struggling or having difficulties. Similar to burnout, compassion fatigue is also most often associated with "the cost of caring" for others who are suffering. However, compassion fatigue emerges among professionals who are specifically engaged with trauma and with traumatized individuals. Burnout, on the other hand, does not contain this element of trauma and is based more on the conditions of the work environment.

An overview of the standard measurement instruments commonly employed in the research on burnout and compassion fatigue is provided next. This discussion provides the context for the empirical research that has been conducted in the field. In addition, since it is recommended that future applied research be conducted on personnel support occupations in the CF, this section provides the methodological approaches most suited to research on burnout and compassion fatigue. For both constructs, there are standardized, accepted measurement instruments that have been empirically validated and are suitable for future research projects.

A review of the research on both burnout and compassion fatigue is also provided. This section discusses the relevant research that has been done in the area, highlights the individual and situational factors that contribute to both constructs, and identifies the intervention and treatment strategies that may be employed to alleviate the impact of both burnout and compassion fatigue. This section also provides the foundation for the conceptual models that have been developed. The conceptual model for burnout is an explanatory framework, while the conceptual model presented for compassion fatigue is a descriptive framework.

The paper concludes with a discussion of the potential implications for the CF, followed by recommendations for future research and analysis. The nature and the type of work that military members in personnel support occupations are engaged in places them at great risk for experiencing burnout and/or compassion fatigue. However, there is a lack of knowledge and understanding with respect to the impact that this work has on military members and it is therefore unclear how these individuals are affected by their work in caring professions. As such, there is a need for further research that would provide greater insight into the prevalence and impact of burnout and/or compassion fatigue in the CF. This research needs to identify those who are presently experiencing burnout and/or compassion fatigue, determine which type of work and which work environments contributes to personnel experiencing either condition, and review potential organizational strategies for prevention and treatment. Based on the existence of standard measurement instruments that have been well established in the literature, it is recommended that a survey comprised of these tools be administered to personnel in personnel support occupations in the CF.

Sommaire

En 2007, le Chef du personnel militaire (CPM) demandait la réalisation d'une étude comparative sur les aumôniers dans les organisations militaires, portant sur les questions et pratiques actuelles dans chaque pays membre du Programme de coopération technique (TTCP) – le Canada, l'Australie, la Nouvelle-Zélande, le Royaume-Uni et les États-Unis. Le rapport contenait plusieurs recommandations de faire des recherches sur certaines questions et préoccupations parmi les plus pressantes concernant les aumôniers des Forces canadiennes (FC). Une de ces recommandations conseillait d'enquêter sur la gravité du stress et du burnout qu'éprouvent les aumôniers des FC dans l'exercice de leur profession et sur les stratégies de prévention possibles. Une revue préliminaire de la littérature a indiqué que les défis et difficultés auxquels les aumôniers des FC devaient faire face résultaient des impératifs d'une profession axée sur la relation d'aide et qu'en conséquence, les autres professionnels oeuvrant dans un domaine similaire avaient probablement à faire face aux mêmes problèmes. Ainsi, on a décidé d'étendre l'analyse à l'ensemble du personnel des FC qui travaille dans les services de soutien au personnel. Le présent article est donc une enquête sur le burnout et l'usure de compassion chez ceux qu'on appelle les fournisseurs de services de soutien au personnel dans la sphère militaire et les fournisseurs de services à la personne dans le domaine civil.

L'auteur donne d'abord une définition des concepts-clés, c'est-à-dire le burnout et l'usure de compassion. On a constaté que les cas de burnout étaient fréquents chez les fournisseurs de services à la personne dont la profession est axée sur la relation d'aide, c'est-à-dire que leur première responsabilité professionnelle consiste à dispenser des soins aux autres. On croit que le burnout est une réponse à la tension chronique engendrée par un engagement continu dans des interactions approfondies avec les autres, en particulier quand ces derniers ont des difficultés et qu'ils les vivent péniblement. Semblable au burnout, l'usure de compassion est également très souvent associée au « coût de l'empathie » à l'égard d'autres personnes souffrantes. Toutefois, parmi les professionnels qui font quotidiennement face aux traumatismes et aux personnes traumatisées, c'est l'usure de compassion qui se manifeste le plus couramment. Or, le burnout n'a rien à voir avec les traumatismes et est davantage lié aux conditions de travail.

L'auteur donne un aperçu des instruments de mesure normalisés qui sont couramment utilisés dans les recherches portant sur le burnout et l'usure de compassion. La discussion qui s'ensuit replace dans son contexte la recherche empirique effectuée sur le terrain. De plus, comme il est recommandé que la recherche appliquée se penche désormais sur les groupes professionnels actifs dans les services de soutien au personnel dans les FC, cette section propose les approches méthodologiques qui conviennent le mieux à la recherche sur le burnout et l'usure de compassion. Pour les deux concepts, il existe des instruments de mesure normalisés et acceptés dont la validité a été démontrée par des faits expérimentaux et qui sont appropriés à de futurs projets de recherche.

Cette section passe également en revue la recherche effectuée sur le burnout et l'usure de compassion. L'auteur discute des recherches pertinentes qui ont été faites dans le domaine; elle souligne les facteurs individuels et situationnels déterminants dans le burnout et l'usure

de compassion; et finalement, elle propose des stratégies d'intervention et de traitement susceptibles d'atténuer l'incidence de ces maladies. Cette section contient également les fondements des modèles conceptuels qui ont été élaborés. Le burnout a pour modèle conceptuel un cadre explicatif, tandis que le modèle conceptuel de l'usure de compassion est un cadre descriptif.

L'auteur conclut son article par une discussion des implications potentielles pour les FC, suivie de recommandations applicables aux futures recherches et analyses. La nature du travail et le type de travail effectué par les militaires des groupes professionnels actifs dans les services de soutien au personnel leur font courir le risque de souffrir un jour de burnout et/ou d'usure de compassion. Cependant, comme on manque de connaissances sur l'incidence de ce travail sur les militaires, on ne sait pas trop comment ils sont affectés par une profession axée sur la relation d'aide. Il y a donc un besoin de nouvelles recherches qui nous donneraient un aperçu plus exact de la prévalence et de l'incidence du burnout et de l'usure de compassion dans les FC. Ces recherches devraient : identifier les personnes qui souffrent de burnout et/ou d'usure de compassion; déterminer les types et milieux de travail qui contribuent à l'apparition de l'une ou l'autre de ces maladies; et examiner d'éventuelles stratégies organisationnelles en matière de prévention et de traitement. La littérature nous ayant appris l'existence d'instruments de mesure normalisés et bien établis, il est recommandé de réaliser un sondage au moyen de ces instruments auprès des membres du personnel qui travaillent dans le secteur des services de soutien au personnel dans les FC.

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1. Introduction

1.1 Background

In 2007, the Chief of Military Personnel (CMP) requested that a benchmark study be conducted on chaplains in the military, examining current issues and practices in each of The Technical Cooperation Program (TTCP) countries - Canada, Australia, New Zealand, the United Kingdom (UK), and the United States (U.S.). The report made several recommendations for future research that would address some of the more pressing concerns and issues regarding chaplains in the Canadian Forces (CF). One of those suggestions was to investigate the extent to which CF chaplains experience stress and burnout in their profession and the possible strategies for prevention. Preliminary review of the literature has indicated that the challenges and issues experienced by chaplains in the CF are reflective of their working in a helping profession and thus, are likely to also be experienced by others who are similarly engaged in caring work. As such, it was thereby determined that the study should be extended to include all personnel in the CF who are engaged in personnel support occupations.

1.2 Personnel Support Occupations

In the CF, there are a number of support occupations that may be classified as part of a helping profession, whereby a significant part of the work consists of supporting and caring for others, particularly those in a position of need or distress. Specifically, there are three types of occupations in the CF that are comparable to the nature of the work of civilian human service providers included in the discussion on burnout and compassion fatigue. These occupations include: chaplains, social workers, and health practitioners. A brief description of each of these occupations has been provided below.

1.2.1 Chaplains

The primary function of a chaplain is “to provide religious ministrations to all members of a [CF] unit regardless of religious affiliation. Their duties include officiating at special functions, providing pastoral care to members and their families, and advising the Commanding Officer regarding the spiritual and ethical well-being and morale of their unit. They may be called upon to liaise with civilian religious faith groups, to refer members to other care providers such as social workers or medical personnel, and to provide directed care after critical incidents.” (CF Recruiting website, 2008). There are several related civilian occupations to CF chaplains, including: professional church worker; youth ministry; special social ministries such as street ministry; pastoral counselling education; hospital, school and university chaplaincies; Correction Services Chaplaincy; church headquarters; ecumenical organizations; and non-governmental organizations (CF Recruiting website, 2008).

1.2.2 Social Workers

Social work officers are “commissioned members of the CF Medical Service [CFMS]. Working in collaboration with other health care professionals, the primary duty of a social work officer is to deliver professional social work services in a military milieu to support the

morale, efficiency, and mental health of Canada's soldiers, sailors and air personnel. As well as the full range of challenges common to Canadian society, [CF] members and their families cope with additional stresses associated with frequent moves and separations caused by service requirements. These stresses can give rise to social and family circumstances that involve complex social work interventions. It is the mission of a social work officer to ensure that CF members and their dependants receive the clinical social work services normally available to civilians through community mental health and social services agencies." (CF Recruiting website, 2008). The challenges associated with this occupation are noted in the recruiting description. Specifically, it states that "extended periods of interviewing and counselling may result in physical and emotional fatigue, and may subject you to unusual degrees of stress as a result of continual involvement in emotionally laden client situations. The uncertainty of caseload demands, the numerous expectations when crises occur, the frustration of limited success, and the lack of opportunity to consult with colleagues may be factors in the stress that affects military social work officers. Appropriate training, environmental clothing and equipment are provided and social work officers' health, safety and morale are closely monitored." (CF Recruiting website, 2008).

1.2.3 Health Practitioners

There are a number of CF occupations that can be classified under this category. They are detailed below.

- ***Nursing:*** Nursing officers "are commissioned members of the [CFMS]. Their primary duty is to nurse sick and injured patients, not only in static facilities such as a garrison, base or wing Health Care Centre, but also in operational facilities such as a Field Hospital. Nursing officers usually work in civilian hospitals and military clinics." (CF Recruiting website, 2008). Again, the recruiting description notes the challenges of the occupation, stating "the intense concentration and effort needed to provide nursing care in varying conditions might result in mental and physical fatigue. Generally, however, the stress involved is similar to that expected in a civilian community or hospital setting. In most assignments, the occupational hazards are comparable to those encountered in civilian practice. The exception to this rule is an operational field unit, where nursing officers encounter the same hazards and conditions as the troops with whom they serve. Appropriate training, environmental clothing and equipment are provided and nursing officers' health, safety and morale are closely monitored" (CF Recruiting website, 2008).

- ***Medical Technician:*** Medical technicians "belong to the CFMS, and are integral members of the military health-care team. They work with physicians, physician assistants, and nurses to treat the sick and injured in all kinds of CF operations and units. An example of some of the primary duties of a medical technician includes: provide care for ill/injured patients; in trauma cases, provide basic life support treatments; recover casualties from the point of injury and transport them to a medical facility; and participate in rescues from crashed vehicles, tanks, ships, aircraft and damaged buildings." (CF Recruiting website, 2008). Some of the challenges of this occupation are described as "medical technicians are expected to work long hours in physically demanding circumstances, including severe weather conditions, and to endure significant mental stress. Shift-work and on-call status are normal.

Appropriate training, environmental clothing and equipment are provided and medical technicians' health, safety and morale are closely monitored." (CF Recruiting website, 2008).

- ***Medical Officer:*** Medical officers are commissioned members of the CFMS. Their primary duty is to practice medicine in the military milieu. In the CF, both at home in Canada and overseas when deployed on operations, medical practice focuses on health protection and education, occupational health and safety, primary care, and environmental medicine, including the physiological challenges of high altitude and deep sea diving." (CF Recruiting website, 2008).

In addition, given the nature of the work and the professional responsibilities, there are two other occupations in the CF that would also be relevant to the discussion at hand. They are described in detail in the next two paragraphs.

1.2.4 Military Police

Military Police "provide around-the-clock service to the military community and may be deployed on military operations anywhere in Canada or around the world, including areas suffering due to armed conflict or natural disasters. They participate in humanitarian support operations, peacekeeping, peacemaking or war fighting, and encounter traumatic events and austere living and working conditions. They are required to overcome physical dangers, with flexibility, innovation and perseverance. Most Military Police members work outdoors, on foot or in a vehicle, exposed to all climatic conditions. They may spend prolonged hours in a vehicle while responding to service calls, or work indoors meeting people, taking statements or completing necessary documentation. They are frequently subjected to physical and mental stress in situations that require them to exercise their lawful authority. Military Police are trained to exercise sound judgement and cope with frequently changing situations while remaining alert." (CF Recruiting Website, 2008).

1.2.5 Search and Rescue

Search and Rescue Technicians (SAR Techs) "are highly trained specialists who provide on-scene medical attention and rescue for aviators, mariners and others in distress in remote or hard to reach areas. They are trained in advanced trauma life-support, land and sea survival, rescue techniques from helicopters, parachuting, diving, mountain climbing and rappelling. In the air, they act as spotters, providing medical care during medical evacuation flights, direct the dropping of equipment and supplies by parachute and parachute and hoist from the planes and helicopters. On the ground, they render on-site medical care to casualties, organize and lead ground search teams and perform mountain rescue operations to assist and recover casualties. They are trained to operate boats and to perform both surface and underwater rescues using scuba gear. They are trained as survival experts under all Canadian climatic and terrain conditions including on land, at sea, in the Arctic, on mountains and on glaciers. They are also trained to communicate with over-flying aircraft by use of radios, flares, smoke, ground and hand signaling devices and other methods." (Canada's Air Force Search and Rescue FAQ, http://www.airforce.forces.gc.ca/site/athomedocs/athome_2_6_e.asp, 2008)

1.3 Aim

This report aims to:

- Provide the theoretical background for the key concepts of burnout and compassion fatigue;
- Summarize the standard measurement instruments employed in the research on burnout and compassion fatigue;
- Review the existing research conducted on burnout and compassion fatigue, identify the key issues and concerns, discuss the impact of both constructs, and present possible approaches to prevention and treatment;
- Develop a conceptual model that provides a framework for both the discussions of burnout and compassion fatigue;
- Discuss the implications for the CF; and
- Provide guidance on the way ahead for future research.

2. The Key Concepts

2.1 Burnout

2.1.1 Definition of Burnout

Burnout can often occur among individuals who are engaged in some form of "people work", referred to in the literature as human service providers. It is a response to the chronic strain from having ongoing extensive interactions with other people, especially when they are troubled or experiencing difficulties. As such, it is considered one form of job stress and, although it has some of the same negative impact as other responses to work stressors, it is unique in that the stress emerges as a consequence of the social interaction between the human service provider and their client[1] (Maslach, 1982).

2.1.2 Conceptualization of Burnout

The first formal identification of the burnout syndrome was by Freudenberger (1974) who based his observations on volunteer workers in a care centre for drug addicts. His profile of the characteristic indicators of the burnout syndrome was rapidly embraced, and burnout was recognized as being a common condition throughout the human service sector (Hills, et al. 2004). Subsequent research over the past 25 years or so has led to the emergence of a conceptualization of job burnout as a psychological syndrome that has materialized as a consequence of chronic interpersonal stressors on the job. Early on there was no standardized accepted definition of burnout; rather, there was a wide range of perspectives regarding what it was and how it could be treated. As the term was often used to mean very different things, the foundation for effective communication about the problem and the potential solutions was lacking. However, in this early research there was an underlying consensus as to the dimensions of burnout and subsequent research on this matter resulted in the development of a multidimensional theory of burnout. The theoretical framework that developed continues to be the predominant construct in the research and literature on burnout (Maslach et al., 2001; Maslach, 1982). In this accepted conceptualization of burnout, there are three key dimensions – emotional exhaustion, depersonalization, and personal achievement (see Figure 1).

2.1.2.1 Emotional Exhaustion

The first dimension is referred to as emotional exhaustion. This component represents the basic individual stress dimension of the concept and is comprised of feelings of being overextended and depleted of the emotional and physical resources that one has available. Emotional exhaustion is the central quality of burnout and is the most obvious manifestation of it. Indeed, when people describe themselves or others as experiencing burnout, most often the references made are in regard to experiencing exhaustion. This aspect is the most widely

[1] The use of the term 'client' is commonly used in the literature to describe the service recipient of the human service providers. While it is acknowledged that it may not be the standard term employed by those in personnel support occupations, for ease of analysis, it will be used in this discussion. In accordance with Cordes & Dougherty (1993), the term 'client' will be used in reference to any individual, internal or external, with whom one interacts on a professional basis.

reported and the focus of most analyses. However, although emotional exhaustion does reflect the stress dimension of burnout, it does not adequately capture the more critical aspect of the relationship that people have with their work. Indeed, exhaustion induces actions that enable individuals to distance themselves both emotionally and cognitively from their work; presumably in an attempt to cope with the overload and demands of work. For those that are actively engaged in the field of human services, the emotional demands of such work can exhaust the ability of the service provider to be involved and sufficiently responsive to the needs of their clients (Maslach et al., 2001).

2.1.2.2 Depersonalization

The second dimension of burnout is referred to as depersonalization and represents the interpersonal context dimension of the construct. It refers to one experiencing responses to various aspects of the job that are negative, unfeeling, cynical or excessively detached. It is an attempt to make the demands of the work more manageable by creating distance between the service provider and their clients through actively ignoring the characteristics that make them unique and treating them as impersonal objects of their work. Distancing is an immediate reaction to emotional exhaustion, and the burnout research has consistently found there to be a strong relationship between exhaustion and depersonalization (Maslach et al., 2001). The depersonalization dimension of burnout appears to be rather specific to those engaged in human service work, and has a different meaning for those whose work does not require them to have personal relationships with clients. For example, in his study of recruit trainers in the CF, Hillier (1989) found that depersonalization did not emerge as a distinct factor in the burnout responses. He postulated that in boot camp, an impersonal view of the recruits was not felt to be a problematic aspect to burnout in this context. In contrast, as human service workers are professionally and ethically committed to maintaining a personal regard for their clients and are invested in a caring profession, experiencing depersonalization is a much more central issue (Leiter, 1991; Hillier, 1989).

2.1.2.3 Personal Achievement

The third dimension of burnout is personal achievement and represents the self-evaluation component of the construct. It refers to experiencing feelings of incompetence and a lack of achievement, and a reduced productivity at work. The relationship of reduced personal achievement, or inefficacy, has a somewhat more complex relationship to the other two dimensions of burnout. In some instances, it appears to some degree to be a function of either emotional exhaustion or depersonalization, while in others it appears to be a combination of the two. One’s sense of effectiveness is likely to be eroded in a work environment that is plagued with chronic, overwhelming demands. Further, both emotional exhaustion and depersonalization interfere with one’s effectiveness as it is challenging to obtain an impression of accomplishment when feeling exhausted or when working with individuals towards whom one is indifferent. The lack of personal achievement appears to develop more clearly from a lack of relevant and available resources, in contrast to emotional exhaustion and depersonalization which appear to emerge from the presence of work overload and social contexts (Maslach et al., 2001).

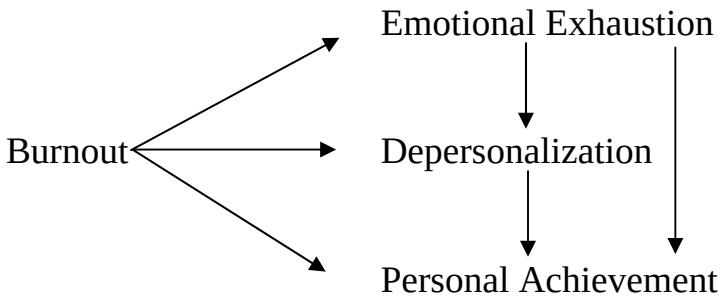

Figure 1: The Key Dimensions of Burnout

2.1.3 Key Characteristics of the Helping Relationship

As detailed above, a key aspect of burnout is the shift in the human service provider's view of other people, namely a shift from being positive and caring to being negative and uncaring. There are four characteristics of the helping relationship that are of particular importance, including:

- The Focus on Problems - By definition, the people receiving help in these relationships are those with problems who are seeking assistance because they are sick, in trouble, failing, struggling to care for themselves, or experiencing other challenges. The focus of human service providers tends to be on these negative aspects as it is what they are most concerned about and involved with by the nature of their profession.

- The Lack of Positive Feedback - It is often the case that individuals in the caring profession receive either little or no positive feedback regarding their work. In addition, given the nature of the work, the positive results of the work are not as tangible or easily quantified, making it difficult to identify the positive contributions that one is making.

- The Level of Emotional Stress - Given that they deal extensively with those in times and positions of need, human service providers also tend to be on the receiving end of very strong emotions, such as anger, fear or frustration, and are often dealing with a high level of emotional distress in others. There may be instances where they feel powerless and are unable to completely help the person in need.

- The Perceived Possibility of Change or Improvement - Human service providers work hard towards making a positive difference or effecting change in the life of another but there may be instances in which things have not gotten better or where there has been no improvement in the situation, despite all the effort and support that

has been provided. Thus, there may be a lack of rewards or feelings of satisfaction from the work being done (Maslach, 1982).

2.2 Compassion Fatigue

2.2.1 Definition of Compassion Fatigue

When an individual brings their traumatic experiences and material to a human service provider, there is a "radiating distress" that can be passed on and which may impact the professional through the process of secondary traumatization. In instances in which this occurs, the overwhelming nature of compassion fatigue precludes the human service provider from functioning effectively in their professional role. In part, compassion fatigue is generally understood as a combination of secondary traumatization and burnout that is precipitated by the direct exposure of human service providers to individuals who are suffering and are traumatized. The convergence of primary and secondary traumatic stress with the cumulative stress associated with burnout in human service providers engaged in caring work therefore contributes to compassion fatigue. High levels of cumulative stress negatively affects the resiliency of human service providers, thereby making them more vulnerable to compassion fatigue (Gentry et al., 2002).

Figley (1995) defined compassion fatigue as "the state of exhaustion and dysfunction – biologically, psychologically and socially – as a result of prolonged exposure to compassion stress and all it evokes. Prolonged exposure means an ongoing sense of responsibility for the care of the sufferer and the suffering over a protracted period of time." (Figley, 1995b: 253). Associated with the prolonged exposure is the lack of relief from the burdens of responsibility and the inability to alleviate the compassion stress (Figley, 1995b). Similar to burnout, compassion fatigue is most often associated with the "cost of caring" for others who are suffering emotionally. It is understood as "a state of tension and preoccupation with the individual or cumulative trauma of clients as manifested in one or more ways: re-experiencing the traumatic events, avoidance/numbing of reminders of the traumatic event, persistent arousal, combined with the added effects of cumulative stress (burnout)." (Gentry et al., 2002: 125).

Compassion fatigue is a term that has been used interchangeably with secondary traumatic stress disorder (STSD), which is almost identical to Post-Traumatic Stress Disorder (PTSD) with the exception that it applies to individuals who are emotionally affected by the trauma of another individual, such as a client or a family member (Figley, 2002). There are a number of other terms that are also used to describe the compassion fatigue phenomenon and which are used interchangeably in the literature, including secondary traumatic stress (STS), secondary victimization, and vicarious traumatisation.[2]

[2] To maintain consistency in the terminology for these empirically validated constructs that are often used interchangeably in the literature, only the term "Compassion Fatigue" will be utilized in this paper.

2.2.1.1 Conceptual and Methodological Limitations

However, it should be noted that there are conceptual and methodological limitations of compassion fatigue, which has caused the research to suffer. While, conceptually, researchers have made attempts to differentiate compassion fatigue from other constructs, such as job burnout, vicarious trauma, and general psychological distress, the constructs have remained vague and imprecise. As a consequence of the lack of conceptual clarity in the area, the implementation and measurement of these constructs has therefore been hindered and the empirical developments impaired. In terms of methodological developments, while there have been several scales proposed for assessing compassion fatigue, there have been few validation studies and minimal information on the psychometric properties of the scales that have been used. As such, in order to better identify those individuals who are the most vulnerable and to further enhance the present understanding of the potential organizational and individual determinants of compassion fatigue, there is a need for greater conceptual clarity and for study designs that are more rigorous (Boscarino, et al., 2004).

2.2.2 Operational Components of Compassion Fatigue

There are three operational components to compassion fatigue:

- Having witnessed or been confronted by actual or threatened death or injury, or by a threat to the physical integrity of oneself or others. Several studies have found that exposure to the injured or dying is extremely stressful and has significant negative consequences on one's mental health. For example, one study examined data from 180 crisis workers who witnessed extensive death and mutilation due to a DC-10 airplane crash. It was found that 80% of the body handlers experienced changes in sleep and appetite and 40% displayed changes in social interaction (Beaton & Murphy, 1995).

- Provocation by the stressor of responses of fear, horror, and helplessness. As well as the intense emotional reaction to the exposure of trauma, some workers identify with the victims they are assisting, particularly if they have similar characteristics to those in the worker's personal life.

- Direct or indirect exposure to an exceptional mental or physical stressor, either brief or prolonged. Human service work can be repetitive and possibly cumulative, and the effects on the workers are real. Exposure of these workers to trauma and traumatic events is much greater than just the "knowledge" of the trauma (Beaton & Murphy, 1995).

2.2.3 Mitigating Effects of Compassion Satisfaction

The experience of being motivated by a sense of satisfaction derived from helping others has been defined as compassion satisfaction (Bride et al, 2007). As not all trauma workers succumb to compassion fatigue, it has been argued that some individuals must have a protective mechanism that helps maintain their well-being. Compassion is defined as "a feeling and acting with deep empathy and sorrow for those who suffer. It is a necessary, though not sufficient, ingredient in human services." (Collins & Long, 2003: 422). It is

evident that the motivation of trauma professionals to do their work is shaped in large part by the satisfaction derived from the work of caring for others. There are many risks associated with working with trauma, such as direct personal exposure and the risk of work-related secondary exposure. Yet, despite these risks, being exposed to a traumatic stressor is not a guarantee that an individual will develop prolonged psychological difficulties (Collins & Long, 2003).

One of the more interesting questions raised in the compassion fatigue literature is whether an individual could still be at high risk for experiencing compassion fatigue while simultaneously experiencing high compassion satisfaction. While the relationship between the two concepts of compassion fatigue and compassion satisfaction has not yet been clearly delineated, it has been suggested that there is a balance between the two experiences. In other words, service providers may experience compassion fatigue and compassion satisfaction simultaneously, although as compassion fatigue increases, the ability of the human service provider to continue to experience compassion satisfaction may suffer a decline (Stamm, 2002; Bride et al., 2007). Thus, the presence of both constructs in a human service provider is not mutually exclusive. For example, one study notes that in conversations with workers in various humanitarian environments, it became evident that while they may believe that they are experiencing compassion fatigue, many of them continue to enjoy their work because they derive positive benefits from it as they believe that they are helping people and because they feel they are making a difference (Stamm, 2002).

2.3 Identifying the Difference Between Burnout and Compassion Fatigue

With both compassion fatigue and burnout, there is a sense of helplessness and confusion, a sense of isolation, and a disconnect between the symptoms and the underlying causes. Although there is an overlap with burnout as it is characterized by the emotionally exhausting nature of working in the caring profession, it has been contended that compassion fatigue is not the same as burnout. Therefore, each should be treated as separate constructs that have a unique effect on the well-being of the human service professional (Adams et al, 2006). The biggest difference between the two constructs is that, unlike compassion fatigue, burnout does not contain a trauma element. While burnout involves a gradual process of wearing down the individual and is generally a consequence of emotional exhaustion, compassion fatigue has an acute onset of symptoms emerging suddenly with little warning. There does appear to be a faster recovery rate with those experiencing compassion fatigue as compared to those experiencing burnout. In addition, rather than a direct response to the conditions of the work environment as is observed with burnout, compassion fatigue is a result of the ‘natural’ consequence of caring for individuals who are suffering from traumatic experiences. It is also suggested that both secondary victimization and burnout are likely central and critical clinical features of compassion fatigue (Adams et al., 2006). Indeed, the likelihood of developing compassion fatigue is increased by the presence of burnout and therefore may be an important risk factor or precursor to compassion fatigue (Figley, 1995; Sabo, 2006; Collins & Long, 2003). Overall however, it is acknowledged that there is a lack of conceptual clarity regarding compassion fatigue and how it differs from the construct of burnout and more effort is needed in the literature to theoretically parse out the differences in both constructs (Adams et al., 2006).

3. Measurement Tools

3.1 Burnout

3.1.1 Maslach Burnout Inventory

There is only one measure that assesses all three of the key dimensions of burnout and that instrument is known as the Maslach Burnout Inventory (MBI). A self-administered test, the MBI is now recognized as the leading measure of burnout in the field (Maslach et al., 1996). Indeed, it was found in 1998 that this three-factor model was employed in approximately 90% of the empirical studies on burnout (Glasberg et al., 2007). The three-dimensional structure of the measure has been validated by several psychometric studies in different settings. There are three versions of the MBI, including: the original measure that was designed for professionals in the human services; an adaptation of the original measure that is used for educators; and, a new version of the MBI that is designed for employees in other occupations.

The MBI has been designed to assess the three aspects of burnout: emotional exhaustion, depersonalization, and a lack of personal achievement. Each aspect is measured by a separate subscale. The emotional exhaustion subscale gauges feelings of being emotionally overwhelmed and exhausted by the work. The depersonalization subscale measures an indifferent and impersonal response toward the recipient of care and service being given by the service provider. The personal achievement subscale measures the feeling of competence and successful achievement in the work an individual does with other people (Maslach et al., 1996). It should be noted that, although the three dimensions are closely related, they are understood to be separate components that are not necessarily predicted by the same variables (Hillier, 1989).

In this framework, burnout is conceptualized as a continuous variable, ranging from low to moderate to high levels of burnout experienced. It is not perceived as a dichotomous variable in which burnout is either present or absent. A high degree of burnout is reflected in high scores on the emotional exhaustion and depersonalization subscales and in low scores on the personal achievement subscale. An average degree of burnout is reflected in moderate scores on each subscale. A low degree of burnout is reflected in low scores on the emotional exhaustion and depersonalization subscales and in high scores on the personal achievement subscale (Maslach et al., 1996).

TABLE 1 - MEASUREMENT SCALES FOR BURNOUT

	Emotional Exhaustion	**Depersonalization**	**Personal Achievement**
High Burnout	High	High	Low
Moderate Burnout	Average	Average	Average
Low Burnout	Low	Low	High

The three-dimensional design of the MBI is thought to provide more precise answers that will enable interventions that are more focused and effective. For example, research that has identified distinct predictors for the three subscales indicates that low scores on personal achievement require a different type of intervention than high scores on emotional exhaustion. As such, an analysis of the scores provides a better foundation under which an intervention can be most effective (Maslach et al., 1996).

3.1.2 Burnout Instrument for Clergy

Very little research amongst the clergy employed the MBI until recently. It has been suggested that the major cause precluding its more extensive use is related to the way in which the wording of some of the individual items did not correspond to the experience and language of religious professionals. One example was the perceived inappropriateness of the term 'clients' used by Maslach for those who are being ministered to by clergy. Thus, a proposed revision of the MBI was developed that modified the survey for use amongst the clergy by Rutledge and Francis (2004).

There were four steps involved in the revision of the MBI for the clergy population. First, the American original was Anglicized. Second, the items were shaped to be more reflective of the experiences and vocabulary of religious professionals. Third, additional items were developed to bring the three subscales to the same length of ten items each. Lastly, the response scale was changed from a seven-point measure of frequency to a five-point measure of attitudinal intensity (Francis, et al., 2004a; Randall, 2004). Despite the modifications, the new version of the MBI had some significant challenges. First, the publishers retained the copyright hold on the modified form of the scale and declined to make it publicly available, therefore creating uncertainty regarding its long-term availability. Second, although the modified version was built on the original Maslach instrument, the modifications precluded strict comparability between studies conducted on clergy and studies conducted on other professional groups using the same instrument (Francis et al. 2004b).

As such, it was argued that a thoroughly new approach should be developed that assesses burnout in the clergy. Thus, the Scale of Emotional Exhaustion in Ministry (SEEM) was developed and tested on a sample of 4,370 Australian clergy who participated in the National Church Life Survey. Emotional exhaustion was assessed by an 11-item scale, with all items scored so that high responses were indicative of emotional exhaustion. The scale was determined to be reliable and construct validity was supported by means of correlations with other survey questions. Therefore, it was shown that the new index of emotional exhaustion was appropriate for use among clergy and would be recommended for future use, although it was noted that further psychometric evaluation would be beneficial (Francis, et al. 2004b).

3.2 Compassion Fatigue

There are several standardized measurement instruments that have been developed specifically to evaluate the prevalence of compassion fatigue and to assess the different components of it in human service providers. Each of the instruments detailed below would be appropriate to use in investigating the prevalence and nature of compassion fatigue in those providing services to a wide range of clients who have experienced trauma, regardless of the

specific nature of the trauma, such as combat, terrorism, disaster relief, etc. (Bride et al., 2007).

3.2.1 Compassion Fatigue Self-Test

There are many different versions of the Compassion Fatigue Self-Test (CFST). It was one of the first measures developed specifically to assess compassion fatigue and is generally still the most commonly used instrument in the literature. The CFST for Helpers is used to identify the presence and level of severity of experiences associated with STS and burnout (Wee and Myers, 2002). It is presently a self-report scale that is comprised of three subscales – estimate of compassion, risk of burnout and compassion fatigue, and degree of satisfaction from helping others (Sabo, 2006).

Originally the CFST was designed to assess both compassion fatigue and job burnout and was comprised of 40 items divided between two subscales: compassion fatigue (23 items) and burnout (17 items). The CFST was developed more fully by Stamm and Figley (1996) with the addition of positively oriented questions that paralleled the negative orientation of the compassion fatigue items, thereby resulting in a 66-item instrument as opposed to the earlier version of 40 items. The addition of these positively oriented questions was intended to also include measurements of compassion satisfaction (Bride et al., 2007).[3]

3.2.2 Professional Quality of Life Scale

The Professional Quality of Life (ProQOL) scale is a revised version of Figley's (1995) CFST and is comprised of three discrete subscales, structured as a 30-item self report measure in which the respondent indicates how frequently each item was experienced in the past 30 days. The first subscale measures compassion satisfaction, defined as the pleasure that is experienced from being effective in their work of helping others. Higher scores on this subscale are indicative of a greater satisfaction derived from the ability of the respondent to be an effective caregiver. The second subscale measures burnout, defined as feelings of hopelessness and struggling to effectively perform one's work. Higher scores on this subscale are indicative of the respondent being at an increased risk for experiencing burnout. The third scale measures compassion fatigue, again with higher scores indicating greater levels of compassion fatigue (Bride et al., 2007).

3.2.3 Secondary Traumatic Stress Scale

The design of the Secondary Traumatic Stress Scale (STSS) was geared toward assessing the frequency of intrusion, avoidance and arousal symptoms that are connected to indirect exposure to traumatic events through work with traumatized clients. The definition of STS by Figley (1995, 1999) as a syndrome of symptoms that are almost identical to those suffering from PTSD was used as a guide in developing the STSS, with each of the 17 items in the scale designed to tap into the standard accepted criteria of measurements of PTSD. Respondents in

[3] The ongoing development of this version has subsequently resulted in a renamed instrument, known as the Professional Quality of Life Scale (Bride et al., 2007).

this instrument report how frequently each item was true for them in the past seven days (Bride et al., 2007).

3.2.4 Considerations in Selecting a Measurement Tool

In considering each of the various measurement instruments that have been detailed above, it becomes apparent that there are many possible options that can be utilized when engaging in an assessment of compassion fatigue in human service providers. Therefore, a number of factors should be considered in advance of selecting a particular instrument for analysis. One such consideration is the domain that the research intends to evaluate. Each of the instruments that were reviewed measures specific aspects of compassion fatigue and serves as a screening tool. For example, the STSS specifically seeks to measure PTSD symptomology that are associated with clinical work with traumatized populations. Thus, researchers who are studying human service providers who work directly with traumatized clients may find the STSS to be the most appropriate measurement tool to employ in their study.

In addition, there are structural differences between the various instruments that are an important consideration in interpreting scores. For example, time frame is a difference amongst the instruments, with some of them asking respondents to report on the symptoms and/or experiences in the past week (i.e. the STSS), while others use a timeframe of 30 days (i.e. the ProQOL), while others do not even impose a time frame (i.e. the CFST) (Bride et al., 2007).

It is important that researchers have a clearly defined concept of which aspects of compassion fatigue are most important to measure before undergoing research. As such, the research objectives should be clearly delineated prior to selecting the instrument most suitable for the objectives of the analysis. It should be noted that no individual measurement instrument of compassion fatigue effectively captures all aspects of the concept (i.e. trauma symptoms, general psychological distress, burnout, etc.). Hence the recommendation is made that more than one measurement instrument be employed in analyses of compassion fatigue in order to best provide an indication as to the complete picture of the experiences of compassion fatigue by human service providers (Bride et al., 2007).

3.3 Additional Measurement Instruments

3.3.1 Eysenck Personality Questionnaire

One measurement instrument that has also been found to be relevant in the field of burnout and compassion fatigue studies is that of the Eysenck Personality Questionnaire (EPQ), which assesses the personality of respondents. The EPQ consists of a 21-item measure of extraversion, a 23-item measure of neuroticism, a 25-item measure of psychotocism, and a 21-item lie scale, now generally considered to be an index of social conformity. Each item is assessed on a dichotomous scale of either Yes or No (Francis, et al., 2004a).

The constructs noted above are operationalized by the following definitions:

- High scores on the extraversion scale is described as someone who is:

  > *"Sociable, likes parties, has many friends, needs to have people to talk to, and does not like reading or studying by himself. He craves excitement, takes chances, often sticks his neck out, acts on the spur of the moment, and is generally an impulsive individual. He is fond of practical jokes, always has a ready answer, and generally likes change."* (Francis, et al., 2004a: 8).

- High scores on the neuroticism scale is described as someone who is:

  > *"An anxious worrying individual, moody and frequently depressed. He is likely to sleep badly, and to suffer from various psychosomatic disorders. He is overly emotional, reacting too strongly to all sorts of stimuli, and finds it difficult to get back on an even keel after each emotionally arousing experience."* (Francis, et al., 2004a: 8).

- High scores on the psychotocism scale is described as someone who:

  > *"May be cruel and inhumane, lacking in feeling and empathy, and altogether insensitive. He is hostile to others, even his own kith and kin, and aggressive, even to loved ones. He has a liking for odd and unusual things, and a disregard for danger; he likes to make fools of other people, and to upset them."* (Francis, et al., 2004a: 8).

3.3.2 Compassion Satisfaction and Fatigue Test

Although compassion fatigue has been identified as a problem for human service providers engaged in trauma work, there are many individuals who work around trauma that are doing well. As such, it is argued that in order to understand the negative "costs of caring", it is necessary to understand the positive "payments" that come from caring work (Stamm, 2002). Previous measurements included questions such as "I feel estranged from others", but did not ask whether "I feel connected to others." Given the scale, it was possible to provide a "No" answer to the former question, but it was not possible to fully interpret the true meaning behind this response. In other words, it was unclear whether the answer, "No, I do not feel estranged from others" could be construed as meaning the same thing as "Yes, I feel connected to others". Indeed, given the understanding of burnout, it could perhaps be reflective of an individual experiencing depersonalization as the respondent simply does not care or is aware as to whether or not s/he is estranged from others. Furthermore, the contention was made that if there is a positive component to being satisfied with the work, then it is important to assess both the negative and the positive sides in order to fully grasp the potential implications of the nature of the work being done. Thus, it is necessary to also consider the elements of satisfaction derived from the work.

Additional concerns were also raised regarding the potential psychometric problems in the existing compassion fatigue measurements. More specifically, that by only asking negative questions based on a negative, symptom-focused format could create a response bias, producing a response that was artificially inflated or deflated negative reporting. Further, a study pointed to evidence that there was a need for positive-oriented questions as some human

service providers who were doing well were disconcerted by the implication through the negative based questioning that there had to be something wrong with the work being done (Stamm, 2002).

Therefore, in order to address the above concerns with the existing compassion fatigue measurement instruments, a new subscale, termed Compassion Satisfaction, was developed which included a series of positive questions parallel to the negative aspects of caring work. There are two uses for the Compassion Satisfaction and Fatigue Test (CSF Test): first, to assist in establishing the presence of secondary exposure to trauma (i.e. compassion fatigue), and second, to identify an individual's risk for the positive and negative aspects of caring work. However, this CSF Test is still in the early stages of being employed in the research and more work is needed to determine its use. In the meantime, it is still considered to be helpful for those exploring the prevalence of compassion fatigue and compassion satisfaction in human service providers (Stamm, 2002).

4. Theoretical Overview of Burnout

4.1 Overview

A part of the daily job routine of human service providers is working closely with other individuals, and the tolerance that one has for this ongoing stress can eventually wear away under the continual bombardment of emotional tension and strain. These interactions are generally focused on the current problems or struggles of the individual, be they psychological, social or physical. Furthermore, as solutions to the problems being experienced may not be easily identified or easily obtained, the situation can be ambiguous and frustrating for the human service provider. For those that work under such conditions, the chronic stress can put an emotional strain on the individual, leading them to experience burnout (Maslach et al., 1996). Thus, it is the type of work and the stress of the job that is the cause of the individual experiencing burnout, since dealing with people, especially those who are having difficulties or are suffering, can be very demanding. It requires much energy to be composed and collected in the midst of an emergency or crisis, to be supportive and compassionate when surrounded by individuals experiencing shame, anger, fear or pain, and to be understanding and responsive to those in need. It is very hard to do this all of the time and yet, this is what is expected of human service providers (Maslach, 1982).

4.2 Situational Factors

As previously indicated, burnout is understood to be an individual experience that is specific to the context of work. As such, the research in the field has consistently focused on the situational factors that are the prime correlates of this construct, thereby presenting a clear picture of the impact of the work environment on the burnout of individuals (Maslach et al., 2001). The literature on burnout has proposed that it is an outcome of both personal and environmental factors, with numerous studies considering one or both of these aspects. However, the research suggests that situational factors, particularly those pertaining to the work setting, display a much stronger relationship to burnout than individual factors, such as personality or demographic variables (Leiter & Maslach, 1988).

4.2.1 Occupational Characteristics

The primary focus of the burnout research has generally been concentrated on the occupational sector of human services providers, those in a caring profession who are engaged in helping others. In this occupation, a primary concern has been the emotional challenges that come with working intensively with other individuals. While burnout has been applied to a wide range of occupations outside of the human services sector, there is still the hypothesis that the emotional stressors of people-work are an aspect that is uniquely related to burnout. While earlier research did not entirely support such a hypothesis, more current research has focused specifically on emotion-work variables, such as the requirement to be emotionally empathetic or to display or suppress emotions on the job, and has determined that these emotion variables do account for additional variance in burnout scores that are over and above job–related stressors (Maslach et al., 2001). Therefore, it would appear that it is the very nature of the occupation itself that poses the risk of experiencing burnout.

4.2.2 Job Characteristics

The research has generally found that there are moderate positive correlations with the dimensions of burnout for several aspects, including: workload; time pressures; time spent interacting with the recipients of care; role ambiguity; and lack of organizational support. Found to be of particular theoretical importance is the balance between the stressors that are related to the job and those related to the interactions with clients. While most occupations possess job-related pressures, pressures related to helping others are specific to the human service professions and are considered to be the primary source of burnout (Hills, et al., 2004).

The relationship of the service provider and the recipient generally occurs within the greater context of a formal institution and, in many ways, the nature of this relationship is shaped by various elements of the job. For example, the available resources that the providers have at their disposal, the constraints that are placed on them and the goals that are established are, for the most part, dictated by the institution under which the service is being provided and not necessarily determined by the individual provider. In addition, relationships such as those between the provider and the recipient, between colleagues, and between staff and management are influenced by the structure of the work environment and the organizational structure. Thus, job characteristics can be an important component in the burnout phenomenon as the work environment may serve to either encourage or reduce stresses in human service providers (Maslach, 1982).

4.2.2.1 Work Overload

Many burnout researchers have studied quantitative job demands, particularly that of work overload (i.e. too much work for the time available) and the findings of this research have provided support to the contention that burnout is partly a response to overload. Indeed, the workload demands and the time pressures of the job have been strongly and consistently related to burnout, particularly with respect to the emotional exhaustion dimension (Maslach et al., 2001). Work overload is common to many different types and work environments of human service providers and, whether this is emotional or material, it can become a burden exceeding the ability of the individual to handle it, thereby resulting in stress. It occurs when there is too much information coming in, with too many demands being made, all of which occurring too quickly for the individual to keep up with the requirements. For those in the human service provider profession, the situation becomes especially primed for burnout when overload translates into too many people to help and too little time to adequately serve them (Maslach, 1982).

4.2.2.2 Role Conflict & Role Ambiguity

For those analyzing qualitative job demands, the focus has primarily been on role conflict and role ambiguity, both of which have consistently displayed a moderate to high correlation with burnout. Role conflict results when there are conflicting demands on the job that need to be satisfied or when one is requested to do something that he or she does not want to do or considers it to be outside the purview of the job. Role ambiguity is a consequence of a lack of sufficient information for one to effectively do the job and confusion regarding the work role (Maslach et al., 2001; Davey, 1995).

One example in which role conflict and role ambiguity is associated with stress is the clergy, primarily due to the close identity between their role and the social and organizational context in which they work (Davey, 1995). Indeed, studies that have examined burnout among clergy have shown it to be a complex construct that occurs as a consequence of the large amounts of interpersonal interactions and the conflict that results from role expectations and overload (Beebe, 2007). Due to the diverse nature of the role of clergy, there can often be conflict between the different functions of the position. Role ambiguity is another challenge faced by religious professionals. There have been several sources of role ambiguity identified in ministry, namely lack of sufficient information about the scope and responsibilities of the work, lack of information about the expectations of others, and insufficient feedback (Davey, 1995).

4.2.2.3 Role Overload

Role overload is also a challenge for those in ministry as these individuals are very rarely considered to be "off duty". Indeed, there is little distinction between the role of the clergy and their non-work role, and consequently the demands of time placed upon these individuals are great (Davey, 1995). Another study was conducted that examined the impact of differentiation of self and role on burnout, conflict management style, and tenure. Based on a sample of 343 clergy who were surveyed, an analysis of the data indicated that clergy functioning at higher levels of differentiation of self and role experienced lower perceived burnout. It was determined that clergy are more likely to experience symptoms of burnout when they perceive their role demands to be overwhelming or ambiguous, while clergy working under clear role expectations were found to function at a higher level of differentiation of self and role, therefore less likely to experience symptoms of burnout (Beebe, 2007).

4.2.2.4 Social Support

Researchers have also investigated the absence of job resources available to employees. This research has consistently established that a lack of social support is linked to burnout; found to be especially important is a lack of support from supervisors. Within the literature, a "buffering" hypothesis suggests that the relationship between job stressors and burnout can be moderated by social support (Maslach et al., 2001). In other words, individuals who have social relationships that are supportive are able to rely on others for help when faced with stress, while those who do not have these supportive networks are more vulnerable to experiencing the effects of stress. As such, social support is understood to be a resource that moderates the negative effect of stress on one's mental and physical well-being (Ross et al., 1989). However, the research on this hypothesis is mixed and total support for it has not been conclusively established (Maslach et al., 2001; Ross et al., 1989). That said, researchers have consistently determined that individuals with high levels of social support are in better physical and mental health. Therefore it has been posited that it would stand to reason that social support may represent an important means to the prevention of burnout (Ross et al., 1989).

To assess this, the effects of stressful job experiences and social support on burnout was investigated in a study by Ross et al. (1989) on counselling centre staff. There were two objectives to this research. First, in accordance with the position that burnout research should

consider both the nature of the work role and the work setting, the study was focused on a specific counselling setting. A second goal was to consider the role of social support as a buffer of the effects of job-related stress on burnout among staff. The measure of social support included the different members in the social network of the respondent, including supervisors, coworkers, friends, and family. In total, 169 staff members were surveyed regarding job-related stress, social support and burnout. Analysis of the data indicated that respondents experienced a wide range of stressful events in their work and that the number of stressful events was predictive of burnout. Not surprisingly, higher amounts of job stress were found to be related to higher levels of burnout. However, there was no evidence of a buffering effect of social support on the relationship between job-related stress and burnout. The explanation offered to account for the contradiction to the theoretical prediction was that the respondents were experiencing such high levels of burnout that social support was largely ineffective in preventing burnout. Indeed, based on the finding that over half of the sample had personally experienced 28 of the stressful events identified in the study, it would appear that these respondents were routinely confronted with multiple stressful events as part of their daily work (Ross et al., 1989).

Another study by Leiter & Maslach (1988) assessed both the positive and negative interpersonal contacts on the job and examined their separate contributions to burnout and to organizational commitment. This study distinguished the two different types of interpersonal job contacts; namely that of colleagues and supervisors, as it was contended that the nature of the contact between coworkers would be different from the nature of the contact between a subordinate and their supervisor. The study was comprised of 52 nurses and support staff in a small private hospital who completed the MBI in addition to a questionnaire on organizational commitment and interpersonal contacts. The results of the research provided support for the perspective of burnout whereby emotional exhaustion leads to greater depersonalization, which subsequently leads to a reduced personal achievement. High levels of burnout were related to a diminished organizational commitment and were more prevalent for those with a negative interpersonal work environment. The findings of the study were consistent with the following sequence: 1) feelings of emotional exhaustion were increased by stressful interactions with supervisors; 2) high levels of emotional exhaustion led to depersonalization, unless there was the presence of frequent supportive contact with colleagues; and 3) as depersonalization persisted, the sense of personal achievement in the work was decreased, although this process was mediated by supportive interpersonal contact with colleagues (Leiter & Maslach, 1988).

4.2.2.5 Lack of Information and Control

Additional job resources that have been found to be associated with burnout have to do with information and control. Consistently related to all three dimensions of burnout is a lack of feedback, with burnout also found to be higher for those individuals with little participation in the decision making process. Further, although the strength of the relationship is weaker, a lack of autonomy is also correlated with burnout (Maslach et al., 2001). Burnout is also high when individuals feel that they have a lack of control over the care and work that they are providing. There are several ways that this lack of control can be experienced, including: being told exactly how to perform their work without any opportunity to assert individuality; little or no direct input on policy decisions that affect the work; few opportunities to withdraw from a stressful situation; and when an individual is given more work than can be handled.

Regardless of the reason for the perception of the lack of autonomy, the perception of having minimal control over the important elements of one's work contributes to the emotional tension and stresses of the helping relationship (Maslach, 1982).

4.3 Individual Factors

Employees bring unique qualities into the workplace with them. The relevant personal factors include demographic variables, such as age or education, enduring personality characteristics, and attitudes toward work. While many of these characteristics have determined to be related to burnout, these individual factors are not as great in size as the situational factors discussed above. This finding indicates that burnout is therefore more of a social phenomenon than an individual one (Maslach et al., 2001). An individual also brings internal characteristics with them, including motivations, needs, values, self-esteem, emotional expressiveness, and personal style; all of which determine how one handles external sources of emotional stress and contributes to explanations as to why one person will experience burnout in a particular setting while another person will not. The relevance of personal characteristics is particularly high for those in human service provider professions as this work requires strong interpersonal skills and high levels of contact with others (Maslach, 1982).

4.3.1 Demographic Characteristics

There have been many demographic characteristics that have been studied in the burnout research. Out of all of them, it is age that has been found to be the one most consistently related to burnout. Specifically, the level of burnout is reported to be higher amongst younger employees than found in those over 30 or 40 years of age. Age is confounded with work experience and experiencing burnout appears to be a greater risk earlier in an individual's career. However, it is important to note that such findings should be considered with caution due to the problem of survival bias; namely, that it is likely that individuals who burnout early in a career end up leaving their jobs, thereby leaving behind the survivors who would consequently display lower levels of burnout (Maslach et al., 2001).

As an example, studies have shown that younger clergy are significantly more susceptible to experiencing emotional exhaustion than older clergy. There are two theories that account for why older clergy are less likely than younger clergy to suffer from either emotional exhaustion or depersonalization: 1) younger clergy may decide to either leave the ministry or seek employment elsewhere if they suffer from burnout, or 2) older clergy may have better developed techniques to manage their work in order to avoid suffering the symptoms of burnout (Francis, et al., 2004a; Francis et al., 2004b).

With respect to another demographic characteristic, marital status, it appears that those who are unmarried may be more prone to burnout as compared to those who are married, while individuals who are single appear to experience even greater levels of burnout than found in those who are divorced (Maslach et al., 2001).

4.3.2 Personality Characteristics

There have been several personality traits studied by researchers in an effort to identify which types of individuals may be at greater risk for experiencing burnout. It has been found that individuals who demonstrate low levels of hardiness, such as involvement in daily activities, a sense of control over events, and openness to change, have burnout scores that are higher, especially on the emotional exhaustion dimension. In addition, burnout has been found to be higher among individuals with an external locus of control (meaning that events and circumstances are attributed to powerful others or to chance) than amongst those with an internal locus of control (meaning that it is one's own effort and ability that is attributed). Further, those who are burned out tend to respond to stressful occurrences in a way that is passive and rather defensive, as opposed to active, confrontive coping where the levels of burnout are lower (Maslach et al., 2001). Finally, lower self-esteem has also been related to all three dimensions of burnout. Overall, the personality profile that has emerged from the research suggests that low levels of hardiness, poor self-esteem, an external locus of control, and an avoidant style to coping typically constitutes the representation of a stress-prone individual (Maslach et al., 2001).

A study was conducted on Roman Catholic clergy in England and Wales which included a sample of 1,468 respondents who completed a modified version of the MBI, in conjunction with the EPQ. While the MBI measured burnout, the EPQ assessed the personality of the respondents. It was found that these three major dimensions of personality function as strong predictors of the susceptibility of individual priests to experience burnout. Specifically, individual priests who scored high in neuroticism, high on psychotocism, and low on extraversion were much more likely to experience emotional exhaustion, depersonalization and a lack of personal achievement as compared to their stable, extraverted counterparts (Francis, et al., 2004a).

Another study was conducted by Rutledge and Francis (2003) on 1,071 full-time stipendiary clergy serving in parochial ministry. Data from their study employing the EPQ model of personality along indicators of emotional exhaustion, depersonalization, and personal achievement determined that both emotional exhaustion and depersonalization were positively related to neuroticism and to psychotocism, and negatively related to extraversion. On the other hand, personal achievement was negatively related to neuroticism and to psychoticism, and positively related to extraversion (Francis et al., 2004a). Thus, the argument is presented that it would therefore be possible to predict and identify the most likely candidates for burnout by conducting routine personality testing long before individuals display any of the indicators. In this way, it would protect both the individual from experiencing the difficulties of clergy burnout and make good strategic sense by reducing turnover (Francis, et al., 2004a).

4.4 Integration of Situational and Individual Factors

In more recent research, efforts have been made to develop new theoretical frameworks that would more clearly integrate the situational and individual factors of burnout, as opposed to managing them in separate either-or terms. In particular, a model has been formulated that focuses on the degree of match, or mismatch, between the human service provider and six domains of the job environment: workload, control, reward, community, fairness, and values.

The greater the mismatch between the person and the job, the greater likelihood of that individual experiencing burnout (Maslach et al., 2001).

4.4.1 Workload

The mismatch is generally found to occur through an excessive workload, whereby there are too many demands placed on an individual which exhausts his or her energy to the degree that recovery becomes unachievable. A workload mismatch may also result as a consequence of the wrong kind of work, such as when individuals lack skills or the inclination for a particular kind of work, even when required in moderate quantities. Especially draining is emotional work when the job requires individuals to display emotions inconsistent with their feelings. Workload is generally most directly related to the emotional exhaustion component of burnout (Maslach et al., 2001; Leiter & Maslach, 1999).

4.4.2 Control

This mismatch is generally related to the reduced personal accomplishment dimension of burnout. It most often indicates that individuals have insufficient control over the resources required to do their work, or have insufficient authority to practice the work in a manner they believe to be the most effective. It is very difficult for an individual to feel a responsibility to produce effective work, one they have a strong commitment towards but for which they lack the capability to deliver results (Maslach et al., 2001; Leiter & Maslach, 1999).

4.4.3 Reward

This mismatch involves a lack of appropriate rewards for the work that individuals are engaged in. These rewards may sometimes be insufficient financial rewards, but even more important at times are the social rewards for the work being performed. For example, when the hard work of an individual is overlooked and not appreciated by others. The lack of recognition leads to a devaluing of both the work and the individual. Another critical part of this mismatch is the lack of intrinsic rewards, such as taking pride in doing important work and doing it well. Lack of reward is closely connected to feelings of inefficacy, the third dimension of burnout but has implications for all three dimensions (Maslach et al., 2001; Leiter & Maslach, 1999).

4.4.4 Community

This mismatch emerges when individuals lack a sense of positive connection with others in the workplace. When individuals share praise, comfort, happiness and humour with others they like and respect in the workplace, they thrive in the community and function most effectively. This form of social support leads to a reaffirming of an individual's membership in a community that has a shared set of values. In contrast, there are some jobs that isolate an individual from others or make social interaction impersonal. However, most destructive to a positive community in the workplace are instances of chronic and unresolved conflict with colleagues as this conflict creates constant negative feelings of frustration and hostility, thereby reducing the opportunity for shared social support (Maslach et al., 2001; Leiter & Maslach, 1999).

4.4.5 Fairness

This fifth mismatch occurs when perceived fairness in the workplace is lacking. Feelings of unfairness can occur when there is an inequity in workload or pay or when evaluations and promotions are handled inappropriately. This lack of fairness contributes to burnout in two ways, as the experience of being treated unfairly in the workplace is distressing and exhausting while it also promotes a deep sense of cynicism about the workplace (Maslach et al., 2001; Leiter & Maslach, 1999).

4.4.6 Values

The final mismatch occurs where there is gap between the values of individuals and that of their organization. For example, there may be a mismatch between the individual's personal goals for their career and the values for the organization. Individuals may also be torn between conflicting values of the organization, such as if there is a discrepancy between the mandate of the organization and the actual practices that occur in the workplace (Maslach et al., 2001; Leiter & Maslach, 1999).

4.5 Additional Research Related to Burnout

4.5.1 Burnout of Clergy[4]

There has been much contention that clergy are exposed to stress due to the particular demands of their ministry. In particular, researchers have noted awareness about the work never being finished and the lack of being able to attain tangible results, thereby reducing the sense of accomplishment in the work being done. It has also been noted that these individuals are required to maintain a particular public image that can be emotionally exhausting to sustain. There may also be a resistance to admitting that they are experiencing stress as there may be the belief that they should be able to cope with it better than their secular counterparts (Hills et al., 2004). Virginia (1998) conducted a study that examined burnout and depression amongst Roman Catholic secular, religious order, and monastic priests. The data indicated that, based on group comparisons, secular clergy experienced the greatest degree of burnout and depression, with the key elements associated with a lack of social support and feelings of isolation. The study noted that secular clergy face multiple demands in their work and are placed on call all hours of the day and night, thereby contributing to greater levels of burnout (Virginia, 1998).

[4] It is acknowledged that the differences between the professions of clergy and that of chaplains in the CF may preclude complete comparisons. However, it is contended that the subject matter at hand is both pertinent and applicable to those serving in a ministry and that many of the challenges and issues related to burnout are experienced by both groups. As such, the position is taken that the research provided in this section can be generalized to chaplains in the CF.

4.5.2 Burnout of Health Practitioners[5]

A second profession in the field of human services that has drawn much attention in the field of burnout research is that of health practitioners. In a review of over 300 documents on nurse burnout, it was demonstrated that workload, role ambiguity, and lower age were the primary correlates of burnout. In contrast, hardiness, active coping and social support were identified as the main buffering factors (Glasberg et al., 2007).

4.5.3 Emotional Dissonance

Two studies were conducted that assessed the hypothesis that emotionally demanding interactions with others may lead to emotional dissonance which may subsequently result in burnout and poor work performance. The studies included 108 nurses and 101 police officers as both professions are routinely subjected to highly intensive emotional interactions with others as part of their daily work and are also required to regulate their feelings and expressions as part of their work role. This work is referred to as emotion work and occurs through in-person contacts with others whereby expressions are regulated as part of the job. The objective of these studies was to investigate how this emotion work impacts the well-being and performance of human service providers, hypothesizing that emotional job demands would explain variance in burnout through their influence on emotional dissonance. Emotional dissonance is defined in this research as "the structural discrepancy between felt emotions on the one hand and the emotional display that is required and appropriate in the working context of the other." (Bakker & Heuven, 2006: 426). By definition, emotional dissonance only occurs among human service providers interacting with clients.

Analysis of the data indicated that the emotional dissonance experienced by the respondents as a result of the emotional demands of their work is an important contributing factor in explaining why both groups become emotionally exhausted and detach themselves from their work. The findings indicated that both types of professionals experience a discrepancy between the felt and displayed emotions due to the heightened emotional interactions, which subsequently leads to emotional exhaustion and cynicism. Overall, the study provided strong support for the theoretical perspective and empirical research that emotion work is very difficult (Bakker & Heuven, 2006).

4.5.4 Stress of Conscience

In the research on the burnout of healthcare professionals, individuals have described experiencing a troubled conscience when they feel that they are unable to provide the quality of care that they would like, and which they believe is their duty. This has led researchers to explore the relationship between burnout and the 'stress of conscience', defined as "a product of the frequency of the stressful situation and of the perceived degree of troubled conscience as rated by healthcare personnel themselves." (Glasberg, et al., 2007:393). It was hypothesized that a troubled conscience would have an impact on burnout among healthcare

[5] Again, it is acknowledged that there are differences between health practitioners in the civilian world and those who are part of the CF. However, it is contended that the basic premise of the work being done along with the challenges and experiences of civilian health practitioners can be generalized to reflect those in the military.

personnel in the cross-sectional study examining the factors that may contribute to burnout among healthcare practitioners. A sample of 423 healthcare individuals completed several questionnaires, including the MBI, Perception of Conscience Questionnaire, Stress of Conscience Questionnaire, Social Interactions Scale, Resilience Scale and a personal/work demographic form. Analysis of the data indicated that emotional exhaustion and depersonalization can be explained by 'stress of conscience.' Further, it was found that respondents with higher levels of emotional exhaustion were those who deaden their conscience in order to continue to work in the healthcare field; those who experience 'stress of conscience' from inadequate time to provide the care needed, being unable to meet the work expectations of others, and having work so demanding it interfered with home life (Glasberg et al., 2007).

4.5.5 Distinction from Depression and Job Satisfaction

There was some question raised early on in the research as to whether burnout truly was a distinct concept from other established constructs, namely depression and job satisfaction. During the development of the MBI, research determined that burnout was related to both depression and job satisfaction. However, the distinction between burnout and depression was subsequently established empirically in several studies. The research determined that for burnout, the problem is specific to the work context, as opposed to depression, which has a tendency to pervade all domains of an individual's life. Hence, the findings provided empirical support to the previous claims that burnout is more job-related and situation-specific than general depression and therefore is accepted as an independent construct. With respect to the distinction between burnout and job satisfaction, the issue stems from the fact that, while the correlation between them is not large enough to conclude that they are actually identical, both constructs are clearly linked. However, there is still much speculation as to the nature of that link. For example, does burnout result in individuals becoming dissatisfied with their work? Alternatively, does a reduction in job satisfaction operate as a precursor to burnout? More research needs to be done before these answers can conclusively be answered (Maslach et al., 2001).

5. Theoretical Overview – Compassion Fatigue

5.1 Overview

It has only been in the last two decades or so that the notion that an individual can be secondarily affected by the suffering of others has become widely acknowledged. During the 1980s and the 1990s, much of the literature in the field of mental health focused on the psychological effects of trauma exposure among the first responders, namely firefighters, police officers, and emergency medical personnel (Myers and Wee, 2002b; Valent, 2002). During the early days of the research on traumatization, it became evident that helpers are subsequently affected by their work with those who are traumatized (Valent, 2002). A breakthrough in the field was made in 1995 when Figley and his contributing authors focused their attention on the professionals who provided therapy to the victims of trauma, namely the crisis workers, trauma counsellors, nurses, psychologists, and others in the caring professions who were subsequently experiencing secondary victimization (Myers and Wee, 2002).

By its very nature, the professional work that involves providing care to those suffering emotionally involves the absorbing of information and details about the suffering, and subsequently, it often consists of the professional absorbing the suffering as well (Figley, 1995). Thus, professionals who work closely with groups and individuals who are traumatized are particularly susceptible to the contagion of this phenomenon. While some professionals appear to display greater resiliency to the transmission of traumatic stress than others, any individual who continually and extensively works with traumatized individuals is vulnerable to feeling overwhelmed at some point during their career (Gentry et al., 2002).

5.2 Vulnerability to Compassion Fatigue

In examining who is vulnerable to compassion fatigue, a theory has been presented that accounts for how and why some people develop compassion fatigue while others do not. At the base of the theory are the concepts of empathy and exposure; namely, that if one is not empathetic or has exposure to the traumatized, there should be little risk of compassion fatigue. Professionals who work with traumatized clients on a regular basis have a particular vulnerability to compassion fatigue and, as such, are more susceptible to it due to the nature of their trauma work. There are a number of reasons that contribute to this vulnerability, with most associated with the fact that these trauma workers are continually surrounded by the extreme intensity of trauma-inducing factors.

Four reasons as to why trauma professionals may be particularly vulnerable to experiencing compassion fatigue include:

- Empathy is a major resource for trauma workers to help the traumatized. Empathy is also a key factor in the induction of traumatic material from the primary to the secondary source.

- Most trauma workers have experienced some traumatic event in their lives. As these individuals work on a wide variety of traumatic events, it is likely they will work

with traumatized individuals who have experienced similar events to those experienced by the trauma worker.

- Unresolved trauma of the worker will be activated by reports of similar trauma in clients. If the trauma worker harbours unresolved traumatic conflicts, issues may be provoked as a result of the traumatic experiences of the client.

- Children's trauma is also provocative. Workers have reported that they are most vulnerable to compassion fatigue when dealing with the pain of children (Figley, 1995).

5.3 Contributing Factors

There are particular factors that may serve to either increase or decrease the vulnerability of a human service provider to compassion fatigue and they include: exposure to trauma, individual, organizational, social, and traumatic event factors. This section contains a discussion of these factors identified in the literature.

5.3.1 Exposure to Trauma

It is often the extent and nature of the direct exposure that one has to trauma and to those suffering from traumatic experiences that is generally understood to have the greatest impact on a human support worker. Indeed, one of the best predictors of symptom development is the intensity and duration of exposure (Munroe et al., 1995). However, it is not only those whose work is dominated by trauma that are affected by compassion fatigue as even those who may have less experience can suffer from the serious and damaging impact of exposure (Dutton and Rubinstein, 1995).

In order to understand the response of human service providers, it is important to understand the unique features of the exposure by working with victims/survivors. These professionals are faced with prolonged aftermath of the trauma, with the effects often compounded. Hence, there are more complex ramifications to the exposure of trauma than there are to the exposure of the trauma event itself (Dutton and Rubinstein, 1995). The following example provides an indication as to the circumstances that surround human service providers in their involvement with their clients:

> *A psychotherapist at a Veterans Administration (VA) hospital has ten Vietnam combat veterans and eight Persian Gulf veterans on her caseload. These men and women describe witnessing the deaths and mutilations of their buddies; participating in the massacre of village people; attempting to cope with active-duty notices that allowed 72 hours or less in which to make plans for child care, financial support for families, and other arrangements before leaving for the Persian Gulf; and experiencing combat wounds, followed by inadequate medical attention that resulted in amputations, blindness, and other permanent disabilities. These reports of neglect and despair are common with clients at VA hospitals and clinics (Dutton and Rubinstein, 1995).*

As is evident by the example, due to the nature of the work, the human service providers working with this population of traumatized veterans would continually be exposed to material and content that is extremely violent and disturbing, placing them at great risk of experiencing negative effects as a result.

5.3.2 Individual Context/Personality Traits

There are several individual factors that have been found to directly impact outcome variables or result in significant differences in the outcome. For example, one study identified neuroticism, as measured by the EPQ, as a predictor of persistent chronic PTSD. There are four major individual factors that have been found to contribute to compassion fatigue, including: poor self-care, previous unresolved trauma, inability or refusal to control work stressors, and a lack of satisfaction for the work being done. It is partly these factors combined that contribute to explanations as to why some human service providers manage in their work and some do not (Radey & Figley, 2007).

In addition, there are several other important individual factors that may impact the response of the trauma workers, including: pre-existing life events stress; role conflict between one's professional and personal roles; health; socioeconomic situation; previous trauma and loss; coping skills; and the methods of assimilating and finding meaning in the trauma. However, it should be noted that none of these individual factors have been able to predict the onset, severity or duration of post-trauma effects (Beaton and Murphy, 2005; Myers and Wee, 2002).

Demographic characteristics are also relevant. For example, one study was conducted on almost 600 U.S. Air Force personnel who recovered and transported the bodily remains of the approximately 1,000 victims of the Jonestown, Guyana mass suicide. Through the administration of a survey, it was found that those who reported more short-term "dysphoria" were respondents who were less than 25 years old, were of African-American ethnicity, were enlisted personnel (versus officers), and were not trained trauma workers. Identification with a victim is an important factor in the secondary development of post-traumatic reactions (Beaton and Murphy, 2005).

5.3.3 Organizational/Occupational Context

There are four organizational influences on the recognition of and recovery from the consequences of trauma work, including: 1) authority and chain of command; 2) size of the organization; 3) role conflicts and ambiguities; and 4) rank of the trauma worker. It is from these factors that the development of group norms arises. In part, the cultural norms present in an organization dictates how a given individual should (and will) respond to a line of duty trauma. This organizational culture is important, not just with respect to the admission and recognition of a post-trauma reaction but also with regard to the recovery and acceptance of receiving treatment (Beaton and Murphy, 2005). Additional organizational factors have been found to mitigate the incidence of compassion fatigue, such as supportive work environments and adequate supervision. Also associated with an increased incidence of compassion fatigue are exposure factors, such as long work hours or length of assignment, and a high proportion of trauma clients (Sprang et al., 2007).

5.3.4 Social Context

Social context refers to the interpersonal environment that gives meaning to the professional roles and responses of trauma workers. Social network studies have demonstrated that individuals require both principal attachment figures and friends and colleagues to help in dealing with stressful experiences. It has been suggested that both types of support, information focused and emotion focused, and their timing, during the trauma and preceding it, are crucial considerations in the connection between stressors and outcomes (Beaton and Murphy, 2005). There are also relevant interpersonal factors that include: relationships, social support, and impact of the disaster on the individual and family. In addition, there are relevant community factors, including: the size and nature of the community, the degree of social solidarity, prior disaster experience, response of the community to the disaster, and the amount of initial and ongoing disruption due to the disaster (Myers and Wee, 2002).

5.3.5 Characteristics of Traumatic Events

There are factors related to the disaster itself that may have an impact upon the human service provider. Some of these characteristics of traumatic events may operate to strengthen and support the worker while others may serve to put a worker at risk for experiencing compassion fatigue. It is important therefore to consider all of these factors in an assessment of compassion fatigue among human service providers engaged in trauma work (Myers & Wee, 2002). There is variation in traumatic events according to their predictability; suddenness and duration of impact; controllability; the presence or absence of a warning; the type of disaster; and the extent of the damage and destruction. The nature and magnitude of the events interacts with the antecedent, mediating, and outcome factors. The potential for personal loss, injury and death has been documented as a concern for trauma workers. The "mission" failure is also a stressor as some experience role stress due to their inability to carry out the tasks that they have been trained to do as the impact of the event is so profound (Beaton and Murphy, 2005; Myers and Wee, 2002).

5.4 Stress Response of Mental Health Workers Following the Oklahoma City Bombing

On 19 April 1995, the Alfred P. Murrah Federal Building in Oklahoma City was destroyed by a bomb, killing 168 people and injuring approximately 700 individuals in both the building and in the nearby area. The emotional and physical devastation of the bombing was extensive. More than 12,000 rescue workers throughout Oklahoma and the nation participated in the recovery process, experiencing unspeakable hardship and horror, while their own lives were threatened by the unstable conditions of the recovery effort. A vast array of stress management approaches were utilized to protect the emotional well-being of the workers involved in all aspects of the disaster, including: critical incident stress management teams providing opportunities to defuse and debrief; emotional and spiritual support provided by chaplains; massage therapy; forms of entertainment and rest; interactions with "pet" therapists, including dogs and rabbits; donations; and letters of support from around the country (Wee and Myers, 2002).

This study on the stress response of the mental health workers following the Oklahoma City bombing explored three related bodies of literature. The first is focused on the psychological impact of disasters on the primary victim, namely those who directly experienced the impact of the event. This body of literature is extensive and provides evidence as to the damaging consequences such an experience can have on an individual, some of which continues long after the disaster. The second concerns the impact of disaster work on emergency service workers; those who respond to the disaster and its victims. The individuals in this group may also be considered victims of the disasters as well, but their primary response is to operate in a professional capacity. The research indicates that these individuals can experience psychological effects and there may be a negative impact on them. The third body of literature addresses the disaster mental health workers who, for extended periods of time following the disaster, assist the disaster victims and personnel with disaster-related mental health challenges. In this body of work, two prominent types of stressors exist for disaster workers engaged in long-term recovery efforts. First identified are the event stressors, which include the type of disaster, personal loss and injury of those disaster workers who are primary victim of the event, fatigue and exposure to trauma. These stressors will have an impact on both the post-impact recovery environment as well as the worker stress during the long-term recovery phase. Second, there are the occupational stressors that have to do with the work itself, and include time and responsibility pressures, as well as the emotional demands through contact with the survivors. The research that has been done has determined that over the tenure of their disaster support work, these workers experience significant levels of symptomatology (Wee & Myers, 2002).

The disaster mental health workers involved in this disaster received an Alfred P. Murrah Federal Building Bombing Reaction Questionnaire packet nine months after the bombing. The 179-item self-report questionnaire contained items concerning demographic information, personal experiences with the bombing, experiences with the crisis counselling program, empathy received from people involved and not involved in the incident, involvement in stress management activities, and several open-ended questions. The instrument contained three standardized measures, including: the Compassion Fatigue Self-Test for Helpers; the Frederick Reaction Index-A, used to examine the presence of symptoms and the level of severity of PTSD; and the Symptom Checklist 90-Revised, used to evaluate the presence and level of severity of psychological distress experienced by the respondents. In total, 34 questionnaires were returned. Overall, it was found that reported stress since the bombing was elevated, with 55.9% reporting stress-related problems since the bombing, 93.9 reported some degree of overall stress since the bombing, 87.9% reported some levels of stress problems currently, and 48.5% reported the experiencing of delayed stress problems. Following the bombing, 64.7% of the disaster mental health workers providing services had some degree of severity of stress disorder. There were two factors significantly associated with a higher level of severity of stress disorder, namely the job classification of administrator and the number of months providing disaster mental health services to bombing survivors. In considering the first factor, the authors suggested that their role of providing administrative and clinical support to direct service workers seeking assistance with difficult cases may have led to an increased level of stress for these workers. As such, their stress may not be related to the number of cases with which they were working clinically but rather, to the intensity of the cases brought to them for their assistance. In considering the second factor, it was determined that an increased number of months working with the bombing survivors was significantly associated with greater risk for compassion fatigue and burnout. More specifically, an

increased duration of time providing crisis counselling and educational services to the victims of the Oklahoma City bombing appeared to be related to increased compassion fatigue (Wee and Myers, 2002).

Overall, the findings of this study indicated that the nature of the bombing as a terrorist act, exposure to the bomb blast and its aftermath, the length of time providing services, and job responsibility of providing disaster mental health services during long-term disaster recovery appeared to have a similar, and perhaps even greater severity of stress response as the shorter-term, high-intensity rescue, disaster, and emergency work done by emergency service workers. Therefore, the results of the study indicate a need for further research on the impact of disaster crisis counselling on the human service providers (Wee and Myers, 2002).

5.5 Compassion Fatigue Following the September 11 Terrorist Attacks: A Study of Secondary Trauma Among New York City Social Workers

The objective of this study was to determine the potential prevalence of compassion fatigue among social workers in New York City who cared for the victims of the September 11, 2001 terrorist attacks. The goal of the researchers was to test the hypothesis that, while controlling for demographics, trauma history, and social support, social workers who had higher levels of involvement in counselling the victims of the attack were at greater risk for compassion fatigue. In addition, the researchers also hypothesized that a supportive work environment would provide protection from compassion fatigue (Boscarino et al., 2004).

The study was based on surveys administered to 236 clinically active social workers in New York City. More than 50 % of respondents reported exposure to one or more traumatic events in their lifetime. In addition, 38 % were moderately to extensively involved with the recovery efforts of the attack, while 67 % were moderately to extensively involved with counselling individuals who were affected by the attack. The research provided support to the contention that a group of mental health professionals who were working with traumatized victims were at significant risk for compassion fatigue. It was suggested that the key variables in predicting the onset of compassion fatigue includes: the degree of exposure to the event and to the victims, personal history, social support, and environmental factors (Boscarino et al., 2004).

5.6 Compassion Fatigue in the Treatment of Combat-Related Trauma During Wartime

Although for the United States, the war in Afghanistan has passed the six-year mark and the Iraq war has passed the four-year mark, there has been little research on the professionals who are providing mental health care to the returning troops. However, previous research on the impact that other conflicts have had on human service providers indicated that being exposed to the narrative of war trauma survivors had significantly increased their risk of developing secondary stress reactions, known as compassion fatigue. For example, in his early research on Vietnam War veterans, Figley (1978) indicated for clinicians working with clients experiencing combat-related trauma, the symptoms of compassion fatigue may be compounded. He asserted that by being empathetically engaged with a combat survivor, the clinician is not only confronted with their own personal vulnerability to devastation, but their

moral attitudes about killing and aggression are also challenged. The construct of "shared trauma" has also emerged and is indicative of the profound effect that can occur when a professional is secondarily exposed to the same traumatic event as their client. In addition to the graphic material presented by their clients, these individuals have also been presented with stimuli such as ambiguous terror alerts, suicide bombings, and video footage of combat operations that serve as a harsh reminder that their sense of safety and meaning in the world is no longer at an equilibrium and a cognitive shift in worldviews may occur. Thus, given the current circumstances of the world, the risk for these professionals to develop compassion fatigue is exacerbated (Tyson, 2007).

The wars in Iraq and Afghanistan are the first sustained U.S. conflicts that have subjected the all-volunteer male and female military force to redeployments to a combat zone that may last up to 18 months at one time. Recently, research has started calculating the mental health impact of deployments in these wars and the studies have indicated a high incidence of PTSD, generalized anxiety, depression, adjustment disorder, substance abuse and profound relational disturbances. The data have also provided some indication as to what military personnel are exposed to during their combat deployment. Specifically, it was found that 94% of soldiers in Iraq reported small-arms fire, 86% reported knowing someone who was seriously injured or killed, 68% reported seeing dead or seriously injured Americans, 51% reported handling or uncovering human remains, 77% reported firing at the enemy, 48% reported being responsible for the death of an enemy combatant, and 28% reported being responsible for the death of a non-combatant. This preliminary data, originally published in 2004, illustrate the grave reality of these individuals and provides an indication as to the amount of exposure to threat and bearing witness to the horrific trauma of others that is experienced in combat. In addition, the war trauma is further compounded by their chronic exposure to sleep deprivation, inadequate equipment, severe environmental hardships, devastation of the occupied country's infrastructure, and an unidentifiable enemy. Upon their return, it is often the human service providers who provide front-line service and care to these military personnel returning from combat. As such, they are at great risk for secondary exposure and compassion fatigue to the trauma witnessed and experienced by these military personnel as they work with their combat trauma clients (Tyson, 2007).

5.7 The Impact of Secondary Trauma on Assumptions, Values and Beliefs

In addition to dealing with exposure of the experience of the client, another source of trauma for human service providers in dealing with the suffering of their client is the nature of that suffering. In being exposed to the trauma of their clients, these professionals are not only aware of the pain and suffering of another human being, they also are faced with the realization that traumatic events do occur, have occurred, perhaps repeatedly, and can occur again. In being exposed to this kind of material, the workers are unable to deny the potential for trauma in their own lives. Faced with this knowledge, the professional is confronted with the reminder of their own personal vulnerability to traumatic loss and devastating events. This cognitive shift is one of the reasons that professionals working with the trauma of disaster survivors are at such high risk for experiencing compassion fatigue (Myers & Wee, 2002).

As part of a larger study exploring the impact of trauma on the personal beliefs and values of human service providers who work with distressed or traumatized clients, a survey was administered to 430 care workers from a range of caring professions who regularly worked with clients who were distressed or traumatized. The data for the study was based on the administration of a 21-item beliefs inventory to the care workers, whereby they were asked about the provision of professional supervision, social support and whether they had any spiritual or religious beliefs. The sources of support identified in the survey included three kinds of supervisions: managerial, personal or professional, and peer supervision. Also included were six kinds of less formal support: talking to friends and colleagues, talking to family, talking to a spiritual guide, priest or vicar and praying, exercise, and relaxation or hobbies. The aim of the survey was to identify the impact that working with distressed and traumatized clients had on caring professionals and to examine the common sources of support and coping methods (Tehrani, 2007).

Analysis of the data indicated that all the negative beliefs were experienced on some occasion by at least one fifth of the participants, such as a loss of meaning to life, feelings of being worthless, and feeling that they might not recover from their exposure. Some of the negative beliefs were experienced at least sometime by over 60% of the participants, such as the world being a dangerous place and the belief of there being no justice in the world. The strongest negative beliefs identified were that the participant should have coped better (60%) and the belief that the world was a dangerous place (64%). It was further found that respondents who believed that they had done a good job or who had experienced a sense of satisfaction reported less negative beliefs. These individuals also reported less frequent experiences of a low sense of achievement or self-worth and of feelings that they should have been able to cope better. In analyzing the data on sources of support, it was found that the most available source of support was talking to friends and colleagues (73%), followed by professional supervision (55%) and talking with family (55%). The least frequently used source of support was managerial support (21%) and talking with a spiritual guide, priest or vicar (13%), although 31% of respondents did report the use of prayer. Over half of the participants regarded themselves as spiritual and over a third as religious. Exercise and hobbies were used by approximately half of the respondents as way of coping with the negative impact of their work. The study suggested that being faced with overwhelming challenges can be destructive to one's personal growth and development, particularly for those human service providers who feel less confident about their abilities. Overall, this study provided support to some of the existing literature on compassion fatigue; particularly with respect to the high proportion of professionals whose work with distressed or traumatized clients impacted their personal assumptions, values and beliefs (Tehrani, 2007).

5.8 Combined Research of Compassion Fatigue, Compassion Satisfaction and Burnout

Sprang et al. (2007) investigated the extent to which compassion fatigue, compassion satisfaction and burnout vary as a function of provider characteristics, including: age, gender, educational level, licensure, years of experience, setting, and the presence of specialized trauma training. This study contributes to the existing literature by exploring compassion fatigue, compassion satisfaction and burnout in a community sample of mental health practitioners whereby the exposure to traumatized clients is comparable to those of the general

provider population, as opposed to those operating in the context of a catastrophic event. Their findings were based on data collected from 1,211 questionnaires completed by mental health providers currently practicing in a rural southern state. As part of a larger study, participants completed the ProQOL Scale, a 30-item self-report measure that assesses the risk of compassion fatigue, potential for compassion satisfaction, and the risk of burnout (see Section 3.2.2). Based on analyses of the data, it was determined that approximately 13% of the provider population sampled was at risk for compassion fatigue or burnout. Such a finding is argued to underscore the relevance of continued research examining the specific provider or setting characteristics that may impact upon the development of these conditions. In addition, the researchers found that prior specialized trauma training did enhance compassion satisfaction and reduce levels of compassion fatigue and burnout. This suggests that some protection against the negative impact of trauma exposure may be offered to service providers through training and knowledge. The experience of training sessions and continuing education opportunities is also contended to potentially create the opportunity for service providers to establish peer support and colleague support; factors identified as mitigating the potential for burnout and compassion fatigue to emerge (Sprang et al., 2007).

6. The Impact of Burnout and Compassion Fatigue

6.1 Burnout

It is the outcome of burnout that is linked to its significance, for both the individual and for the organization. The majority of the outcomes that have been investigated have been those related to job performance and, given that burnout is considered to be a stress phenomenon, individual outcomes (Maslach et al., 2001).

6.1.1 Individual Well-being

There appears to be a correlation between burnout and various self-reported indicators of personal dysfunction, including physical exhaustion, insomnia, increased usage of alcohol and drugs, and marital and/or family problems (Maslach et al., 1996). There are many symptoms of burnout that have been identified and they can be separated into physiological, behavioural, psychological and, for some, spiritual features. Physiological symptoms may include: physical depletion and fatigue; headaches; weight loss and sleeplessness. Behavioural symptoms can include: coming late to work; loss of enthusiasm; reduced work performance; boredom; difficulty making decisions; withdrawing from colleagues; increased irritation with coworkers; and closing out new input. Psychological features of burnout may include: depression; feelings of helplessness and hopelessness; emotional drain; and the development of a negative self-concept and negative attitudes toward work, life and other people; and emptiness. Spiritual features can include: a loss of faith, meaning and purpose; a crisis of values; changes in religious ideas; alienation and estrangement; and lack of inspiration (Ross et al., 1989; Grosch & Olsen, 1994; Cordes & Dougherty, 1993).

Too often burnout is defined only by its symptoms. As such, many human service providers do not recognize the problem until their level of burnout has reached a critical point. The early onset of burnout tends to be mistaken for simple tiredness or by low energy levels and it is not until burnout has become more acute, when the symptoms are more pronounced and the negative impact greater, that it is usually recognized and identified. At this point, the problem of burnout is already quite advanced (Grosch & Olsen, 1994).

Of the three key components of burnout, the emotional exhaustion dimension is more predictive of stress related outcomes. With respect to mental health, the link to burnout is complex. A common assumption made is that burnout causes mental dysfunction. Specifically, that it precipitates negative effects in terms of mental health, such as anxiety, depression, reduced self-esteem, etc. Alternatively, the argument is presented that individuals who are mentally fit are better able to cope with chronic stressors and therefore less likely to experience burnout (Maslach et al., 2001).

6.1.2 Job Performance and Turnover

There are various forms of job withdrawal that have been linked to burnout, including absenteeism, intention to leave the job, and actual turnover. Turnover and the intention or desire to leave the organization is one of the most detrimental consequences of burnout, negatively impacting both the individual and the organization. For those individuals that stay

on the job, experiencing burnout results in a decreased productivity and effectiveness in their work. As such, it is associated with lower job satisfaction and a reduced commitment to the job and to the organization. Findings also indicate that burnout can result in a reduced quality of care or service that is provided by the service worker (Maslach et al., 1996). There may also be a negative impact on the colleagues of individuals who are experiencing burnout as they may cause greater interpersonal conflict and disrupt job tasks. Hence, burnout may in fact be "contagious", perpetuating itself through informal interactions in the workplace (Maslach et al., 2001).

In studying burnout of clergy, there has been some research on the numbers of individuals who have left the clergy. However, given the difficulties in accessing those who have left the ministry, the reasons as to why these individuals have left are generally only inferred and no conclusive answers have been provided. Rather, it has been postulated that observing the indicators of clergy dissatisfaction prior to the person leaving would be a more efficient manner in studying burnout of clergy. As such, a study was conducted that examined whether burnout was a predictor of Anglican clergy leaving the ministry. As part of a longitudinal study of 340 clergy ordained in the Church of England and the Church of Wales, a 30-item modified form of the MBI was completed in year seven of their ministry along with a question regarding the frequency of contemplating leaving the ministry. The data determined that higher levels of emotional exhaustion, depersonalization and lack of personal achievement is correlated with the frequency of considering leaving the ministry. Therefore, the study concluded that it is possible to measure the proneness to burnout amongst clergy who are contemplating leaving the ministry prior to them making the move to leave. Further, since it would be possible to identify the potential candidates for burnout and turnover, it would also be possible to provide specific help and support to those at greatest risk, thereby reducing the likelihood for these individuals experiencing burnout and subsequently leaving (Randall, 2004).

6.1.3 Coping Strategies for Burnout

The response of the individual to job demands is one factor that has a significant impact upon the onset and progression of burnout. These *coping strategies* are perceived to be the personal resources that are the key elements in the mediation or prevention of burnout (Jenaro et al., 2007). Examining effective coping strategies to burnout, in addition to investigating approaches to preventing its occurrence, is done with the objective of alleviating the number of individuals suffering from burnout (Maslach, 1982).

6.1.3.1 Coping Strategies of Human Service Providers

A study conducted on Spanish human service providers had three objectives. First, the goal was to establish the burnout rate among this population. Second, the intent was to assess the frequency of various coping strategies. Lastly, the aim was to determine the relationship between coping strategies, job features and burnout. In total, 211 human service practitioners from several institutions were surveyed, using the MBI in combination with an instrument employed to assess cognitive and behavioural coping strategies. These coping strategies were distinguished between action-oriented strategies, focused on efforts to solve the situation and on social support, and passive-oriented strategies, focused on emotions and the venting of emotions and disengagement, that individuals employ when faced with a stressful situation.

The high levels of burnout found in this study were argued to be sufficient justification for the implementation of psychological interventions that would improve the work satisfaction of human service providers, while subsequently enhancing the quality of care that their clients were receiving. It was found that for the employees who displayed little or no symptoms of burnout, the majority of workers tended to use adaptive, active or problem-focused strategies more frequently than passive or emotion-focused strategies. Therefore, the contention was made that the focus of intervention techniques should be on increasing the use of active coping skills by employees. In addition, it was posited that overall job satisfaction may be increased by the more frequent use of active coping skills by those currently experiencing burnout. Burnout cannot be prevented solely by coping strategies but there is evidence to suggest that it may help to reduce employee turnover. Overall, it was determined that high job and salary satisfaction in conjunction with active coping strategies have a key role in promoting personal achievement. Alternatively, low job and salary satisfaction and the use of passive or emotional coping strategies are predictive of heightened levels of emotional exhaustion (Jenaro et al., 2007).

In order to investigate the effects of coping on psychological strain and "burnout" produced by job stress, another study administered a survey to 141 human service workers who represented a broad sample of professionals. In this study, coping was defined as efforts made to reduce stress and strain and was conceptualized on three levels, namely: 1) strategies used by individual workers; 2) strategies undertaken by groups of workers to aid one another (social support); and 3) strategies initiated by human service agencies. The contention was made that one important step in reducing burnout is the identification of the stressors that cause psychological strain for human service providers. A second step is the identification of coping strategies that ameliorate stress and strain. Respondents were asked to identify coping strategies for reducing stress at the individual, group and organizational level. It was hypothesized that, while group and organizational strategies would be effective in impacting job related stress, individual coping strategies would have a minimal impact (Shinn et al., 1984). The results of the study identified five primary areas of stressors experienced by the respondents, including: job design, involving excessive workload and role conflict (47%); agency, referring to a lack of recognition and support from the organization (44%); professional helping role, referring to feelings of inadequacy relative to personal high expectations or pressure to cure clients (34%); interpersonal, involving conflicts with other staff members (19%); and clients, involving the emotional demands of the job and the failure of clients to improve (23%). With respect to coping strategies, respondents reported a number of personal strategies that were employed to alleviate job stress and burnout. The most common response was that of focusing attention on family and friends or hobbies, instead of on the job (64%), while 30% reported building competence, primarily by attending workshops and conferences. Taking breaks or vacations, and the use of cognitive or emotional strategies, such as withdrawal, anger, self-blame or the focusing on the positive aspects of the work were both strategies employed by 31% of the sample. The last common strategy, employed by only 22% of the sample, was to change the job itself. As hypothesized, individual responses had little effect on job stress and strain (Shinn et al., 1984).

6.1.3.2 Coping Strategies of Clergy

One study examined the correlation between burnout, coping strategies, and spiritual attitudes of religious leaders. The premise of the study was to address the little research that had been

done to correlate coping strategies, attitudes and spirituality with burnout. The subsequent objective was to identify the constructive coping strategies employed by clergy against burnout. The data for the study was based on a total of 222 United Methodist parish clergy and included data obtained from three validated instruments, including the MBI, the Hatch Spiritual Involvement and Beliefs Scale (SIBS), and validated coping scales. The SIBS assesses the broader themes of spiritual life that address both internal beliefs (such as the concept of God) and external practices (such as the frequency of worship); it also examines relational qualities of spirituality, such as personal humility and forgiveness and existential beliefs. The validated coping scales assessed the individual's coping strategies in response to stress. It was determined that certain positively adaptive coping strategies may protect against burnout. For example, acceptance, active coping, planning, and positive reframing were correlated with higher personal achievement. Alternatively, some maladaptive coping strategies correlated with greater burnout. For example, self-blame, disengagement, venting, distraction, and denial were correlated with increased emotional exhaustion and depersonalization (Doolittle, 2007).

6.1.4 Intervention

Various intervention strategies have been proposed in the burnout literature with some studies suggesting to treat burnout after it has emerged and others focusing on how to prevent burnout. Of note is the observation that most of the discussions regarding burnout interventions essentially focus on individual-oriented solutions, such as removing the individual from the job, or on individual strategies for employees to utilize that would either strengthen their internal resources or change their work behaviour. This approach is particularly paradoxical as the burnout literature has generally established that situational and organizational factors play a larger role in burnout than individuals factors. Thus, while individual-centred approaches, such as learning effective coping or relaxation skills, may help to alleviate emotional exhaustion in the individual, they do not address the other two dimensions of burnout. In addition, individual-based strategies are relatively ineffective in work environments in which the employee has much less control over workplace stressors than in other domains of life. Such orientations are reflective of existing notions of employee causality and responsibility and the assumption that it is both easier and more cost effective to change individuals as opposed to the organization (Maslach et al., 2001).

6.1.4.1 Individual-Oriented Approaches

Primarily, the focus of studies on reducing burnout has been on educational interventions that enhance the ability of individuals to cope with stressors in the workplace. The main goal of these studies has been directed toward alleviating incidents of burnout in the employee. There are generally three questions at the root of these approaches. The first question surrounds whether individuals can learn coping skills. Much of the literature indicates that individuals can learn new ways of coping and that educational sessions have the capacity to enhance the ability of human service providers to cope with the demands of their jobs. The second question pertains to whether individuals can apply this learning at work. The answer to this question is not quite as positive as individuals are operating under various constraints in the workplace, thus it can be a challenge to apply new knowledge at work. Due to the particular roles at work, individuals are required to behave in specialized ways, with organizational conditions stipulating the way in which work is performed. The last question examines

whether new ways of coping can affect burnout. There has been a wide range of intervention strategies that have been undertaken, including relaxation, time management, assertiveness training, training in interpersonal and social skills, teambuilding, meditation, etc. However, the research findings are inconclusive on this matter as in some cases, a reduction in emotional exhaustion has been reported while in other cases it has not. In addition, it is rare that any programs report a change in either depersonalization or personal achievement (Maslach et al., 2001).

6.1.4.2 Organizational-Oriented Approaches

The burnout research has demonstrated that it is essential for interventions to also focus on the job environment in addition to the individual in that environment. Thus, it is postulated that the most effective interventions combine changes in the organization concurrent with the individual-oriented approaches as previously described. Although organizational interventions are essential to effecting change in any of the six areas of work-life previously presented, they will be insufficient without the individual-oriented interventions that convey the required individual skills and attitudes. Indeed, the contention is made that neither changing the work environment nor the individual is enough to successfully effect change; rather, this occurs when both develop through an integrated strategy. There is an additional advantage of such a combined approach to intervention, namely that it tends to emphasize fostering engagement with work. By establishing a positive goal for intervention in building employee engagement, rather than on reducing burnout, the accountability of the intervention is enhanced (Maslach et al., 2001).

6.2 Compassion Fatigue

As previously stated, compassion fatigue is nearly identical to PTSD, with the exception of it generally being experienced through indirect trauma acquired by a client, as opposed to direct personal experience. In an effort to demonstrate the close relationship between the two constructs, Figley (2002) generated a table delineating the contrast between the symptom criteria for PTSD and that of compassion fatigue. A selection of relevant items were extracted from this illustration and are presented in Table 2. For a more detailed overview of the symptom criteria between compassion fatigue and PTSD as produced in the original table, see Figley (2002).

TABLE 2 - TRAUMATIC SYMPTOMS OF PRIMARY AND SECONDARY TRAUMATIC STRESS DISORDER STRESSORS

Primary (PTSD) Stressors	Secondary Compassion Fatigue Stressors
A. Experienced an event outside the range of usual human experiences that would be markedly distressing to almost anyone; an event such as September 11 terrorist attack, family violence, combat, or other terrifying experiences.	Experienced indirectly the primary traumatic stressors through helping those who had experienced those traumas: helping in such roles as a nurse, social worker, counsellor, or other roles and activities.
B. Traumatic event is persistently re-experienced in one (or more) of the following ways:	
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.	Recurrent and intrusive distressing recollections of the *client*/event, including images, thoughts or perceptions.
2. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.	Intense psychological distress at exposure to internal or external cues that symbolize or resemble the aspect of *the work of helping others.*
3. Physiological reactivity on exposure to trauma cues.	Physiological reactivity on exposure to trauma cues *that are associated with the role of the helper.*
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three or more of the following:	
1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.	Efforts to avoid thoughts, feelings, or conversations associated with *the client's* trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.	Efforts to avoid activities, places, or people that arouse recollections of *the client's* traumas.
3. Feelings of detachment or estrangement from others.	Feelings of detachment or estrangement from others.
4. Sense of foreshortened future (i.e. does not expect to have a career, marriage, children, or a normal life again).	Sense of foreshortened future (i.e. does not expect or want to have a long career).
D. Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning:	
Evidenced by increase in family conflict, poor interpersonal communication, increased dependency, reduced social support, poor stress-coping methods.	Evidenced by increased work conflict, missed work, insensitivity to clients, lingering distress caused by trauma material, reduced social support, and poor stress-coping methods.

Figley (2002: 4-5)

Compassion fatigue is believed to not only impair the ability of human service providers to effectively help others; it is also thought to reduce the satisfaction experienced in doing their work (Bride et al. 2007). While compassion fatigue is a relatively recent construct, it is likely that it has affected all those who have worked extensively with traumatized individuals. The research on compassion fatigue has demonstrated that it is a very real concern that has the

potential to reduce one's capacity to function effectively at work, home, and within their personal lives (Gentry et al., 2002).

6.2.1 Indications of Its Impact

Figley (2002) also generated a table that delineated several examples of the various symptoms of compassion fatigue, and it has been partially reproduced in this report (refer to Table 3). For a more comprehensive review of the original production, see Figley (2002). As a review of the table will demonstrate, there are many consequences that one may experience when they are suffering from compassion fatigue. It should be noted however, that this is not considered to be an exhaustive detailing of the symptoms of compassion fatigue but rather provides an indication as to the possible impact of the phenomenon. Some additional psychological symptoms include: sadness, grief, depression, dread, horror, fear, rage, shame, flashbacks, numbing and avoidance phenomena, and cognitive shifts in viewing the world and oneself, such as suspiciousness and cynicism (Valent, 2002).

TABLE 3 - EXAMPLES OF COMPASSION FATIGUE SYMPTOMS

Cognitive	Emotional	Behavioural	Spiritual	Personal Relations	Somatic	Work Performance
Difficulty concentrating	Powerlessness	Impatient	Lack of purpose	Withdrawal	Shock	Low morale/ motivation
Decreased self-esteem	Anxiety	Irritable	Lack of self-satisfaction	Mistrust	Rapid heartbeat	Absenteeism
Apathy	Guilt	Withdrawn	Pervasive hopelessness	Isolation from others	Breathing difficulties	Staff conflicts
Preoccupation with trauma	Anger/rage	Sleep disturbances	Questioning of prior religious beliefs	Projection of anger or blame	Dizziness	Apathy/ detachment
Thoughts of self-harm or harm to others	Fear	Appetite changes	Loss of faith in a higher power	Intolerance	Sweating	Poor work commitments
Disorientation	Survivor guilt	Elevated startle response	Greater scepticism about religion	Interpersonal conflicts	Impaired immune system	Withdrawal from colleagues

Figley (2002: 7)

All of the symptoms identified constitute a selection of behaviours that indicate the presence of compassion fatigue. These symptoms may appear in isolation or in conjunction with other symptoms, however it is important to note that any of these symptoms may signal the positive existence of compassion fatigue in an individual (Gentry et al., 2002).

6.2.2 Health Consequences

6.2.2.1 Immediate Post-Exposure Effects

During the traumatic event, there are many stressors for the disaster workers, such as handling dead bodies, exposure to dangerous situations, witnessing of property and environmental loss, working in difficult conditions, physical strain, and interactions with the families or friends of the victims. One immediate trauma symptom that is frequently reported by trauma workers is that of depersonalization, in which they continue to function while feeling a sense of unreality. Indeed, the majority of trauma workers continue to function in spite of the crisis and therefore, in order to render help and assistance effectively, overwhelming emotions are usually suppressed during the critical events (Beaton and Murphy, 1995).

6.2.2.2 Short-Term Post-Exposure Effects

Short-term post-trauma reactions include re-experiencing the traumatic event and numbing of responsiveness. This acute phase begins in the immediate aftermath of an event and presumably lasts for several months. It was reported that 80% of rescue personnel experienced at least one post-traumatic symptom following an apartment building explosion. The most common symptom was intrusive thoughts about the disaster and was observed in 74% of disaster-site rescue personnel (Beaton and Murphy, 1995).

6.2.2.3 Long-Term Post-Exposure Effects

A study was conducted that examined the prevalence and magnitude of post-incident stress symptoms in 2,000 firefighters and paramedics by asking respondents to recall their most stressful line of duty experience within the past 12 months. It was found that 87% of respondents experienced at least one post-trauma symptom following an unspecified line of duty incident within the past year. The total average score for the sample represented mild-to-moderate level of post-trauma symptomatology (Beaton and Murphy, 1995).

In summarizing the health implications, there are two important trends that emerged in a review of the studies that have been conducted. First, the range of health outcome effects indicates that worker exposure is a key factor and second, the findings provide support to the position that some responses are normal reactions to extreme situations and are not evident of psychiatric disorders (Beaton and Murphy, 1995).

6.2.3 Silencing Response

Human service providers are most vulnerable to the silencing response when they feel overwhelmed and in need of skills and when their ability to listen becomes compromised. This section explores individuals experiencing compassion fatigue who become vulnerable to employing the silencing response with their clients as an approach to managing their own pain and discomfort. The silencing response is a reaction based on a set of assumptions that direct the human service provider to redirect, shutdown, minimize, or neglect the traumatic material that has been brought to them by an individual (Barankowsky, 2002). This set of assumptions composes an interconnected framework that individually or as a group impacts the ability of the human service provider to effectively attend to the recollections of traumatic material:

- "I can't do anything about it" – the notion that listening won't do anything to help so there is no interest in hearing about it;

- "If we touch on the traumatic event, the person will fall apart or be destroyed" – the main notion that it will only make things worse to talk about the trauma;

- "I will be destroyed if I hear about the traumatic event" – the fear of knowing about the terror that the individual has experienced;

- "Good things happen to good people" – the perception that the individual must be bad for this to have happened to them;

- "This is too terrible to be true";

- "This violates my assumptive world" – for example, my neighbourhood is safe and thus, that can't have happened here;

- A strong need on the professional's part to have the client "just get over it"; and

- "If it happened to you, it could happen to me" – the vulnerability to terrible events may cause the professional to feel that what happened could somehow be contagious (Barankowsky, 2002).

In an effort to make the silencing response more personally relevant, a silencing response scale was developed.[6] The primary objective was to aid human service providers who would like to identify the impact of silencing response in their professional work. The scale remains in the developmental stages, although it can be used in its current state. Preliminary analysis of the scale indicates that as compassion fatigue scores increase, silencing response scores increase, leading to the hypothesis that when the human service provider begins to suffer from compassion fatigue, and hence is overwhelmed by work, the silencing response becomes active and further impedes the work (Barankowsky, 2002).

Some indicators of the silencing response include: changing the subject; avoiding the topic; providing pat answers; minimizing client distress; wishing or suggesting the client would "just get over it"; boredom; being angry or sarcastic with clients; using humour to change or minimize the subject; faking interest or listening; fearing what the client has to say; fearing they will not be able to help; blaming clients for their experiences; not believing clients; feeling numb or avoidant prior to sessions; not being able to pay attention to the client; and constantly being reminded of personal traumatic experiences when working with certain clients. Compassion fatigue provides an indication that one is overwhelmed by the work and the silencing response shuts down the therapeutic process, impeding effective communication and blocking the ability of the client to be heard. Acting as a buffer to compassion fatigue and reducing the usage of the silencing response is the development of skills and self-reflection; crucial to providing the client with the opportunity to work through their traumatic

[6] For a more detailed review of the Silencing Response scale, please refer to Barankowsky, 2002.

experiences and for an effective relationship to be maintained between the client and the human service provider (Barankowsky, 2002).

6.2.4 Prevention and Treatment

The first step in preventing or mediating compassion fatigue is to recognize the signs and symptoms indicative of its emergence. On an individual level, human service providers may be able to prevent the onset of more negative components of compassion fatigue if they remain diligent in continually monitoring themselves for the presence of symptoms (Bride et al., 2007). To protect themselves from secondary trauma through their work with traumatized clients, human service providers should aim to attain a balanced life that takes their own personal needs into account along with those of work, family and friends. Also found to be most helpful are discussing cases with colleagues, attending training workshops, spending time with family and friends, taking vacations, socializing, exercising, limiting the workload, developing a spiritual life and accessing support from supervisors (Tehrani, 2007).

On an organizational level, the following describes the workplace environment that best facilitates the recovery of traumatized personnel:

- Stressors are accepted as real and legitimate;
- The problem is viewed as an institutional problem and not as a problem that is limited to the individual;
- The general approach to the problem is to seek solutions and not assign blame;
- There is a high level of tolerance for individual disturbance;
- Support is expressed clearly, directly, and abundantly in the form of praise, commitment and affection;
- Communication is open and effective;
- There is a high degree of cohesion;
- There is considerable flexibility of roles; and
- Resources – material, social, and institutional – are effectively employed (Catherall, 1995).

6.2.4.1 Requirements for Organizational Policies and Procedures

Figley (2002b) has provided the following suggestions for organizations managing professionals who are at risk for compassion fatigue:

- Awareness of the risks and costs of working with the suffering – The need for recognition of the potential pain and discomfort that human service providers could experience in working with trauma clients;

- Commitment to lower the risks and costs - The need for a constant source of support to the workers and overt displays that the organization is committed to lowering the risks of compassion fatigue amongst its staff;

- Adequate applicant screening for resilience and awareness – Those at greatest risk are those without resiliency;

- Adequate policies and procedures to educate and protect workers – Every orientation and post-orientation debriefing for employees should include information about compassion fatigue, providing sufficient education on the relevant issues;

- Facilitation for employee health and self-care – Promotion of health, healthy living and self-care; and

- Letting go of work – The need for boundaries to be established that make it easier to maintain the work-life balance (Figley, 2002b).

Detailed below are some examples of specific organizational strategies for the prevention and treatment of personnel who are or who have been engaged in trauma and disaster work and who are at risk of experiencing compassion fatigue.

6.2.4.2 Strategies for Managing Disaster Worker Stress

The focus in this section is on what can be done before, during and after disaster assignments to maintain the psychological health and well-being of human service providers[7]. Based on the research and practice that has been documented in the literature, recommendations are provided for the prevention and treatment of compassion fatigue among disaster workers. These strategies have been organized into three categories, including pre-disaster, during disaster, and post-disaster (Myers and Wee, 2002).

Pre-Disaster – This category consist of actions that can be taken by an organization prior to a disaster as part of an effort to ensure that their workers are well-prepared should they be called into duty for such an event. The primary objective is to prevent or minimize compassion fatigue and burnout in these professionals by providing them with knowledge, skills, tools and other supports that will be required to perform the work.

- *Designing an appropriate disaster mental health plan* – It is imperative that a disaster mental health program be realistically designed and based on proven models and concepts. Crucial to the immediate aftermath of the disaster is a crisis intervention approach and active outreach into the community.

[7] It should be noted that the material addresses strategies specifically directed toward mental health workers. However, given the similar nature of the contact and exposure of disaster work in other professions, the contention is made that these recommendations can also be generalized to all human service providers engaged in all types of trauma work.

- *Selection of disaster mental health staff* – In order to minimize much of the confusion and stress at the time of the disaster, it is important for the organization to identify pre-designated staff that are trained as part of a disaster response team.

- *Pre-disaster stress assessment* – Conducting a systematic assessment of the personal and professional stress of a worker prior to deploying them on a disaster mental health assignment will help screen out those who may be at high risk for compassion fatigue. Furthermore, prior to assigning individuals to disaster work, consideration should also be given to the assessment of compassion fatigue for those already engaged in trauma work. Use of measurement tools such as the CFST is recommended. The organization should also take care to determine which of its members have been directly affected by the disaster and assign deployments accordingly.

- *Education and training of staff* – Professionals working in any field of trauma must be provided with the opportunity to access ongoing and specialized training. In addition, conferences, workshops, and other fora of continuing education are necessary for the maintaining and updating of knowledge and skills that provide opportunities to access professional and collegial support (Myers and Wee, 2002).

During Disaster – This category details strategies that can be taken by an organization to prevent and minimize incidents of compassion fatigue during the period of the disaster deployment. Suggested approaches include:

- *Supervision of personnel* – During the immediate disaster recovery phase, workers tend to overextend themselves in their efforts. Disaster workers are usually not able to fully judge their own level of functioning and often underestimate the impact of the stress and fatigue on their performance and well-being. As such, it is imperative to have strong supervision of personnel both on-scene in the immediate disaster aftermath and as personnel shift into long-term recovery work with the clients and the community. Ensuring there is appropriate supervision and support will help to ensure that personnel do not become overwhelmed and stressed.

- *Continuing education and training* – Similar to the discussion in the pre-disaster period, it is imperative that personnel be provided with in-depth training and education in several subjects including: stress management interventions for survivors and workers, long-term recovery issues and interventions, outreach techniques for long-term recovery; treatment of PTSD, anxiety and depression, etc.

- *Organized support and workplace strategies* – This is conveyed to personnel by offering assistance with concrete, disaster-related needs, such as time off to decompress, adequate briefings, etc. Other workplace strategies that have been suggested include adjusting caseloads of workers to include a diverse client population, thereby reducing the amount of their direct contact with severely traumatized clients, and diversifying work-related activities beyond front-line contact with clients.

- *Defusing and debriefing* – This is a highly effective intervention for personnel in highly stressful disaster deployments. A defusing consists of a meeting with a small number of personnel that is usually conducted at the end of the day lasting about 20 to 45 minutes whereby personnel are provided with the opportunity to talk about their work and their responses. The objective is to mitigate the impact of the day, reduce stress symptoms, educate about coping strategies, provide group support, and assess the need for further interventions amongst individual workers.

- *Working as a team* – Building a team approach can provide both prevention and active intervention with compassion fatigue as a strong team can provide the necessary social support for personnel, providing them with support and encouragement.

- *Professional strategies* – Many publications have provided suggestions for self-care in the period following the disaster. Some of the recommendations include:
    - Encourage and support colleagues;
    - Take breaks if your effectiveness is diminishing;
    - Let yourself defuse at the end of each shift;
    - Enjoy recreation during off-work hours; and
    - Attend periodic debriefing or worker support groups to discuss the emotional impact the work is having.

- *Personal strategies* – These include lifestyle choices such as exercise, a healthy diet, a balance between work and play and rest. Also helpful are other informal strategies such as maintaining strong personal support networks of family and friends, developing diverse interests, and seeking positive experiences (Myers and Wee, 2002).

Post-Disaster – The strategies for ameliorating stress for personnel include:

- *Planning for the ending of the deployment* – Personnel should receive counselling and training and schedule planning sessions as to how it will be ended. There is often a mixture of feelings at the end of the work and there may be some difficulty in transitioning back to their regular job and responsibilities.

- *Critique of the project* – This can help personnel by bringing closure to a deployment. This is a critical evaluation of the difficulties and successes experienced in the work and can help to improve the disaster plan, policies and procedures to improve the mental health of personnel in the next deployment.

- *Debriefing of staff* – The objective of a formal debriefing is to address the emotional and psychological impact the experience has had on personnel. It should provide them with the opportunity to talk about the feelings associated with the assignment, provides a “normalization” of their responses and creates the opportunity for peer support. It also serves an educational purpose as it informs personnel as to the common stress and grief reactions and the transition issues that can be expected.

- *Follow-up* – It is important to provide follow-up for personnel after the completion of their disaster assignments. Consideration should be given to a formalized follow-up in the form of a questionnaire or stress assessment, with the use of the CFST recommended as the measurement instrument to be employed. The assessments can provide an indication as to whether there is a need for additional de-briefing, support or other assistance to treat the compassion fatigue.

- *Recognition of staff* – By recognizing the efforts and accomplishments of personnel will help not only to bring closure but also to provide validation as to the value and importance of their work (Myers and Wee, 2002).

6.2.4.3 Trauma Treatment Training for Bosnian and Croatian Mental Health Workers

This study was an attempt to address the lack of empirically tested trauma treatment interventions in the repertoire of Bosnian, Croatian, or Serbian mental health professionals. The war in the former Yugoslavia (1992-1995) brought widespread devastation, displacement and death to the civilian population in addition to the military casualties. Based on the expectation that the human service providers would be especially vulnerable to experiencing compassion fatigue, there was the desire to offer some form of trauma training to the mental health professionals engaged in the Balkans. There were three objectives to the study:

- Train indigenous mental health workers in effective trauma treatment methods;

- Evaluate and treat the secondary PTSD (compassion fatigue) of those mental health workers; and

- Develop regularly scheduled peer supervision/consultation groups so trainees would have regularly scheduled opportunities to discuss and practice their new skills.

A rather new but empirically based method, known as the Eye-Movement Desensitization and Reprocessing (EMDR), was employed in the study. It is a short-term treatment for trauma-based mental disorders. Three highly skilled EMDR trainers were sent to Croatia, Bosnia and eventually Serbia to conduct the workshops. Two three-day training programs were conducted in 1995 and the trainers trained approximately 40 psychologists and psychiatrists who worked in diverse environments. Built into the training program was the CFST as the measurement tool employed to identify evidence of compassion fatigue in the mental health professionals. The formal and informal evaluations of the program indicated that the workshop participants were satisfied with the training they had received. The supervisors of the follow up consultation groups were pleased with the quick assessment tool for evaluating compassion fatigue and indicated that it had improved their ability to identify individuals who are in distress and the trainees were provided with a form of self-monitoring (White, 2002).

6.2.4.4 Accelerated Recovery Program (ARP) for Compassion Fatigue

The primary focus of the Accelerated Recovery Program (ARP) is to facilitate the process of recovery for the human service provider suffering from compassion fatigue. This treatment program is directed toward individuals who have had little recourse for alleviating the

symptoms that emerged as a direct result of their professional duties. It was developed by Gentry, Baranowsky, and Dunning (1997) under the direction of Dr. Charles Figley. The ARP is a five-session model for the treatment of the negative effects of compassion fatigue on the lives of professionals who are secondarily exposed to trauma through their work. All ARP models were designed to address prevention and treatment of compassion fatigue for a wide range of professionals. It was designed to assist these professionals in reducing the intensity, frequency, and duration of symptoms experienced with compassion fatigue. Treatment sessions are standardized and are directed toward the completion of the program goals, including: symptom identification; recognize compassion fatigue triggers; identify and utilize resources; review personal and professional history to the present day; master arousal reduction methods; learn grounding and containment skills; contract for life enhancement; resolve impediments to efficacy; initiate conflict resolution; and implement supportive after-care plan, utilizing the PATHWAYS self-care program (Gentry et al., 2002).

The ARP follows a standardized component treatment model that is comprised of the following elements:

- *Therapeutic Alliance* – Particularly important in a model that offers care for individuals who consider themselves to be care providers and are subsequently reluctant to seek help for themselves. The unique challenges of a human service provider asking for help, thereby leaving his or her identification of a care provider, was a central tenet of the ARP.

- *Assessment – Quantitative* – The ARP employs a compassion fatigue assessment profile; an assessment package that provides information on the many components of compassion fatigue.

- *Assessment – Qualitative* – This portion of the program consists of a participant interview that acknowledges the importance of approaches with participants that are depathologized, collaborative and strength-based.

- *Anxiety Management* – Each ARP participant is introduced to a variety of anxiety reduction tools that will assist with managing stress and reducing negative arousal.

- *Narrative* – Aiding in the rebuilding of professional and personal quality of life is the power of the story and the healing quality of personal self-awareness.

- *Exposure/Resolution of Secondary Traumatic Stress (STS)* – It is common to use "exposure" methods in the treatment of PTSD and anxiety disorders and, as such, it is believed that exposure methods can also work in the treatment of compassion fatigue.

- *Cognitive Restructuring (Self-Care and Integration)* – If individuals have been through a difficult experience, there may be the belief that they are no longer living in a safe world even when they are. As such, challenging the inner dialogue may help to shift the automatic thoughts and beliefs to create a more harmonious inner world.

- *PATHWAYS: Self-Directed Resiliency and After-Care Plan* – This is an integral component of the ARP and constitutes an after-care element that encourages the development of personal well-ness and the responsibility to work on this throughout the program and in the period subsequent (Gentry et al, 2002).

The ARP encourages participants to master the PATHWAYS, which represents the self-care, after-care prevention portion of the program. Five identified pathways have been designed that will enhance skills development and operate as a buffer, preventative medication, and means of distress resolution. These five areas have been identified and supported in the literature as being instrumental in the development of healthy lifestyles that consist of minimal distress and greatest satisfaction. Participants are challenged to address five primary pathways as they relate to well-being in both their professional and personal lives. These are as follows:

- *Resiliency Skills* – Non-Anxious Presence and Self-Validated Caregiving – The belief embedded within the ARP is that professionals who are able to develop and maintain the above skills will experience an increased sense of resiliency to compassion fatigue. As such, the program is designed to challenge the participants into integrating these concepts into their lives.

- *Self-Management and Self-Care* – Participants are challenged to reflect upon what it is that causes them to feel over-extended in their work and what self-care skills are needed.

- *Connection with Others* – Mandatory in the prevention of compassion fatigue is developing a personal "therapeutic community" as breaking isolation often provides an immediate reduction of the problems associated with compassion fatigue. Identifying and developing underutilized resources for support is one challenge for participants.

- *Skills Acquisition* – When adequate training or supervision is provided, one becomes more vulnerable to feelings of inadequacy and low self-esteem. Thus, the ARP focuses on opportunities for participants to acquire the training that would enable them to become well-skilled in their field.

- *Conflict Resolution* –
    - *Internal* – Internal conflict leads to a reduction in the energy available for valuable resources from current-day issues to previous, unresolved issues. Participants are asked to identify the symptoms that indicate they are caught in an internal conflict.
    - *External* – Reduction of Primary Traumatic Stress – When a professional has had personal experience with trauma, the primary trauma may become re-triggered through their professional work. Resolving this past trauma is important in being most effective and least reactive in the work.

Positive results have been found in preliminary testing, in which compassion fatigue has been found to be very responsive to ARP treatment. The crucial first step for many professionals is reaching out and asking for help, upon which many have reported feeling more empowered,

more energetic and a greater sense of personal self-worth. The program attempts to approach compassion fatigue holistically and addresses the symptoms of compassion fatigue, while also working to address the underlying causes. The collaboration of the treatment/training strategies, integrated into the program components and objectives, and the focus on the self-care plan have combined to make this program an effective means for the resolution and alleviation of compassion fatigue in professional human service providers (Gentry et al., 2002).

6.2.4.5 A Team Treatment Model to Preventing Compassion Fatigue – The Veterans' Improvement Program

The Veterans' Improvement Program (VIP) provides long-term intensive outpatient treatment. The program provides treatment for Vietnam combat veterans who have been diagnosed with PTSD. The majority have severe trauma histories, such as numerous combat tours, and several have had additional trauma histories from both prior to and following their military service. These individuals suffer from the severe, disabling, and often life-threatening sequence of prolonged, repeated trauma under circumstances in which escape was impossible. Further complicating matters is the role of the combat veteran as it is one that includes being a perpetrator in addition to being a victim of violence and trauma (Munroe et al., 1995).

Working with this population presents a significant risk of secondary trauma for the professionals engaged in the program. As such, there are three key tenets regarding the functioning of the team and secondary trauma. First is the tenet of acceptance of the reality of secondary trauma and the understanding and expectation that the work being done with traumatized veterans will have an affect on the team members. The second tenet is that the worker's responses will be regarded as a natural and valued process as opposed to an inadequacy of the team member. The third tenet of team functioning is the presumption that each member in the team is able to be a keen observer of how the other members are personally responding to secondary trauma. Team members are granted the opportunity and the responsibility to verbalize their observations regarding the other team members. For successful team functioning, it is important that team members learn to trust and listen to each other (Munroe et al., 1995).

The practices employed in this program strive to provide a supportive and collaborative environment, while giving careful consideration to the presence of secondary victimization and seeking to identify approaches to prevention. The central component to this program is the development and maintenance of communication and strong social support for all team members. By having the team continually focus on identification and prevention, it is contended that more effective and long lasting work on behalf of the professionals can be achieved (Munroe et al., 1995).

6.2.4.6 A Program for Canadian Military Chaplains

The Mental Health Department of the CF Support Unit developed a program to help participants cope with stressful events that were experienced either directly or secondarily from North Atlantic Treaty Organization (NATO) and United Nations (UN) military missions of the 1990s. The program, Care for the Caregivers, was created after various military care providers received complaints of post-deployment stress. In recognizing that their chaplains

were vulnerable to post-deployment difficulties, the CF instituted this preventative medical education program. The objective was to improve the skills of support personnel and to alleviate some of the distress that caregivers experienced. In addition, the program was intended to offer information regarding the potential negative consequences of combat-related traumatic experiences, provide the opportunity for informal dialogue between participants and staff with regards to the chaplains' deployment ministry, and to provide direct access to the PTSD treatment team for the chaplains and their military units (Zimmerman & Wesley, 2000).

Participants are primarily Regular and Reserve Force chaplains who have served in NATO or UN peacekeeping operations. Excluded from the program are chaplains under treatment for PTSD. The teaching staff, including both military and civilian are from the PTSD clinical treatment team and include psychiatrists, mental health nurses, a clinical psychologist, a chaplain and a social worker. Group sizes range from five to eight. Topics covered in the educational four-day small-group workshops include: PTSD, coping techniques, spirituality, self-care and family issues. The location is typically a non-stressful, non-military and non-threatening retreat centre, and teaching staff and participants are not required to wear uniforms. There are also no tests or standards attached to the program (Zimmerman & Wesley, 2000). At the point of this publication, a similar program is being considered for CFMS military personnel.

A preliminary evaluation of the CF's Care for the Caregivers Program found that reactions of participants were consistently positive with all reporting that the program was a valuable use of their time. The majority reported that they believed the program must be continued, would recommend the program to others and indicated they would want to return after another tour. The reported professional benefits included increased awareness of the negative impact of deployment stress and an increased ability to identify/refer potential PTSD victims. Personal benefits reported included: insight, closure, spiritual renewal, increase mutual respect, and a reduced sense of aloneness. There was some indication that the chaplains were undervaluing their contributions as caregivers, as surprise was expressed that the staff genuinely respected the chaplains, believed their work was significant to the military mission and viewed them as professionally competent. The program, however, did not allow much opportunity for participants to discuss the deployment stressors, such as authority styles, chain of command, role conflicts and ambiguities, and the rank of the worker. Incorporation of these stressors may be beneficial (Zimmerman & Wesley, 2000).

The program has become a concluding part of every CF chaplain's deployment whereby there is the potential for traumatic experiences. While the program has made progress in addressing the needs specific to clergy following stressful military deployments, there are still questions remaining. For example, it is not clear what the program is affecting. Manifestations of secondary trauma and burnout in military chaplains has not yet been explored. The preventative value of this program has not yet been evaluated and the implications for pre-deployment selection and training for trauma workers has yet to be researched. As such, it is clear that more work is needed in this area (Zimmerman & Wesley, 2000).

7. Conceptual Model – Burnout

A conceptual model has been developed based upon the prior review of the research in which a number of factors were determined to be associated with burnout. It is an explanatory framework that summarizes the relationships of the supports and the demands of the environment and identifies the relevant constructs. As indicated in the model, shown in Figure 2, there are understood to be two primary determinants of burnout. The principal set of primary stressors found to contribute to an individual experiencing burnout are the *Situational Factors,* which include characteristics such as work overload, role overload, role ambiguity, and a lack of organizational resources provided. The second stressors of the three dimensions of burnout are the *Individual Factors,* which includes characteristics determined to be pertinent such as age, gender, marital status, personality traits and coping strategies. As previously indicated in Chapter 4, the research has generally determined that situational factors display a much stronger relationship to burnout than individual factors. However, it is contended that individual factors still make a significant contribution to an individual experiencing burnout. As such, the conceptual model employs an integrative approach that takes both the individual and situational factors into consideration, acknowledging their combined contribution, rather than perceiving them in separate either-or terms.

The model also depicts three factors contended to potentially alleviate the impact that individual and situational factors may have on burnout. As the relationship between these constructs and burnout has not been entirely parsed out in the research, the extent to which they moderate the occurrence of burnout has not been conclusively determined. As such, the model acknowledges the direct impact that individual and situational factors have on burnout. The first moderating construct identified in the model is *Social Support,* and refers to the extent to which an individual has supportive networks and other sources of support that help to sustain an individual's well-being. Examples include the support from a supervisor or from colleagues, and other networks of support such as those provided by friends and family. Research has determined that a lack of social support is linked to burnout, indicating that an individual without sources of support is more vulnerable to burnout if the necessary conditions for it are present in the work environment. In other words, if an individual experiences role conflict and work overload, in addition to an absence of support being offered by a supervisor, then that person is at greater risk of suffering from burnout. In addition, although the research has not been conclusive, there is some evidence to suggest that social support may have a buffering effect on burnout. It is therefore contended that the availability one has to professional and personal supportive resources moderates the impact of burnout.

The second moderating construct included in the model is *Job Satisfaction*, and refers to the extent to which an individual derives personal satisfaction from the work that is being done. While there may be many challenges associated with the nature of the work of human service providers, it is also understood to offer one a highly rewarding and fulfilling career. Thus, the contention is made that the extent to which an individual experiences job satisfaction will moderate the potential impact of the individual and situational factors on burnout. In other words, an individual who derives a great deal of satisfaction from their work may be less vulnerable to the effects of the causes of burnout, thereby alleviating the degree to which one will subsequently suffer from burnout.

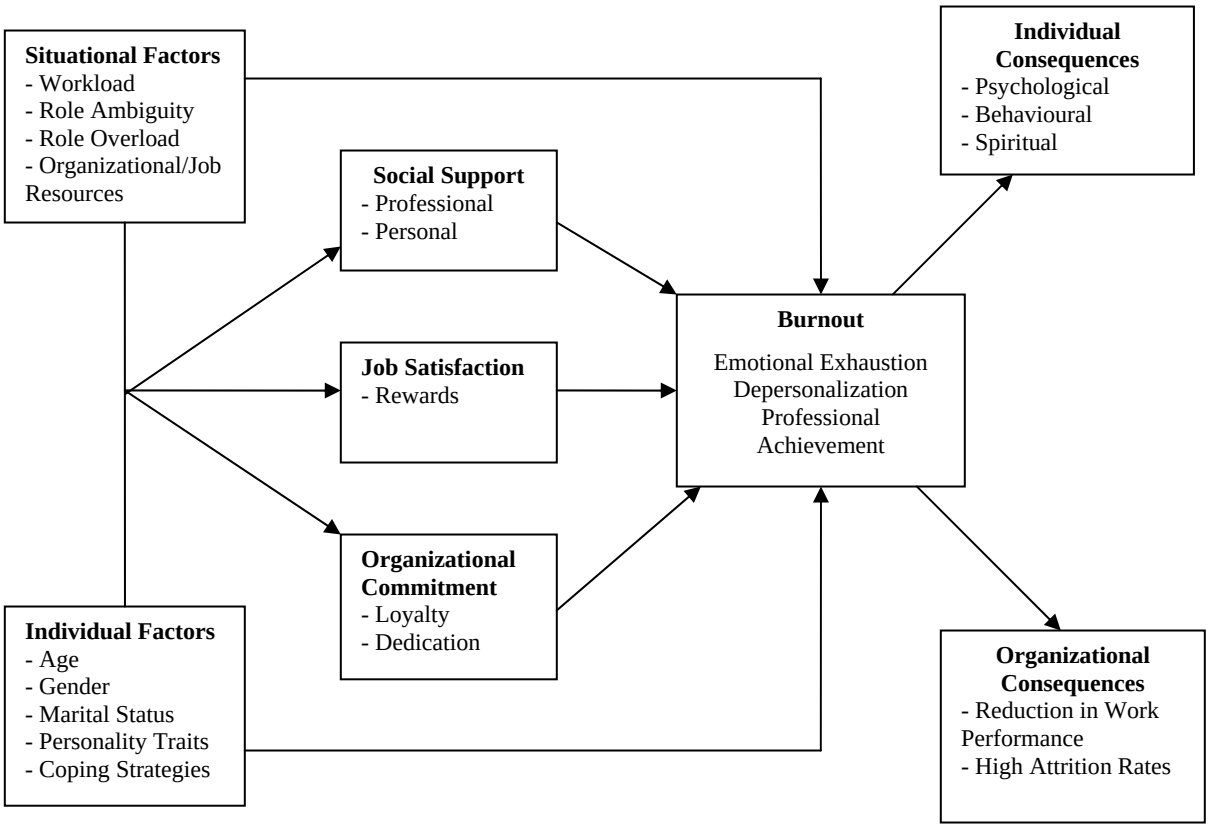

Figure 2: Conceptual Model for Burnout

The third construct identified in the model is that of *Organizational Commitment*, and refers to the level of commitment that one has towards the organization. This is of particular importance in a military organization whereby its members typically display a much greater level of commitment and dedication than is observed in employees in a civilian organization. The proposition put forth is that the greater degree of commitment that one has towards an organization, the more protection there will be with respect to the impact of individual and situation factors. In other words, if individuals are highly committed and strongly devoted to the institution in which they are employed, it will buffer the negative consequences that may be experienced in their work and their risk of burnout will be mediated. Alternatively, if individuals have a lower level of commitment to their organization, they may be more vulnerable to experiencing burnout as they are more susceptible to being negatively affected by the stressors in their work.

The model also identifies the negative impact of burnout and recognizes that there are both individual and organizational consequences. In terms of individual consequences, the research has clearly identified that there are multiple negative effects that one experiences when

suffering from burnout and which lead to many difficulties for the individual. Some examples of the impact that burnout has on an individual include: fatigue, lack of motivation, withdrawal, irritability, and negative attitudes towards others. With respect to the consequences of burnout from an organizational perspective, the research has determined that there are many negative costs. For example, the two most significant organizational consequences include reduced job performance and turnover; both of which are highly detrimental to an organization.

8. Conceptual Model – Compassion Fatigue

While the conceptual model developed for burnout is an explanatory framework, the one presented below for compassion fatigue is more of a descriptive framework as it depicts the variables that either potentially contribute to, or ameliorate, its impact. It has been developed based upon the prior review of research in Chapter 5 that identified a number of factors determined to be associated with compassion fatigue. The framework in Figure 3 summarizes the relationship of the supports and the demands of the environment and identifies the relevant constructs. As indicated in the model, there are eight relevant components found to be associated with compassion fatigue, with many containing variables that may serve to either contribute to or moderate the effects of working with trauma and traumatized clients.

One component included is that of the *Characteristics of the Traumatic Experience.* This includes variables such as the type of disaster/traumatizing experience, the scope of the disaster/traumatizing experience, the duration of the disaster/traumatizing experience, and the extent of the damage and destruction caused by the disaster/traumatizing event. In this category, it is the traits and characteristics of the traumatic experience that may contribute to the extent to which one experiences compassion fatigue. For example, trauma professionals who are working with the victims of an earthquake may be less prone to experiencing compassion fatigue as compared to those working with the victims of a terrorist bombing. However, it should be noted that the nature of the work still places all human service providers at risk for experiencing compassion fatigue.

The next two components in the descriptive framework are that of *Exposure* and *Pre-Existing Exposure.* With respect to exposure, it is understood in the literature that this is a key variable that determines the presence or absence of a human service provider experiencing compassion fatigue. The general contention is that the greater the level of exposure to trauma and traumatized clients and the greater the intensity of that exposure, the more vulnerable a human service provider is to suffering from compassion fatigue. For example, those who spend the majority of their working career dealing with severely traumatized clients over an extended period of time will be more vulnerable to experiencing compassion fatigue as compared to a human service provider who spends minimal time with clients who are less severely traumatized. With respect to pre-existing exposure, this refers to the degree to which the human service provider has previously been exposed to trauma or traumatized individuals. It is understood that the greater exposure already experienced through their professional work prior to engaging in further work, the greater the likelihood that they will be susceptible to the negative effects of the work. For example, human service providers who have already worked on a prior disaster site may be more vulnerable to experiencing compassion fatigue in their subsequent experiences than may be observed in those engaged in their first exposure.

The middle two components are the two theoretical constructs previously addressed in the paper, namely *Burnout* and *Compassion Satisfaction.* With respect to burnout, it has been contended in the literature that the presence of burnout in an individual places that individual at greater risk for subsequently experiencing compassion fatigue. Indeed, it is maintained that burnout is an indicator or precursor to compassion fatigue and therefore understood to be a

contributing variable. With respect to compassion satisfaction, it has been contended that the presence of compassion satisfaction may help to moderate the negative consequences of being

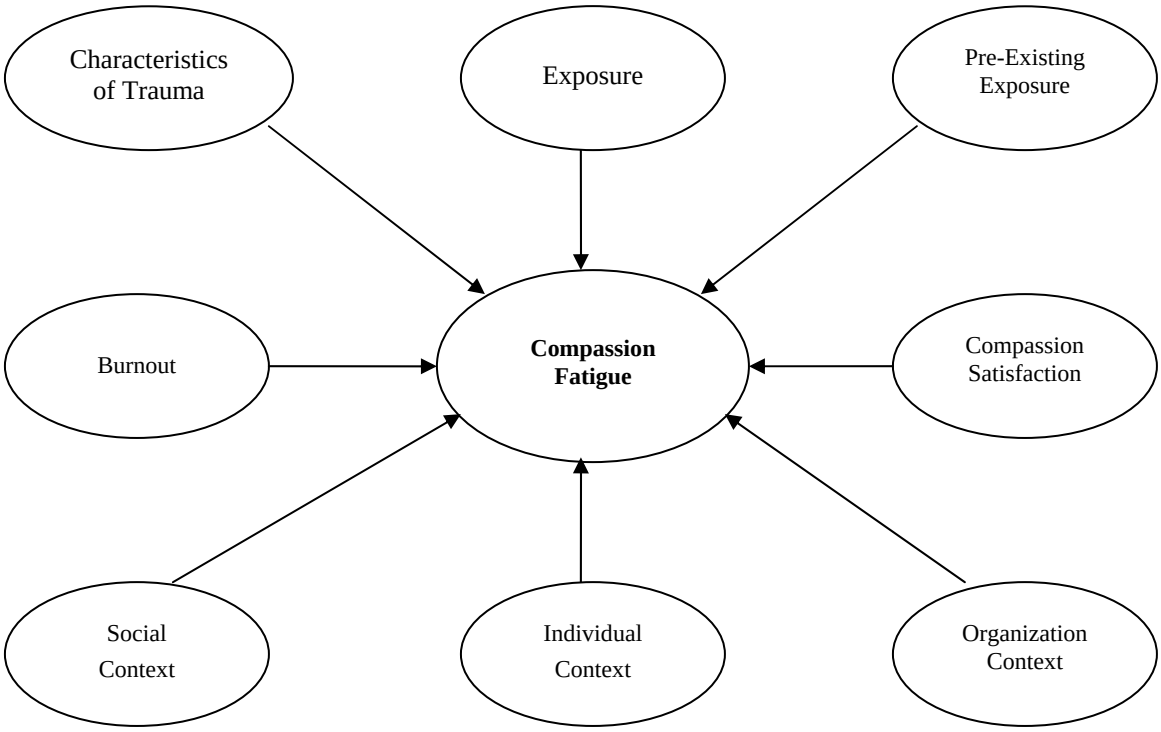

Figure 3: Conceptual Model for Compassion Fatigue

engaged with trauma work. Therefore, it is understood to be a mediating variable on compassion fatigue. However, it should be noted that the relationships of these two constructs to that of compassion fatigue has not been sufficiently parsed out and evaluated, and more research is needed before any conclusive assertions regarding the strength of these associations can be made.

Another component included is that of the *Social Context.* This includes variables that are specific to the social environment of the human service provider. This construct refers to factors such as the presence or absence of social support in the workplace, such as support provided by supervisors, peers and colleagues, the nature of personal and professional relationships, and access to supportive networks, both personal and professional. In this category, it is the social relationships that an individual has that determines the degree to which they may experience compassion fatigue through their work. For example, an individual that has minimal access to supportive peer networks, lacks support from

supervisors and has minimal personal support will be more prone to experiencing compassion fatigue.

An additional component included is the *Individual Context*, and includes the variables specific to the individual human service provider. This construct refers to factors such as the presence of pre-existing stressors (such as marital disruption, financial difficulties), personality (such as hardiness), coping skills, demographics, and perceptions and interpretations of the experience. In this category, it is the individual variables that may determine the degree to which a human service provider may experience compassion fatigue through their work. For example, an individual with poor coping skills who is experiencing financial difficulties may be more prone to experiencing compassion fatigue as compared to an individual with strong coping skill and no pre-existing stressors.

A final component is that of the *Organizational Context*. This includes variables that are specific to the work environment of the human service provider. This construct refers to factors, such as the presence or absence of a supportive workplace, level of supervision, role conflicts or ambiguities, the organizational culture, the organizational response to personnel experiencing compassion fatigue, and the training and education available to personnel. In this category, it is the organizational variables that may determine the degree to which a human service provider may experience compassion fatigue through their work. For example, a professional who works in an organization that provides minimal training and education for its personnel, provides inadequate supervision, includes a work environment that is not supportive and which fails to acknowledge the presence or possibility of compassion fatigue, will be more vulnerable to suffering from the negative impact of the work being done.

9. The Way Ahead

9.1 Implications for the CF

As has been discussed, human service providers who are continually engaged in caring work often suffer from the effects of extensive interactions with others, particularly when they work with those who are suffering or are troubled. This type of work often leads to an individual suffering from burnout as they become emotionally exhausted, experience feelings of depersonalization, and feelings of a lack of achievement. Given the type of work performed by members in the personnel support occupations of the CF, such as chaplains, nurses and social workers, and the similarity of this work with civilian human service providers, it is evident that they too could be at a high risk for experiencing burnout.

The current operations of the CF in Afghanistan will likely have some impact on many of the military personnel who have been engaged in operations, as they may experience serious physical or mental challenges as a consequence of their experiences. As such, there will continue to be considerable demands made upon those in the personnel support occupations who are engaged in caring work for these individuals. Professionals who work with trauma and with those who have experienced trauma are often vulnerable to experiencing a secondary victimization as the exposure of these experiences often lead them to suffer from compassion fatigue. Given the high likelihood that members in personnel support occupations in the CF will be exposed either directly to trauma or indirectly through their professional work with those who are suffering from a traumatic experience, it is evident that they could be at a high risk for experiencing compassion fatigue.

Therefore, due to the nature and intensity of the work of members in personnel support occupations in the CF, it is clear that these individuals may subsequently be at risk of experiencing both burnout and compassion fatigue. However, there is little understanding as to the extent to which members in the personnel support occupations have or are experiencing either burnout or compassion fatigue, and its prevalence in the organization is unknown. More information is needed in order to ascertain the impact of this type of work on military personnel and to develop strategies for alleviating the consequences of their work.

9.2 Recommendations

In order to address the lack of knowledge and understanding regarding the impact of the work of members of the personnel support occupations in the CF, it is recommended that further research be conducted. There are three central objectives that need to be considered in a future study of burnout and compassion fatigue in the CF. First, there is a need to identify who in the organization is suffering from burnout and/or compassion fatigue. It is important that the specific proportion of personnel experiencing either condition be determined in order to ascertain the extent to which either condition is prevalent in the organization. Second, there is a need to determine what type of work is being done and what types of work conditions are contributing to these professionals experiencing either syndrome. It is important that those most vulnerable and at greatest risk for burnout and compassion fatigue be identified in order to provide information for the third objective, which is to review the potential organizational strategies that could be implemented in order to prevent and treat both conditions in members

of the personnel support occupations. This objective would hopefully provide strategies that would help mediate the negative consequences of the work being done by those in personnel support occupations in the CF.

Overall, it is clear that there is a need for data to be gathered that will answer some of the questions raised in this investigation. It is therefore recommended that further research be conducted through the administration of a survey to members in the relevant personnel support occupations in the CF. Given that there are standard measurement instruments that have been well established in the literature, it is recommended that the survey be comprised of these tools. As concerns have been identified regarding both burnout and compassion fatigue, it is recommended that the survey consist of measurement instruments from both fields of research. Specifically, it is suggested that the data be collected on burnout through the use of the MBI and the data be collected on compassion fatigue through the use of CFST and/or the CSF Test.

In conclusion, it is imperative that attention be given towards the well-being of the caregivers in the organization who are responsible for supporting the men and women in uniform, thereby helping them to perform as effectively as possible.

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In 2007, the Chief of Military Personnel (CMP) requested that a benchmark study be conducted on chaplains in the military, examining current issues and practices in each of The Technical Cooperation Program (TTCP) countries - Canada, Australia, New Zealand, the United Kingdom, and the United States. The report made several recommendations for future research that would address some of the more pressing concerns and issues regarding chaplains in the Canadian Forces (CF). One of those suggestions was to investigate the extent to which CF chaplains experience stress and burnout in their profession and the possible strategies for prevention. Preliminary review of the literature has indicated that the challenges and issues experienced by chaplains in the CF are reflective of their working in a helping profession and thus, are likely to also be experienced by others who are similarly engaged in caring work. As such, it was thereby determined that the analysis should be extended to include all personnel in the CF who are engaged in personnel support occupations. Thus, this paper is an investigation into burnout and compassion fatigue in what will be referred to as personnel support providers in the military or human service providers in the civilian sector. The paper first provides definitions of the key constructs of burnout and compassion fatigue. Following this discussion, the standard measurement instruments employed in the research for both constructs are detailed. A review of the research in both the areas of burnout and compassion fatigue is then discussed, providing a theoretical overview of each, their impact, and the applicable strategies for prevention and treatment. This review of relevant research provides the foundation for the development of two conceptual models – one for burnout and one for compassion fatigue. The paper then concludes with a discussion of the potential implications for the CF, followed by recommendations for future research and analysis.

En 2007, le Chef du personnel militaire (CPM) demandait la réalisation d'une étude comparative sur les aumôniers dans les organisations militaires, portant sur les questions et pratiques actuelles dans chaque pays membre du Programme de coopération technique (TTCP) – le Canada, l'Australie, la Nouvelle-Zélande, le Royaume-Uni et les États-Unis. Le rapport contenait plusieurs recommandations de faire des recherches sur certaines questions et préoccupations parmi les plus pressantes concernant les aumôniers des Forces canadiennes (FC). Une de ces recommandations conseillait d'enquêter sur la gravité du stress et du burnout qu'éprouvent les aumôniers des FC dans l'exercice de leur profession et sur les stratégies de prévention possibles. Une revue préliminaire de la littérature a indiqué que les défis et difficultés auxquels les aumôniers des FC devaient faire face résultaient des impératifs d'une profession axée sur la relation d'aide et qu'en conséquence, les autres professionnels oeuvrant dans un domaine similaire avaient probablement à faire face aux mêmes problèmes. Ainsi, on a décidé d'étendre l'analyse à l'ensemble du personnel des FC qui travaille dans les services de soutien au personnel. Le présent article est donc une enquête sur le burnout et l'usure de compassion chez ceux qu'on appelle les fournisseurs de services de soutien au personnel dans la sphère militaire et les fournisseurs de services à la personne dans le domaine civil. L'auteur entame son article par une définition et une discussion des concepts-clés de burnout et d'usure de compassion. Elle décrit en détail les instruments de mesure normalisés qui sont utilisés dans les recherches portant sur ces deux concepts. L'auteur passe ensuite en revue les travaux de recherche qui ont été effectués dans les domaines du burnout et de l'usure de compassion. Elle expose la théorie derrière ces concepts, souligne l'incidence de ces maladies et propose des stratégies de prévention et de traitement. Cette revue de la littérature pertinente pose les fondements nécessaires à l'élaboration de deux modèles conceptuels – un pour le burnout et un autre pour l'usure de compassion. L'auteur conclut son article par une discussion des implications potentielles pour les FC, suivie de recommandations applicables à de futures recherches et analyses.

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