Traumatology

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Online First Publication, November 29, 2021. http://dx.doi.org/10.1037/trm0000362

AMERICAN PSYCHOLOGICAL ASSOCIATION
GREEN CROSS Academy of Traumatology
Traumatology


ISSN: 1085-9373
https://doi.org/10.1037/trm0000362

# Examining the Relationship Between Self-Care and Compassion Fatigue in Mental Health Professionals: A Critical Review

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Mental health providers represent one of the highest risk groups in health care for compassion fatigue. As we work to understand how self-care can be adapted, used, and practiced effectively by counselors, psychologists, family therapists, and other like-minded healers, it is important that we improve the quality, complexity, and sophistication of the scholarship we conduct. This critical review examines 9 articles published between 2005 and 2019. Selection criteria included the following: (a) studies were empirical/peer-reviewed, (b) samples engaged were composed of mental health professionals, and (c) investigative foci targeted the relationship(s) between self-care and compassion fatigue. Analysis revealed a lack of cohesive theory, limited sample designs, inconsistent measurement, underpowered analyses, and disorganized results. Implications for supportive clinical and policy practices, alongside responsive calls for future scholars, are put forth in conclusion.

*Keywords:* burnout, compassion fatigue, critical review, mental health providers, self-care

*Supplemental materials:* https://doi.org/10.1037/trm0000362.supp



Mental health professionals are trained to help the general public cope with a host of psychosocial presentations. Clients frequently present with complex issues (e.g., trauma, abuse, neglect, depression, anxiety), which in turn can lead to considerable stress and secondary trauma symptoms for said professionals (Robinson-Keilig, 2014). Research has established that many mental health professionals become vulnerable when consistently bearing witness to others' suffering (Aukštinaitytė & Zajančkauskaitė-Staskevičienė, 2010; Killian, 2008; Lauvrud et al., 2009; O'Sullivan & Whelan, 2011; Thomas & Otis, 2010; Thompson et al., 2014). Although it may seem commonsense that providers of mental health services and support would seamlessly implement their knowledge about helping and healing practices into their own lives, this is often not the case (Figley, 2002; Kottler, 2011; Norcross & Vandenbos, 2018; Skovholt & Trotter-Mathison, 2011).

## Compassion Fatigue

Compassion fatigue is a term first coined by Carla Joinson (1992) to describe "the loss of the ability to nurture" in the nursing profession (p. 118). This term was then adopted and modified by Charles Figley to encompass a more multifaceted definition that applies to a range of professions (Figley, 1995a, 1995b, 1995c). He described this term as "a state of exhaustion and dysfunction biologically, psychologically, and socially as a result of prolonged exposure to compassion stress and all it invokes" (Figley, 1995c, p. 253). Others have characterized it more simply as the "cost" of caring (Elwood et al., 2011; Mathieu, 2007; Newell et al., 2016). Compassion fatigue gained the attention of mental health professionals over the years as its effects became increasingly recognized in the workplace (Cocker & Joss, 2016; Sweileh, 2020).

As researchers have investigated compassion fatigue, a number of concepts have emerged to describe similar and overlapping foci. These include, but are not limited to, burnout, vicarious traumatization, secondary traumatic stress, secondary victimization, and secondary traumatization (Cieslak et al., 2014; Greinacher et al., 2019; Molnar et al., 2017; National Child Traumatic Stress Network, 2011; Orth, 2002). Although similar, compassion fatigue is distinct from these concepts in some important ways. Compassion fatigue incorporates aspects of secondary traumatic stress and burnout together (Sinclair et al., 2017). Secondary traumatic stress essentially replicates symptoms of posttraumatic stress disorder but is concentrated in the individual experiencing the details after the fact rather than those who lived through it (Jenkins & Baird, 2002; Sprang et al., 2019). Burnout encompasses exhaustion due to the continuity of listening to traumatic events and providing care (Cieslak et al., 2014). These concepts together produce compassion fatigue; its symptoms include "(1) reexperiencing of the primary survivor's traumatic event; (2) avoidance of reminders and/or numbing in response to reminders; and (3) persistent arousal" (Figley, 1995a; Jenkins & Baird, 2002, p. 424). In short, compassion fatigue is an umbrella term that captures the cognitive schema of struggling providers, whereas the other terms articulate

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narrower foci on specific components of the phenomenon (Figley, n.d.; Figley & Ludick, 2017; Robino, 2019). Compassion fatigue's broader lens is why it was selected as a key search term—and focus of and for—this article.

### Affected Populations

Compassion fatigue occurs across a number of helping professions (Okoli et al., 2020; Robino, 2019). However, as research regarding compassion fatigue has grown, mental health professionals have been identified as an especially high-risk group (Singh et al., 2020; Turgoose & Maddox, 2017). Paradoxically, too, most published articles about preventing and/or mitigating compassion fatigue appear to position mental health professionals as the persons who are primarily responsible for creating support systems and interventions that take care of biomedical professionals (Mendenhall, in press). This presents the following question: Who is taking care of the mental health professionals? A seemingly clever solution would be to take findings from biomedical populations and apply them to mental health professionals. However, the cultures of these two professions are different enough that we should not risk confounding or diluting extant findings (Hodgson et al., 2014; Hunter et al., 2009; Mendenhall, Lamson, et al., 2018). It is for this reason that the review presented here focused on literature targeting self-care and compassion fatigue within mental health professional populations, specifically.

### Self-Care

Extant scholarship has found that self-care may help to mitigate some of compassion fatigue's effects. Ideally, this takes into account individuals' physical (biological), psychological (mental/emotional), social (relational), and spiritual (faith) well-being (Adimando, 2018; Cohen & Koenig, 2003; Klein et al., 2018). These are essential practices toward helping individual providers' own selves, alongside better equipping them to offer support and care to others (Bloomquist et al., 2016; Lee & Miller, 2013). Common examples of self-care include exercising, eating a healthy diet, journaling, practicing sleep hygiene, engaging in hobbies, nurturing one's marital union, spending quality time with friends and family, participating in volunteer activities, taking part in faith activities, etc. Engaging in these types of activities parallels the same types of advice that many of us recommend to our clients (Bonamer & Aquino-Russell, 2019; Owens-King, 2019).

### Aims

Researchers have studied compassion fatigue prevention and mitigation by creating, describing, and evaluating strategies and/or interventions oriented primarily to self-care models (Awa et al., 2010; Coetzee & Laschinger, 2018; Sorenson et al., 2016). Said strategies and interventions represent a range across both structure and intentionality, from generic recommendations about things to do on one's own to workplace-guided supports and/or responses for low- to high-functioning personnel (Adimando, 2018; Price et al., 2021; Schmidt & Haglund, 2017). However, these programs appear premature as there is far less research that has established clear relationships between self-care and compassion fatigue per se—at least beyond face validity. Is self-care really the answer? Is it that powerful (almost similar to a panacea)—on its own—in mitigating compassion fatigue? This article aims to understand the relationship between these two variables (self-care, compassion fatigue) through a critical review of existing literature.

## Method

### Critical Review

Careful consideration was taken in selecting a critical review structure over a systematic review structure for our analysis of this topic. As noted previously, there are few studies that focus on understanding if and how self-care practices can mitigate compassion fatigue in mental health professionals. A critical review framework is designed for such focused and niche research topics because it seeks to establish if the independent variable is a key contributor to variance in the dependent variable (Bhattacharya, 2018). This framework aligns with our topic better than a systemic review. The latter is more appropriately suited for a research topic with a wealth of extant studies that must be consolidated for readers by summarizing what is known and identifying gaps in knowledge (Editage Insights, 2019).

Another characteristic of this article that aligned with critical review tenets is our choice to select peer-reviewed published articles only. Gray literature (e.g., unpublished studies, reports, dissertations, conference papers and abstracts, and ongoing clinical—but not yet peer-reviewed—trials), which is often included in systemic reviews, was categorically excluded here. Within the qualified articles included in this article, there were inconsistent findings and conclusions. These contradictions require analyses via a critical review—in comparison with a systematic review—which presents and discusses topics through a lens (es) broadly held by multiple researchers (Bhattacharya, 2018; Editage Insights, 2019). In light of conflicting findings, it is necessary to compare articles so as to articulate their similarities and differences. Comparisons similar to this represent a core element in critical reviews, whereas systemic reviews do not compare sources in such ways.

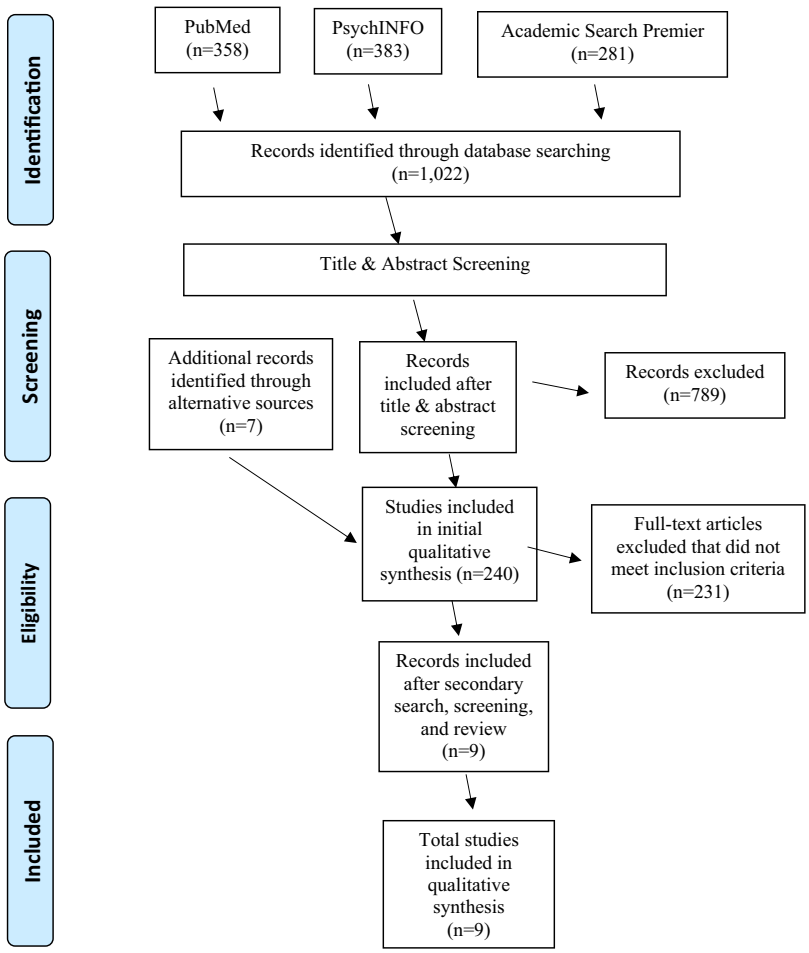
### Outline of the Article

The purpose of this article is to provide a critical review of literature that examines the relationship(s) between self-care and compassion fatigue—specifically within mental health professionals. In the following text, the authors describe the process in which research articles were selected, alongside the inclusion and exclusion criteria that they used. They then organized said articles into categories (scholars' use of theory, methodology, and investigative results) to review, compare, contrast, and critique the studies. Limitations across this body of literature, implications for both policy and clinical practice, and directions for future research are described in conclusion.

### Article Selection Process

Databases used to find articles included PsycINFO, PubMed, and Academic Search Premier. Within these, a broad range of psychological, familial, medical, and health journals were considered. The authors followed a standard PRISMA sequence; see Figure 1 (PRISMA, 2021).

**Figure 1**
*Article Search and Identification Process*




## Search Terms

Search terms used were consistent across the databases initially; they were then revised and differentiated in accord with respective search engines' unique organizational characteristics. PsycINFO allows the user to enter customized keywords and, based on the initial entry, provides suggested search terms that the user can select from. The selected (suggested) search terms are then used to summon relevant articles. PubMed allows the user to search by customized key terms and compiles relevant articles based on those customized searches. An advanced search is also available in this search engine by allowing the search to be specified by title, text word, publisher, year, author, etc. Similar to PubMed, Academic Search Premier allows searching by customized key terms. This search engine also has drop-down tabs that provide the ability to extend and specify the search by categories such as author, title, subject terms, multiple key terms, etc. In sum, because these search engines function in distinct ways, it was not possible to use the exact same search strings across them. Every effort was made, however, to use said engines in a consistent and comprehensive manner.

## Literature Search

Search terms categorized by search engine were as follows. In PsycINFO, terms included "self-care skills AND compassion fatigue"; "self-care AND mental health personnel''; "self-care AND mental health personnel AND compassion fatigue"; "health behavior (additional ORs) AND mental health personnel (additional ORs)" and "health behavior (additional ORs) AND mental health personnel." PubMed produced several articles under the terms "self-care AND compassion fatigue"; "self-care AND compassion fatigue AND mental health providers"; and "compassion fatigue AND mental health professional." Academic Search Premier produced articles with the terms "self-care AND compassion fatigue"; "compassion fatigue AND mental health"; and "self-care AND psycholog* OR counselor*."

## Inclusion and Exclusion Criteria

Articles were chosen using the following criteria: (a) empirical studies/peer-reviewed, (b) samples engaged mental health professionals, and (c) investigations focused on relationship(s) between self-care and compassion fatigue.

Articles were excluded if they focused only on interventions for—versus predictors of or contributors to —compassion fatigue. Dissertations and summative books, book chapters, and literature reviews were also excluded. Nine articles met the search criteria for this critical review; see Figure 1. They were then analyzed according to foci described in the following text; for detailed study-by-study content, see Table S1 in the online supplemental materials.

## Study Analysis

### Theoretical Lens(es)

Theory is a cornerstone in social sciences that informs clinical work, ethical practice, and scholarship. It is vital in research because of the structure and foundation it provides upon which studies are conducted. Theory illuminates authors' perspective(s) about their foci and aids in explaining the purpose of important choices made within their investigations (e.g., measures used, methods advanced). Of the nine articles examined in this critical review, one grounded its research in theory, three mentioned *theory* to emphasize several points, and five did not describe *theory(ies)* as elemental to their conduct.

Owens-King (2019) is the author of the only article that positioned research on a foundation of theory. She dedicated a section of her article to chronic stress theory and provided an extensive review of its concepts and beliefs about its relationship(s) to providers' well-being.

This theory says that constant engagement with stressful situations at work will negatively impact providers' mental health. Organizational and personal factors should also be considered, according to this theory, in understanding how ongoing stress pairs with secondary trauma outcomes. Chronic stress theory aligns with Owens-King's work insofar as she hypothesized that the same phenomena were occurring in her sample population. Although she did not explicitly articulate how the theory informed her methods, there were clear links between it and said methods. For example, she posited that as more time is spent working with trauma-exposed clients, providers will begin to experience higher levels of stress. Measures included the Secondary Traumatic Stress Scale, Coping Strategies Inventory, the National Association of Social Workers' Standardized Workplace Questionnaire, and a new questionnaire made for the purposes of the study. These measures take into account levels of secondary traumatic stress, the magnitude of work, levels of effective self-care, and job satisfaction vis-à-vis a framework of factors contributing to chronic stress. Therefore, understanding the essence of this theory served as a guide for Owens-King to understand possible patterns and compassion fatigue phenomena that were occurring in her sample population.

The next collection of articles identified theory in their work—however, theories were only mentioned to support specific points, rather than being foundational to respective efforts. In Eastwood and Ecklund's (2008) research, etiological theory was put forth to guide a discussion about compassion fatigue in relation to self-care. This aligns with the topic of the investigation insofar as it described several key concepts and concomitant explanations for study findings. Although the theory made sense in the study, the researchers did not explicitly state that this was the theoretical approach used to ground the article nor did they articulate its principal components and/or propositions.

Killian (2008) cited grounded theory as an approach to coding his interviews. This "theory" is, indeed, more of a method than a theory in its conventional sense. However, it is important to recognize that it uses data to form theoretical perspectives via inductive reasoning and coding of that data. Further, shifting from exclusively focusing on the individual, Killian posited that understanding people in a social–political structure would allow researchers to recognize the ways in which they are affected in all of the aspects of their life.

Xu et al. (2019) similarly implemented *theory* in an anecdotal manner. They cited Bronfenbrenner's socioecological perspectives, noted how they are useful in understanding self-care, and then included Lee and Miller's (2013) self-care framework as a continuation of that explanation. This framework rests on the importance of (a) individual self-care and (b) work/environmental self-care. These two phenomena interact with each other, stimulating or hindering self-care behaviors. This modified theory was likely chosen because it aligns with what researchers predicted to occur in their sample.

The remaining five articles did not identify or mention any theory throughout the entirety of their work (Kraus, 2005; La Mott & Martin, 2019; Lovasova & Raczova, 2017; Mavridis et al., 2019; Salloum et al., 2019).

#### *Critique of Theory*

Theory is an important component of any research study in social science. As described earlier, it provides structure, guides how scholarship is conducted, and enables the reader to check and/or have confidence in the consistency (reliability), validity, and credibility of the work.

Although some articles presented theoretical perspectives, the overwhelming majority did not carry theoretical frameworks through the respective sections of their published writings. Only Killian's (2008) study provided an extensive description of *theory*. Even so, he only mentioned theory in the introduction portion (i.e., not returning to it in the discussion). This potentially creates confusion and a lack of trust for consumers of the research. More importantly, the paucity of theory in many of these articles is cause for concern. Neglecting theory can produce confusion in knowing how the research was guided, if any outside factors were influencing decisions made in the study (e.g., measures used, methods advanced), and how researchers compared and explained their results.

### Method

#### *Study Designs*

Across the nine studies, both descriptive and exploratory study designs were used. Eight studies used a quantitative method (Eastwood & Ecklund, 2008; Kraus, 2005; La Mott & Martin, 2019; Lovasova & Raczova, 2017; Mavridis et al., 2019; Owens-King, 2019; Salloum et al., 2019; Xu et al., 2019); one used a mixed-method approach (Killian, 2008).

#### *Sampling Methods*

The majority of studies used nonprobability sampling. For example, La Mott and Martin (2019) and Salloum et al. (2019)

described reaching out to potential participants via email; other investigators simply said that participants were "recruited" and/or that participation was "voluntary." Convenience sampling was used by Mavridis et al. (2019), as they only worked with participants who took part in the Family Developmental Credential training program. Eastwood and Ecklund (2008) similarly asked for participant volunteers from a group of residential childcare workers prior to participating in an in-service training.

Probability sampling was used in two of the studies that randomly selected participants from an extensive list with names. Owens-King (2019) recruited from an email list of 5,000 social workers that she purchased from InFocus Marketing Incorporated. Her sample consisted of any/all of those who self-selected to participate. Xu et al. (2019) randomly selected and recruited participants from a state-level social work board's address list. Their final sample, too, consisted of any/all those who self-selected to participate. Finally, two studies did not provide clear descriptions of their sampling method. Killian (2008) did not expand on how participants were selected whatsoever, and Lovasova and Raczova (2017) simply characterized their sampling method as "intentional" (p. 130).

### *Samples*

Quantitative studies' sample sizes ranged from 57 (Eastwood & Ecklund, 2008) to 371 (La Mott & Martin, 2019). Killian's (2008) mixed-methods design included 20 participants in the qualitative portion and 104 in the quantitative section. Mean ages across these studies ranged from 33 (Eastwood & Ecklund, 2008) to 51 (Owens-King, 2019) years old.

This critical review is interested in mental health professionals, broadly defined. These included residential care providers working with children (Eastwood & Ecklund, 2008), social workers (Killian, 2008; La Mott & Martin, 2019; Owens-King, 2019; Xu et al., 2019), counseling psychologists (Killian, 2008), clinical psychologists (La Mott & Martin, 2019), professional counselors/therapists (Killian, 2008; Kraus, 2005), marriage and family therapists (Killian, 2008; La Mott & Martin, 2019), child welfare case managers (Salloum et al., 2019; Kraus, 2005), home visitors (Mavridis et al., 2019), intake specialists (Mavridis et al., 2019), parent support group leaders (Mavridis et al., 2019), residential counselors (Kraus, 2005), direct care providers (Kraus, 2005), supervisors/directors (Kraus, 2005), court counselors (Kraus, 2005), treatment managers (Kraus, 2005), and an unclear grouping of several mental health providers together (Lovasova & Raczova, 2017).

Due to this wide range of mental health occupations, it was expected that a wide range of educational attainment would be clear. Within Eastwood and Ecklund's (2008) sample, 38.6% completed college (not defined) and 8.8% completed graduate school. La Mott and Martin (2019) found that 83.8% of their sample held master's degrees and 16.2% held doctorate degrees. Salloum et al.'s (2019) study described 74.01% of their sample as holding a bachelor's degree, 22.6% a master's degree, and 1.13% a doctorate. Mavridis et al.'s (2019) study identified 42% of their sample to have earned a 2- to 4-year degree. Xu et al.'s (2019) sample contained 70.5% of participants with a bachelor's degree and 27.8% with a master's and or doctoral degree. Owens-King (2019) described 94% of participants with a master's degree, and Kraus (2005) found 48% of her sample to have a master's degree or higher. Two studies did not report educational demographics (Killian, 2008; Lovasova & Raczova, 2017).

### *Measures*

Although this critical review was specifically concerned with self-care and compassion fatigue, additional variables were examined within bounds of these foci. Compassion satisfaction (Eastwood & Ecklund, 2008; Killian, 2008; Kraus, 2005; Lovasova & Raczova, 2017; Owens-King, 2019; Xu et al., 2019), burnout (Eastwood & Ecklund, 2008; Killian, 2008; Lovasova & Raczova, 2017; Salloum et al., 2019; Xu et al., 2019; Kraus, 2005), frequency of different types of self-care practices (Eastwood & Ecklund, 2008; Kraus, 2005; La Mott & Martin, 2019; Lovasova & Raczova, 2017; Mavridis et al., 2019; Owens-King, 2019; Salloum et al., 2019; Xu et al., 2019), self-care barriers (Xu et al., 2019), social support (Killian, 2008), personal trauma history (Killian, 2008; La Mott & Martin, 2019), affective coping style (Killian, 2008), emotional self-awareness (Killian, 2008; Lovasova & Raczova, 2017), work environment stressors and resources (Killian, 2008; Owens-King, 2019), work drain (Killian, 2008), overall health (Lovasova & Raczova, 2017; Salloum et al., 2019), resilience (La Mott & Martin, 2019), and overall stress (Mavridis et al., 2019) were also assessed.

Consistent with the fact that so many variables were targeted, a wide variety of assessment tools were used. Making sense of established tools and one-time-use (or piloted) tools is paramount in understanding how each study arrived upon its findings. Established tools are more trustworthy because they have traversed multiple iterations of use and revisions en route to venerable and visible reliability and validity. Newer tools—although potentially excellent in their own right(s)—have not yet earned this regard. Comparatively, cautious interpretation is thereby indicated.

The most frequently used assessment tools in the articles reviewed were questionnaires and surveys. Most common among them were self-care questionnaires (Eastwood & Ecklund, 2008; Kraus, 2005; La Mott & Martin, 2019; Lovasova & Raczova, 2017; Owens-King, 2019; Salloum et al., 2019; Xu et al., 2019), albeit with a patent lack of consistency across types. They differed in the number of list items, underlying constructs (e.g., frequency of self-care, type of self-care), and a priori reported reliability and validity data.

The only consistently used established tool was the Professional Quality of Life Scale (ProQOL); this measure assesses compassion satisfaction, compassion fatigue, and burnout. Eastwood and Ecklund (2008) and Killian (2008) used Version 3 of this tool; the rest of the researchers who used this tool used Version 5 (La Mott & Martin, 2019; Lovasova & Raczova, 2017; Salloum et al., 2019; Xu et al., 2019).

Other studies used a variety of assessments. The Brief Resilience Scale and Self-Care Assessment Worksheet were implemented by La Mott and Martin (2019). This team also administered the Adolescent Childhood Experiences (ACEs) questionnaire to understand the relationship(s) between providers' past traumas and later health outcomes. Salloum et al. (2019) used the SF-12v2 Health Survey. Kraus (2005) used the Compassion Satisfaction and Fatigue test to measure the risk of burnout, fatigue, and degree of satisfaction. Owens-King (2019) combined three established tools, including the Secondary Traumatic Stress Scale,

Coping Strategies Inventory, and the National Association of Social Workers' Standardized Workplace Questionnaire. Lovasova and Raczova (2017) implemented another established tool called Self-Regulation in Self-Care. Mavridis et al. (2019) used the Family Development Credential. Finally, Killian (2008) used the Social Support Index, Brief COPE Inventory, the Maslach Burnout Inventory, and an unnamed tool to measure autonomy.

### *Critique of Methods*

It is important to note that the bulk of these studies are in the beginning stages of research and may thereby not be as deeply explored as preferred. However, it is still of value to critically analyze the shortcomings of current investigations. To start, a majority of the articles described a quantitative study design, and only one used mixed-methods. Although this makes sense in terms of assessing certain variables, it does not shed light on the many voices and personal accounts of those experiencing compassion fatigue. Qualitative data provide contextual and/or experiential descriptions that help inform quantitative findings. Therefore, mixed-methods study designs can provide a more holistic picture(s) of the variables that are being studied across this work.

With regard to sampling methods, the majority of studies used nonprobability sampling. Although conventional research designs would prefer probability sampling to capture more representative samples, it is common in social science research to use nonprobability sampling. In the case of the articles in this critical review, nonprobability sampling was mostly used due to the population of mental health professionals being studied. Having access to mental health professionals at a variety of institutions and with a range of job titles is very difficult and usually only occurs via self-selected sampling. This eliminates the opportunity for random sampling to occur. An aspect that may benefit the generalizability of studies using this sampling method would be researchers reaching out to more diverse mental health professionals/groups across more diverse disciplines and education levels.

Demographics of the samples present an interesting issue, as well. During the process of selecting articles, it became apparent that exploratory research across a wide range of occupations could be categorized as happening under "mental health." There was not one occupation that held a majority in the research examined for this review. This limits our understanding(s) about how strategies in self-care can mitigate compassion fatigue because the answer(s) may vary across respective—albeit like-minded —occupations. In addition, other demographics such as level of education and age may have an influence on compassion fatigue—as other scholars have shown (Craig & Sprang, 2010; Dorociak et al., 2017; Turgoose & Maddox, 2017).

Measures used across these respective studies were as diverse as the sample demographics that they were applied to. Although this allows for a broad range of knowledge about the phenomena occurring between studies' variables, it does not allow researchers to deeply understand the root(s) of observed interactions. When many different measures are used to analyze similar phenomena, different results leading to different (or even inconclusive) understandings can follow. The articles considered here engaged a wide range of mental health professionals and used a wide range of measures. Future work should endeavor to use more consistent measures.

## Analysis

### *Considerations of Power*

Power analyses are important to quantitative studies so as to inform the reader that they can trust that findings presented to them met indicated statistical parameters paired with the research analyses conducted. These parameters include sample size, effect size, significance level, and statistical power.

Eastwood and Ecklund (2008) used a power analysis with their small sample and thereby adjusted significance levels to accommodate described results. La Mott and Martin (2019) also ran a power analysis vis-à-vis their small sample, reporting significance cutoffs at $p \geq .05$ for all analyses except regression. Xu et al. (2019) stated that their study was "adequately powered" (p. 14) at $\beta > .80$; however, there was no direct mention of how that affected their sample size. Mavridis et al. (2019) noted that they were not able to do an analysis on the sample because "individual background data was not linked to participants and therefore not available for analysis" (p. 238). Similarly, Salloum et al. (2019) presented an extensive analysis of their data but did not mention running a power analysis. The rest of the quantitative studies neglected to use a power analysis to determine if the samples they used were adequately proportioned to the methods and analyses that they advanced (Killian, 2008; Kraus, 2005; Lovasova & Raczova, 2017; Owens-King, 2019).

### *Representativeness of Samples*

Acknowledgments regarding the representativeness of samples were frequently put forth in the articles reviewed here. Eastwood and Ecklund (2008), as described earlier, noted that due to weak power and a small sample size, they had to adjust the significance of their findings. Lovasova and Raczova (2017) maintained that the principal limits of their findings were related to a small sample size and an uneven representation of gender. Xu et al. (2019) also discovered a disproportionate representation of gender (favoring binary women). Killian (2008) felt that he had a diverse sample but called for a larger one in future research so that more advanced statistical procedures could be used. La Mott and Martin (2019) reported that the homogenous nature of their participants, in comparison with the general public, may be cause for concern. However, because such homogeneity is reflective of mental health providers in general, they endorsed value in their findings. Salloum et al. (2019) discussed that the specificity of their population should be grounds for caution in the generalizability of findings. Mavridis et al. (2019) considered that their sampling method may limit the representation of providers across different cultural, geographic, and institutional settings. Owens-King (2019) stated that the lack of diversity in her sample created limitations in representativeness. Finally, Kraus (2005) observed that the lack of diversity in geographic location and race in her sample served to fall short of adequately representing the intended population.

### *Reliability and Validity of Measures*

Reliability and validity of measures brings confidence to a study's findings by ensuring that the measurement tool(s) is consistently used throughout, produces the same results with the same participants across different raters, and measures the construct that

it claims to. Throughout the studies evaluated here, there were uses of standardized and nonstandardized measures.

Self-care was measured in a variety of ways across studies, and not all these were tested for reliability or validity. Eastwood and Ecklund (2008) and Kraus (2005), for example, developed their own measures—and neither described having ever tested them for reliability. Five studies tested their measures for reliability via internal consistency (La Mott & Martin, 2019; Lovasova & Raczova, 2017; Salloum et al., 2019; Xu et al., 2019). Owens-King (2019) was the only study to use a self-care measure and entirely not comment on the reliability of said measure. As a whole, too, these studies failed to analyze the construct validity related to the measures used.

Compassion fatigue was most commonly measured using the standardized ProQOL survey. This measure has been known across mental health professionals since its conception in 1995 (ProQOL: Professional Quality of Life, 2021) and is commonly used to measure constructs such as compassion fatigue, secondary trauma, and burnout. Similar to all good measures, the ProQOL has been extensively critiqued; recent scholars evaluating the measure call into question its construct and discriminant validity (Geoffrion et al., 2019; Stamm et al., 2012; Vang et al., 2020). Nevertheless, its continued utility across multiple disciplines remains patent in extant research (Buselli et al., 2020; Van Kirk, 2021; Wolf et al., 2021).

### *Critique of Analysis*

It was disappointing to see that only two of the nine studies used an a priori power analysis to determine what sample size they needed (so as to be adequately powered) and/or to evaluate the power of their findings based on the sample size that they acquired. This weakens confidence in the findings reported. Future efforts in this work should comply with contemporary recommendations to plan investigations with power in mind and then construct and advance them accordingly (Bakker et al., 2020; Thompson, 2002).

The overall representation of samples in this group of studies is also weak. This cohort of researchers commonly understood that their sample was either too small or lacked demographic variance. Future efforts should compensate for this, from recruiting adequately powered numbers of participants (per se)—and to do this within either one provider type (e.g., social workers) so that findings can be confidently personalized and utilized to that provider-group and/or across a broad range of provider-types (e.g., social workers, family therapists, psychologists) in a way that universally-beneficent guidance can be integrated across diverse education-, training-, practice-, and policy- arenas.

It was reassuring to see that some of the measures were standardized and therefore can be assumed to have good reliability. In a majority of the nonstandardized measures, researchers accounted for this by reporting a Cronbach's $\alpha$ score. However, they neglected to address the validity of used measures (or plans/steps toward establishing it). The reader could assume face validity by reading the description(s) of said measures; however, this is not adequate grounds to trust measurement tools very far. At the present time, readers are left to wonder about whether the measures are actually capturing the variables that researchers purport to be measuring.

## Findings

The following is a summary and critique of findings described in the nine studies evaluated in this review: Eastwood and Ecklund (2008) assessed providers' most frequent self-care behaviors and tested whether there was a correlation between self-care and compassion fatigue. The most frequent negative self-care practices that they found included consuming caffeinated beverages, consuming junk and/or snack-food, and watching more than 1 hr of TV per day. They found that the most frequent positive self-care practices included socializing with friends and family, taking short breaks at work, getting sufficient sleep, and eating nutritious meals. Further, bivariate correlational analyses revealed that the most frequent positive self-care practices were not among the most likely to mitigate compassion fatigue. Instead, they found that "feelings of being supported outside of work, engaging in a hobby, reading for pleasure, and taking pleasure trips or vacations" reduced compassion fatigue the most (p. 112).

Lovasova and Raczova (2017) found that the more that participants felt exhaustion and compassion fatigue, the more they were inclined to seek out appropriate self-care. Not surprisingly, this study found that care professionals reported compassion fatigue more than the general public. Statistically significant relationships between self-care and compassion fatigue included subcategories of personal growth (and development) and emotional control (and development).

Salloum et al. (2019) similarly reported that a third of their sample struggled with mental health functioning (i.e., more than the general population). They also reported that almost one quarter had high levels of burnout and one-in-five had high levels of compassion fatigue. Overall mental health functioning was significantly correlated with organizational resources and supports, organizational practices, personal self-care practices, burnout, secondary trauma, and years of experience. When self-care was purposefully used, it was discovered to partially help mediate the effects of burnout—but not compassion fatigue or overall mental health functioning.

La Mott and Martin (2019) were particularly interested in the relationship between past personal trauma and compassion fatigue. They found differences in levels of compassion fatigue and compassion satisfaction (but not in burnout) between those with a history of ACEs versus those without a history of ACEs. Although self-care and ACEs scores were moderators in predicting burnout, self-care did not moderate rates of compassion fatigue. This change was attributed to resilience. Moreover, the researchers found that the type of self-care was less important than simply practicing it in general.

Mavridis et al. (2019) reported quantitative findings based on coded responses to reflective questions from the Family Development Credential training program. When writing about self-care, over 60% of participants mentioned practicing mindfulness, along with other self-care practices, in their daily routines. The most effective of these practices appeared to be reframing self- and client expectations and seeking support at home. When the researchers analyzed the relationship between stress levels and self-care, however, they found positive efforts and outcomes only as long as stress levels stayed at a moderate level. When participants reported five or more stressors, they reported feeling too overwhelmed to consistently participate in self-care anymore.

Xu et al. (2019) investigated the predictive nature of self-care barriers (including workload, family obligations, community obligations, and social life) toward higher rates of burnout and compassion fatigue. They found that "bachelor's degree holders have significantly different [higher] levels of compassion satisfaction and burnout than master's [and] doctoral degree holders" and that "direct practitioners had lower levels of compassion satisfaction and higher levels of burnout than nonpractitioners" (p. 16). Further, their data showed that practicing self-care significantly reduces risks for burnout—but not compassion fatigue.

Owens-King's (2019) findings supported the claim that more exposure to trauma-exposed clients increases providers' levels of compassion fatigue. Her study specifically investigated how self-care interacts with secondary traumatic stress, which is a key component of compassion fatigue. Data showed that the social workers who consistently practiced self-care did better. However, self-care was found to only be responsible for 6% of the variance in secondary traumatic stress, which leaves the high majority of this construct unexplained.

Kraus's (2005) research "did not support current literature that practicing self-care and sustaining relationships decreases negative effects of helping" (p. 86). Although she found strong positive correlations between self-care and compassion satisfaction, she did not find any statistical significance in the relationship between self-care and compassion fatigue or self-care and burnout. These data also revealed expected negative trend correlations between compassion fatigue and compassion satisfaction, albeit without statistical significance. Kraus concluded that compassion satisfaction may have a stronger role in mitigating compassion fatigue and burnout than what has been identified in previous work.

Findings from the mixed-methods study reviewed here provided extensive results from a long list of measures. After coding qualitative interviews, Killian (2008) found that most of the participating professionals were able to identify stress coming from their work environment and some felt as though they had nothing left to. There was mention of compassion fatigue as some participants reported reliving the experiences of their clients outside of the workplace. Risk factors identified through these interviews included high case load, workaholism, personal history of trauma, regular access to supervision, lack of supportive work environment, lack of supportive social network, social isolation, world view (optimism vs. cynicism), and ability to recognize and meet one's own needs. These findings helped guide the quantitative portion of the study.

Killian (2008) measured for social support, personal trauma history, coping, compassion satisfaction, compassion fatigue, burnout, ability to identify emotional state, perceptions of work environment, sense of autonomy, and work drain. He found that providers' sense of powerlessness, emotional self-awareness, and trauma history accounted for 54% of compassion fatigue. When specifically looking at burnout, a key factor in the onset of compassion fatigue, 71% was attributed to work drain, lack of work morale, and neuroticism. To combat these affects, Killian identified self-care practices that were attributed to compassion satisfaction, otherwise called the "positive opposite" (p. 33) of compassion fatigue. A total of 41% of the effects of compassion satisfaction were attributable to social support, work hours, and internal locus of control at work.

### *Critique of Findings*

An expectation from this critical review was to find positive associations between self-care and the mitigation of compassion fatigue. Although this was true for some of the studies, considerable variation was extant in reported results. This creates an intriguing conversation about current and future interventions. Although it is widely presumed that self-care is one the most important variables toward predicting mental health professionals' well-being (and is why it is so often included in supportive guides and/or interventions), we must consider the complex intersections of provider demographics (e.g., physical health, age, relational and/or family functioning/quality, years-of-education/training, years-of-practice, disciplinary background), workplace expectations and characteristics (e.g., required hours, performance metrics, sole provider vs. team-based approaches, presence or absence of on-the-job support mechanisms like team-debriefings/huddles/buddy systems), and broader contextual foci that are undoubtedly influential on the health and well-being of our mental health workforce. Future research (and the interventions that these pursuits evaluate) should cast a broader net than singularly focusing on self-care pursuits personally advanced by providers.

## Discussion

Mental health professionals often suffer from compassion fatigue and are thereby in need of effective protective and/or reparative supports. The authors of this critical review were interested in understanding the relationship(s) between self-care and compassion fatigue—specifically, that is, if self-care is a significant protective factor against compassion fatigue. Based on this review, the answer is inconclusive. Critiques of studies described and reviewed herein illuminate shortcomings in the quality of investigations that inform our knowledge. Although summative results suggest that there are many important factors that contribute to the mitigation of compassion fatigue, we need scholarship that is better and more consistently informed by theory, adequately powered, engages representative samples, and uses established (reliable, valid) instruments with widespread endorsement. As scholars endeavor to improve what we know, interventionists will be better informed to design preventive and/or reparative programming to support mental health professionals in their work.

## Research Implications

Because of the strong role(s) and guidance that theory maintains in the everyday practice(s) of mental health professionals, it was surprising to see foundational theory(ies) neglected in the scholarship described in this review. Future work must be better guided by theory. This means that theory should back important decisions (e.g., sampling, methods, measures, analyses, interpretations of results) that characterize good scholarship. The reader should be able to reflect back to theory and understand why, for example, researchers chose to use a qualitative approach versus a quantitative or mixed-methods approach, nonprobability sampling versus probability sampling, an established measure versus a unique measure created for a unique study, etc. Doing this will also enable researchers (and consumers of research) to better match and/or conceptualize how multiple studies fit together in a mosaic of scholarship that endeavors to create a holistic understanding (s) about this complex phenomenon.

Directly related to this need is the patent lack of consistency in measures used across studies that target similar variables (such as self-care and compassion fatigue). Although some researchers used established measures with compelling reliability, others created their own tools to measure what appears to be the same thing(s). It may sometimes be justifiable and/or necessary to create measures for specific studies, but it would also be advantageous to use consistent—and robust—measures oriented to similar evaluative pursuits. This, again, will enable scholars to build upon each other's work. It will synchronously enable consumers of said work to integrate findings across multiple studies in a coherent manner.

Finally, future scholars must better attend to the samples of "mental health providers" that they engage in their efforts to understand phenomena relevant to the prevention and/or mitigation of compassion fatigue. Although all sibling disciplines under this large umbrella share some important similarities and/or struggles (for example, less professional prestige and lower salaries vis-à-vis biomedical providers, social presumptions that it is their responsibility to support biomedical providers' well-being but not vice versa, front-line positionality to surviving victims' emotional suffering and/or decompensation), they also maintain considerably different baseline resources going into the work that they do (e.g., low income vs. high income, salaried pay vs. hourly pay, untenured vs. tenured job security, universal third-party coverage versus inconsistent coverage, personal agency to set hours vs. lack of agency to do so). Scholarship so far has almost haphazardly mixed mental health disciplines together, simultaneously trying to promote representative results while cautioning against representation in said results. Future work should endeavor to engage large enough samples so as to be adequately powered in whatever they measure, and in doing so either engage single disciplinary membership in those samples (e.g., low-income masters-level counselors; high-income doctoral-level psychologists) or stratified representation of across disciplines in a way(s) that is informative regarding both commonalities and differences.

## Clinical and Workplace Implications

Self-care plays a role in preventing and mitigating compassion fatigue, and it is thereby important to encourage it in whatever form(s) is helpful for the person who is doing it. This is important in its own right (i.e., self-care is good) but especially for those of us engaged in the provision of mental health services. Research—and common knowledge—is longstanding regarding how poorly mental health providers practice what they preach (Figley, 2002; Kottler, 2011; Norcross & Vandenbos, 2018; Skovholt & Trotter-Mathison, 2011).

As shown by the research, however, efforts to facilitate and/or maintain wellness in mental health provider samples are not wholly attributed to self-care. The systems in which they function—our clinics, hospitals, trauma-response teams, and others—are also highly influential. One of the top predictors of compassion fatigue, for example, is the amount of time these systems required clinicians to be exposed to trauma (Regehr & Bober, 2005). These systems need to be held accountable, too, for the well-being of their employees. It should not all be "on" the providers themselves.

One solution here could be to distribute workload to limit clinicians' exposure to traumatized groups seeking their services. However, in a field where the needs of populations served tend to outnumber the practitioners offering service, this can be an impossible call. La Mott and Martin (2019), instead, suggested adding a self-care training program as a part of providers' initial and ongoing clinical work. This could work to simultaneously educate about self-care and create a working environment in which it is encouraged, normalized, and lauded. Killian (2008) alluded to this, too, by suggesting proactive in-house attention to providers' mental health. Other workplace strategies are arguably myriad (for example, administrative clarity and sensitivity regarding caseload expectations, daily defusing and group-processing sequences, regular team huddles and team-planning exercises, time-limited deployments, buddy systems, confidential wellness-tracking apps and related online technologies). These contributors to workforce wellness in mental health cohorts should be purposefully advanced by the systems in which they are positioned (Coss, 2020; La Mott & Martin, 2019; Mendenhall, 2006; Mendenhall & Berge, 2010; Mendenhall, Bundt, & Yumbul, 2018; Xu et al., 2019). By discovering the protective factors of compassion fatigue, practitioners can create proactive interventions that prevent the onset of compassion fatigue in mental health professionals. Ergo, compassion fatigue interventions should focus on advocacy for safer working conditions alongside personal responsibility in following one's own advice (Price et al., 2021; Regehr & Bober, 2005).

## Conclusion

Mental health providers represent one of the highest risk groups in health care for compassion fatigue. And although self-care is a concept that they are readily conversant with, said providers tend to be better at encouraging its practice to others than they are at practicing it themselves. As our efforts to understand how self-care can be adapted, used, and practiced effectively by counselors, psychologists, family therapists, and other like-minded healers, it is important that we improve the quality, complexity, and sophistication of the scholarship we conduct. As future scholars respond to the calls for improved next steps outlined herein, our understanding(s) about how to best support the well-being mental health workers will improve in synchrony.

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Received July 23, 2021
Accepted September 15, 2021 ■