Compassion fatigue: how much can I give?

An increasing number of publications examine the disturbing effects on clinicians of witnessing or learning of trauma experienced by their patients. This vicarious traumatisation is described in various terms, including secondary victimisation, secondary survival, emotional contagion, counter-transference, burnout and compassion fatigue. It is generally accepted that, while they have significant similarities, there are also differences between these phenomena. Central to these processes is the use of empathy by clinicians. What is the role of empathy in the doctor–patient relationship?

Clues … were ignored, with the doctor usually exploring the diagnostic aspects of symptoms

The nature of empathy and its role in a helping relationship has been debated from a variety of theoretical viewpoints over several decades. Reynolds'[1] review of the role of empathy illustrates the development of the construct and presents a view that it is multidimensional and has emotive, moral, cognitive and behavioural components. Definitions of empathy vary. Gerald Egan,[2] reviewing the work of Carl Rogers,[3] describes empathy as 'a way of being', where the helper, without judgement, enters the private world of the client. Egan further describes a deeper level of empathy, where the helper gains an insight, beyond that of the client, into the client's own story. A study by Suchman *et al.*[4] of doctors working in a primary care setting showed this empathic understanding of the 'story behind the story' to be lacking. The study found that both clues and direct expression of affect were ignored, with the doctor usually exploring the diagnostic aspects of symptoms. Reynolds[1] extends Rogers' definition by including the communication of this understanding of the 'story behind the story' to the client as a means of validating the client's world. Other research has indicated that there is a relationship between clinicians' empathy and compassion and the quality of the care they provide.[5] If this is the case, why is it that empathy and compassion often appear to be lacking in therapeutic relationships?

Central to these processes is the use of empathy by clinicians

Halpern[6] gives the following reasons why doctors might seek detachment from, rather than emotional engagement with, their patients: protection from burnout, improved concentration, rationing of time, maintenance of impartiality, and that the fact that 'emotions are inherently subjective influences that interfere with objectivity'. She also reports that detachment does not protect doctors from burnout; rather, burnout can be linked to time pressures and other organisational issues that prevent the development of doctor–patient relationships. Research on burnout has shown that it is a process that begins gradually and progressively worsens, and that a key element of it is emotional exhaustion.[7] Figley has researched the field of stress related to the use of empathy and compassion and has described a stress response that emerges suddenly and without warning and that includes characteristics such as a sense of helplessness and confusion, feelings of isolation from supporters and symptoms that are often disconnected from their real cause. However, there appears to be a faster recovery rate from this particular stress response than there is from burnout. Figley uses the term 'compassion fatigue' to describe this process, which he regards as secondary traumatic stress, or the stress resulting from the learning of, or witnessing of, a traumatising event involving some other significant person.

Detachment does not protect physicians from burnout

While empathic engagement with patients may be independent of the development of burnout, Figley describes the use of empathy as one of the particular reasons why trauma workers are especially vulnerable to compassion fatigue. While only a portion of clinicians is exposed on a frequent basis to traumatic material, those who are may experience emotions similar to those of their patients. Elsewhere in Figley's book, the development of compassion fatigue is described as being possibly due to an over-intensive identification with the survival strategies adopted by patients, and inappropriate or lacking personal survival strategies.

'Compassion fatigue', or secondary traumatic stress, results from the learning of, or witnessing of, a traumatising event involving some other significant person

Pearlman and Saakvitne[8] describe a process for managing and treating compassion fatigue. Their interventions are grouped into personal, professional and organisational categories. Personal strategies include identifying and making sense of disrupted schemas, striking an appropriate work–life balance, undertaking personal psychotherapy, identifying healing activities and attending to

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spiritual needs. Professional strategies include undertaking regular professional supervision with an experienced senior colleague where patients can be discussed and the clinician's own responses to them examined without embarrassment and fear of censure, engaging in appropriate self-care practices, developing and maintaining professional networks, having a realistic tolerance of failure, and being aware of work and personal goals. Organisational strategies include developing a workplace environment that is as comfortable as possible, and ensuring a culture of support and respect within the workplace that relates to employees as well as to patients.

Compassion fatigue is described as being possibly due to inappropriate or lacking personal survival strategies

What are the requirements of a medical education programme that will prepare doctors to manage the effects of processes such as compassion fatigue? Public opinion since ancient times has required that doctors be equipped with such characteristics as integrity, sacrifice and compassion. The quality of compassion is one of the key components in the development of the humanistic doctor.[9] Although the 'fatigue of compassion' can be managed as described above, to do so requires the development of skills in self-awareness that enable medical students and doctors to more effectively engage empathetically with their patients and to gain insight into their own responses to their patients' stories. This path of personal growth will lead to greater well-being,[9] to greater use, by doctors, of themselves as therapeutic agents[10] and to an increased capacity on the part of doctors to give of themselves in their therapeutic relationships with their patients. The humanistic educator-physician can have a major influence as a role model at one of the most important and impressionable times of a young doctor's life – namely, during their medical education.

In 'caring for the carers', the challenge for health care organisations lies in developing respect and care for their employees in the same way that they require their employees to care for patients. In doing this, health care organisations will support and assist their employees in sustaining and further developing their humanism. Health professionals will then be able to give of themselves in the therapeutic relationship in a manner that enhances the physician–patient relationship and the lives of both the care-giver and the patient.

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