

A systematic review of the literature on recommended interventions

Preventing, managing and treating compassion fatigue

Francis Vu, Patrick Bodenmann

Department of Ambulatory Care and Community Medicine, University of Lausanne, Switzerland

Summary

In the helping and social professions, professionals are usually expected to use compassion and empathy when engaging with traumatised and suffering individuals, although that it may require a “cost of caring”. In the literature, the psychological and physical negative effects resulting from such an empathic and compassionate engagement is referred as “compassion fatigue”. Over the last two decades, a rising number of interventions to mitigate the risks of compassion fatigue have been advocated in the literature. The main purpose of this article is to provide a critical appraisal and review of the existing recommendations to combat compassion fatigue. A systematic review of the literature shows that compassion fatigue can be combated among helping and social organisations and professionals, which requires increasing their (self-)awareness of occupational hazards through education, debriefings and supervisions, and equipping them with adequate knowledge and skills that will enhance their coping and resiliency resources. It also requires developing and nurturing self-care and self-management strategies, and promoting organisational and structural changes that will mitigate work environment constraints.

Key words: compassion fatigue; (self-)awareness; occupational hazards; coping; resiliency



Introduction

Definition and symptoms of compassion fatigue

In helping and social professions, such as healthcare, professional rescue and social work, it is usually expected and required that professionals employ compassion and empathy with patients and clients, which can provide a great sense of strength, satisfaction and fulfilment [1]. In the recent literature, the term «compassion satisfaction» has been used to describe the positive aspects of this work, such as pleasure and sense of purpose, resulting from working effectively with suffering or traumatised people [2–4]. Compassion satisfaction is believed to aid helping professionals in their professional development and improve their personal, emotional and physical well-being by developing healthy coping mechanisms and resources

to process traumatic and stressful events experienced at work [4]. Although helping and social professionals may experience compassion satisfaction while working with traumatised and suffering people, their chronic use of compassion and empathy in their practice can be at the same time a great source of stress that can have negative emotional, physiological, biological and cognitive effects on them. These negative effects of work have been associated in the literature with a condition referred as «compassion fatigue» [3], a concept that was first introduced by Joinson in 1992 as she described in her research the work-related risk of emergency nurses losing their «ability to nurture patients» [5]. Compassion fatigue has been further studied in particular in the field of psychotraumatology. In the early to mid-1990s, compassion fatigue has been used interchangeably with the term «secondary traumatic stress». Figley’s early conceptualisation of «compassion fatigue/secondary traumatic stress» implied that clinicians who were engaging in an empathic relationship with traumatised patients suffering from posttraumatic stress disorder could actually develop signs that mirrored their patients’ symptoms by being secondarily exposed to their trauma [6]. The definition of compassion fatigue has been further developed and debated in the literature within different disciplines, without a common definition being identified and agreed on universally to this day [7–9]. Central to the various definitions of compassion fatigue suggested in the literature are the emotional and physiological reactions of an individual to the stress resulting from his or her chronic empathic and compassionate engagement with a suffering or traumatised person [10]. As it is beyond the scope of this article to address the controversies surrounding the concept of compassion fatigue, we will propose for the purpose of this review the following definition of compassion fatigue, based on the concepts that have been suggested in the literature: «a state of advanced and profound exhaustion and distress that can mimic a wide array of psychological, behavioural, cognitive and physical disorders, resulting from the repeated empathic and compassionate engagement with traumatised and suffering individuals».

Because of the conceptual ambiguity of the term, compassion fatigue has been associated with a wide array of signs and symptoms that can be similar to symptoms from other syndromes and disorders such as professional burnout (with feelings of hopelessness and difficulties dealing with work) [11], substance use disorders (e.g., excessive use of nicotine, alcohol, illicit drugs) [12], depressive and anxiety disorders [12], and posttraumatic stress disorder (with intrusive thoughts, sleep disturbances, traumatic memories, nightmares, mental fatigue, chronic irritability, angry outbursts, difficulty concentrating) [8]. Physical signs and symptoms have also been associated with compassion fatigue: lack of energy, loss of endurance, loss of strength, proneness to accidents, weariness, physical fatigue and exhaustion, headaches, digestive problems, muscle tension and cardiac symptoms [7, 12–14]. Symptoms of compassion fatigue may be insidious and difficult to identify, but it is important to note that compassion fatigue can lead to very serious and sometimes life-threatening situations, such as severe depression with suicidal thoughts, in which case medical help is urgently required [15].

Relation between compassion fatigue and other occupational syndromes

In the last three decades, clinicians and researchers have gradually acknowledged that helping professionals may suffer from occupational hazards that may be overlooked and underestimated [1]. Three main terms have been used interchangeably in the literature to describe the negative effects that helping professionals may experience when being repeatedly exposed to traumatic material shared by patients/clients: vicarious traumatisation, secondary traumatic stress and compassion fatigue [8]. Although they share similarities in their conceptualisation and can have overlapping symptoms, these three concepts may differ in other aspects. «Vicarious traumatisation» was first introduced in the literature in the early to mid-1990s [16, 17] to characterise the deep and potentially permanent shift (cognitive change) in world view (e.g., about key issues such as safety, trust, control) that therapists may experience when engaging with traumatised individuals [18, 19]. This can result in the loss of the therapist's ability to provide care to anybody [8]. Although the term «secondary traumatic stress» has been used as a synonym for compassion fatigue, some authors suggested that compassion fatigue was perhaps a more general and more user-friendly term than secondary traumatic stress to describe the emotional and psychological fatigue resulting from the empathic and compassionate engagement of helping professionals with

suffering individuals [6, 8, 9]. Moreover, as opposed to secondary traumatic stress and vicarious traumatisation, compassion fatigue may be considered to be the result of providing care through professional activities without experiencing fearful or life threatening circumstances. Compassion fatigue, secondary traumatic stress and vicarious traumatisation are the outcomes of the emotional and psychological processes that helping professionals may experience when providing empathic and compassionate care in trauma work, whereas professional burnout may differ from these concepts in its causes, as it is mainly the result of organisational stressors such as heavy or inadequate workload, work role confusion, difficult relationships within teams or with supervisors, and lack of resources in the work environment [20, 21]. Clinically, professional burnout is best characterised by three core components: emotional exhaustion, depersonalisation, reduced sense of personal accomplishment [22–24].

Risk factors, groups at risk, and screening for compassion fatigue

Despite a growing body of literature on compassion fatigue, it remains difficult to identify who is at risk as several risk factors have been suggested by clinicians and researchers without clear evidence proving their causal relationship to the development of compassion fatigue [25]. It has been gradually acknowledged in the literature that compassion fatigue can be experienced by all types of helping professionals who are secondarily exposed to the trauma and suffering of their patients/clients on a daily basis [26], such as in nurses [7, 12, 14, 27–30], physicians [13, 25, 28, 31–35], trauma therapists [36–40], social workers [10, 28, 41–43], workers in child protective services [44–48] and military healthcare teams [9, 49]. Other risk factors of compassion fatigue that have also been suggested in the literature and are summarised in figure 1. It is important to mention that the risk factors of compassion fatigue suggested in the literature have been mainly studied in developed countries, and data from developing countries are scarce. In extreme settings such as conflict zones, stress factors such as separation from family, difficult living conditions, chronic and increased feelings of danger, the physical demands of the job, and limits to one's sense of effectiveness may have negative effects on the emotional, psychological and physical well-being of military healthcare providers. However, their association with the development of compassion fatigue remains uncertain [9, 50].

To date, several instruments have been developed for identifying of compassion fatigue [7], the most fre-

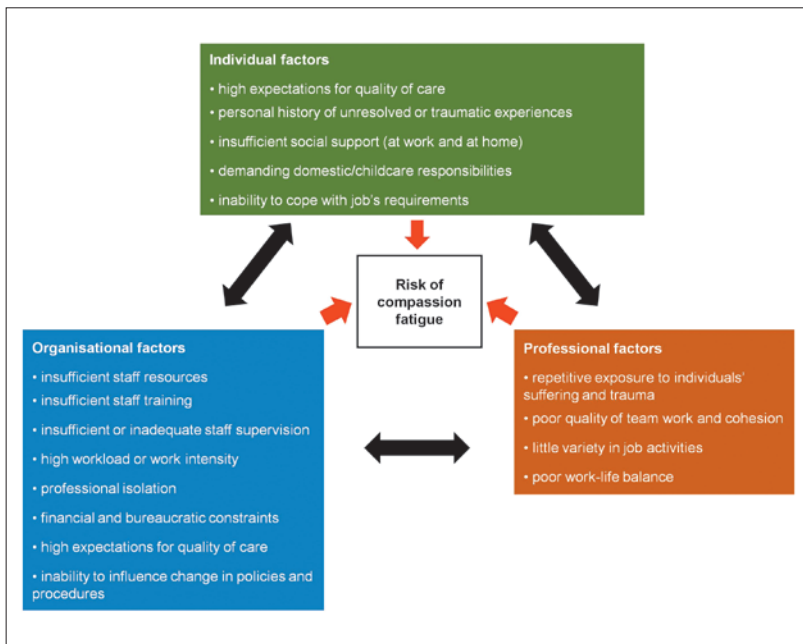


Figure 1: Hypothesised explanatory model for compassion fatigue (adapted from Dasan et al. [22]).

quently used in studies in social work and nursing being the Compassion Fatigue Scale [10, 51], the Secondary Traumatic Stress Scale [52–55] and the Professional Quality of Life Scale [11, 56]. Because of the on-going divergence among clinicians and researchers in the definition, conceptualisation and understanding of the underlying mechanisms of compassion fatigue, the need for a «gold-standard» screening instrument for compassion fatigue remains unmet to this day [35]. This lack of consensus may have contributed to the discrepancies in compassion fatigue prevalence measured across studies in the literature. For example, Van Mol et al. [35] found, in their systematic review, compassion fatigue prevalence ranging from 7.3 to 40% among healthcare providers in intensive care units.

Compassion fatigue: what are the consequences if it is overlooked and left untreated?

Despite the on-going ambiguities in the conceptualisation of compassion fatigue, a growing body of literature acknowledges the implications and risks taken, both for the professionals and the organisations they work for, if signs and symptoms of compassion fatigue are not recognised and are left untreated. For individuals experiencing compassion fatigue, a decline in their mental and physical health can be observed in parallel with the gradual increase of symptom severity. This puts them at risk for depression, anxiety, lack of empa-

thy and compassion towards those they are responsible for, and a wide array of other mental and physical symptoms [9, 14]. This can negatively impact on healthcare organisations in several ways, causing helping professionals to experience a decline in job performance and efficiency, an increase in professional mistakes, a rise in sick leaves and in absenteeism, a disruption of team cohesiveness, and an increased risk of leaving the job [9, 14, 57, 58]. In those circumstances, patients' and clients' satisfaction and safety may be compromised [14, 21].

Over the last two decades, a rising number of clinicians and researchers have called for actions and interventions to mitigate the risks of compassion fatigue, and have provided specific recommendations in many literature sources. The aim of this article is to provide a critical appraisal of the strategies and interventions suggested in the literature to prevent, manage and treat compassion fatigue, which may be particularly of use for helping and social professionals and organisations in regards to the human and organisational costs of untreated compassion fatigue.

Methodology

Search strategy

The core material used for this article was identified through the systematic review of five electronic databases: Medline/PubMed, Embase, Web of Science, CINAHL plus and PsycINFO. These databases were searched for peer- and non peer- reviewed journal articles published from January 1980 to March 2016, with no limit to the searches by country of origin of the paper. However, only papers in English or French were included. Because of the conceptual ambiguity of compassion fatigue, the first search strategy was to identify titles and abstracts by using the term «compassion fatigue» and the terms that were used interchangeably with it in the literature (namely «secondary traumatic stress» and «vicarious traumatisation»), including their synonyms and their corresponding French translation (see table 1). Several papers were duplicates or did not provide an abstract and were removed. Papers with titles and abstracts not related to the topic of this study were also removed (see fig. 2). The second part of the search process was to review and identify abstracts containing suggested strategies and interventions for prevention, management and/or treatment of compassion fatigue. The flow diagram is presented in figure 2. Reviewed abstracts that were not relevant for the study were removed. The literature search was completed by hand searching reference lists.

Data analysis

An evaluation form guided the data extraction process used to identify articles containing valid evidence that supported the purpose of this dissertation. Each study was entered into the evaluation form, according to key terms and entries. The evaluation form was

adapted from the methodology checklists provided figureonline by the National Institute for Clinical Excellence (<http://www.nice.org.uk>) to critically appraise qualitative and quantitative studies.

Results

Fifty published original articles met the inclusion criteria. A summary of the databases searches is presented in table 2.

Owing to the methodological, clinical and statistical heterogeneity of these studies, it was not possible to conduct systematic and rigorous comparisons between them. The heterogeneity of the studies may explain why a meta-analysis on the topic could not be found in the literature. Two thirds of the studies were published recently (within the last six years)

Table 1: Identified search terms used for the systematic literature review.

Terms	Synonym(s)	French translation
“Compassion fatigue”	–	“Fatigue compassionnelle” or “fatigue de compassion” or “fatigue de la compassion”
“Secondary traumatic stress”	“Secondary traumatic stress disorder” or “secondary trauma”	“Stress traumatique secondaire” or “stress secondaire”
“Vicarious traumatization”	“Vicarious trauma”	“Traumatisme vicariant” or “trauma vicariant”

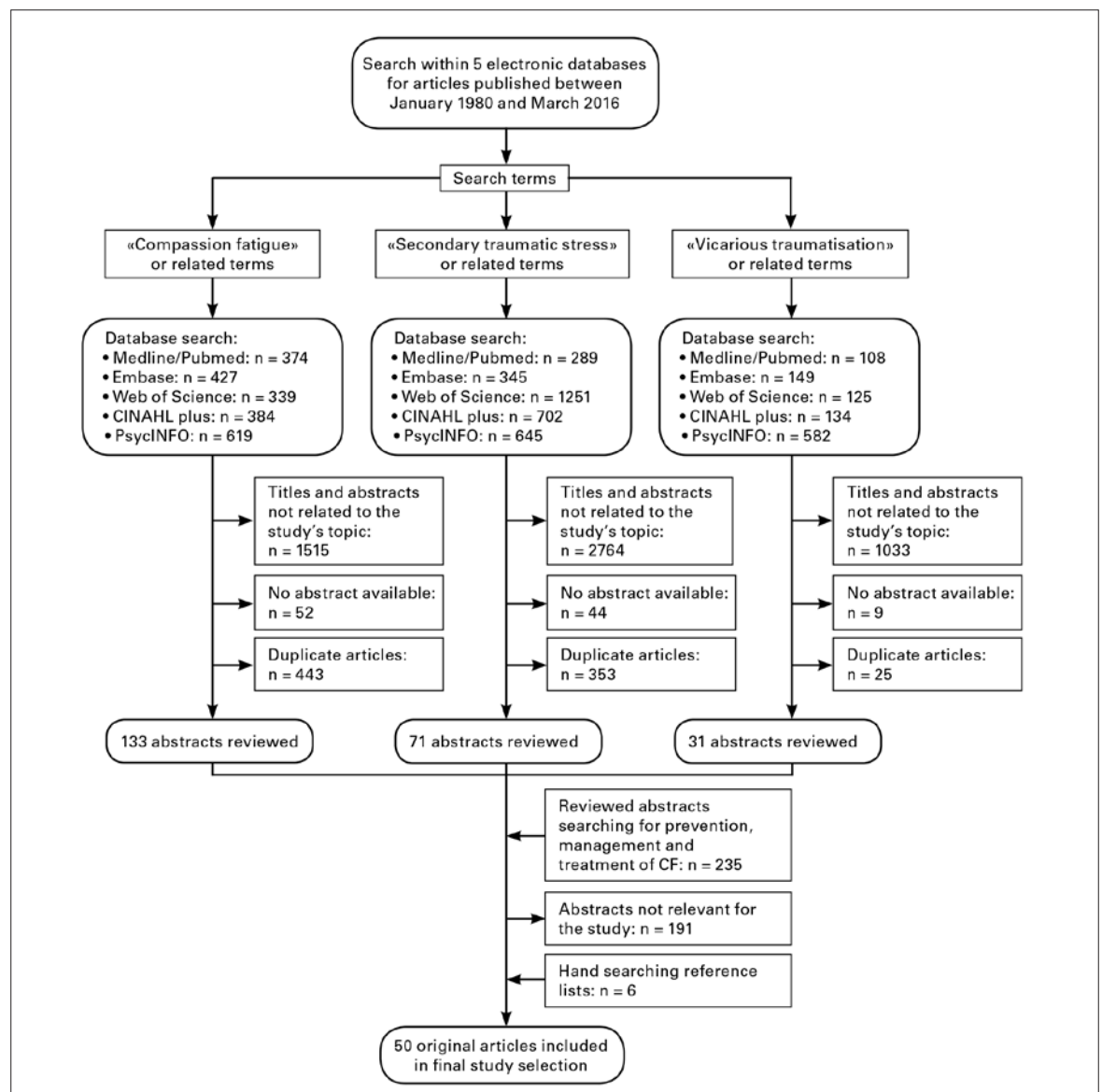


Figure 2: Flow diagram of search process (n = number of articles). CF = compassion fatigue.

and the vast majority of them were conducted in the nursing field. Only one study was conducted in a low-income country [59] and only one study was published in French [60]. In two descriptive studies [27, 61], the suggested strategies to combat compassion fatigue were not directly correlated with the research results and were based on the authors' or experts' opinion. Three systematic literature reviews were identified [35, 62, 63]: Beck [62] focused her review on determining if nurses did experience secondary traumatic stress or not; Najjar et al. [63] reviewed the available literature on compassion fatigue in cancer-care providers; and van Mol et al. [35] researched the prevalence of compassion fatigue and burnout among healthcare providers in intensive care units.

Discussion

Strategies and interventions to combat compassion fatigue

Since the mid-1990s, clinicians and researchers have proposed and studied strategies and interventions to prevent, manage and treat compassion fatigue in helping and social professionals. A summary of the recommendations to combat compassion fatigue suggested in the literature is presented in figure 3.

Table 2: Summary of the databases searches (total number of included original articles = 50).

Categories	Number of articles (%)
Field of publication	
Nursing journal	23 (46%)
Medical journal	11 (22%)
Social sciences journal	4 (8%)
Psychology journal	12 (24%)
Country of researchers by continent	
North America (USA, Canada, Mexico)	40 (80%)
Europe (UK, Netherlands, Belgium)	3 (6%)
Africa (Uganda, South Africa)	2 (4%)
Australia (Australia, New Zealand)	5 (10%)
Type of study	
Systematic literature review	3 (6%)
Experimental randomised nonplacebo study	1 (2%)
Experimental non randomised study	6 (12%)
Descriptive study (cross-sectional study, survey)	6 (12%)
Qualitative study	7 (14%)
Mixed method study (qualitative and quantitative data)	2 (4%)
Evidence based on authors' or experts' opinion	25 (50%)

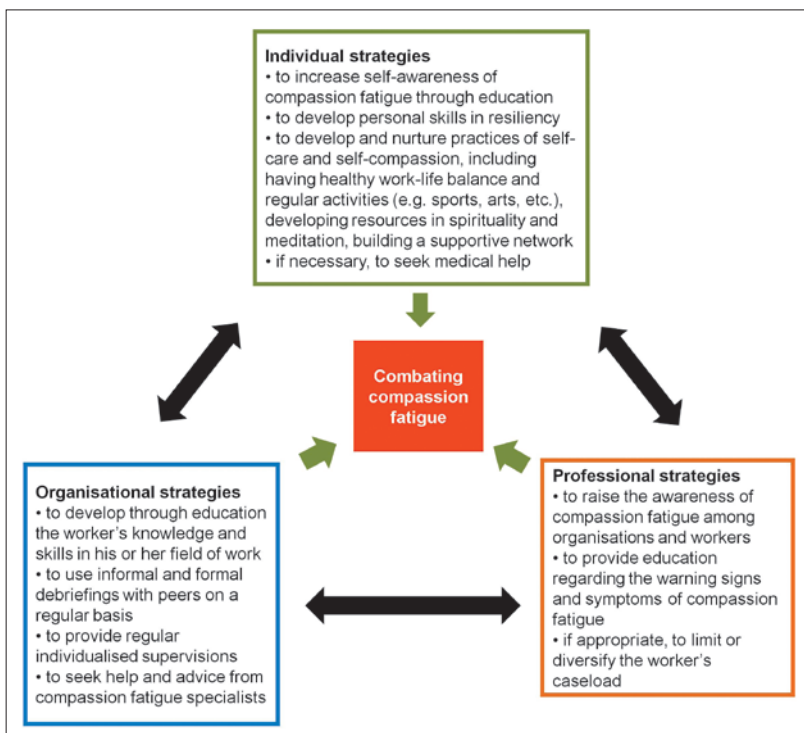


Figure 3: Summary of the recommendations in the literature to combat compassion fatigue.

Among *professional strategies*, a first critical step is acknowledging in a supportive way that compassion fatigue not only exists, but is an expected reality in helping professions [31, 36, 64], and that experiencing emotional distress can be a normal response to difficult and complex patient/client situations [50, 65]. To increase the awareness of compassion fatigue, organisations managers/leaders need to be informed on the propensity of their personnel to develop compassion fatigue, and professionals should be educated regarding the signs and symptoms that may be associated with compassion fatigue [42, 50, 60, 66–68]. Furthermore, the warning signs of compassion fatigue need to be delivered through education as early as possible in professional educational programmes [19]. In order to reduce the direct work of helping professionals with suffering and traumatised patients/clients, limiting or diversifying their caseload should be considered to better manage the proportion of difficult and complex situations they are responsible for [69].

Among *organisational strategies* suggested to reduce the risks of compassion fatigue, providing sufficient theoretical knowledge and clinical skills for helping professionals in their field of work should be consid-

ered to enhance their working and coping skills (e.g., delivering specific training in the management of substance users, psychiatric patients, etc.) [27]. Informal and formal debriefings with team colleagues and co-workers have also been recommended to alleviate the feelings of professional isolation and promote peer support [27, 30, 42, 70–73]; debriefings should occur on a regular basis rather than in response to crisis situations [36]. Great caution should be taken, however, when informal debriefings occur with family and friends as they may not be equipped to offer support without being negatively impacted in the process [39]. Whenever possible, individual supervisions should be offered regularly to helping professionals [39, 44, 63, 72], which may not only provide individualised professional support, but also allow early intervention if compassion fatigue is suspected or is occurring. Workers' caseloads can be reviewed and redistributed during supervisions if judged appropriate [70, 74]. Organisational measures to reduce or address operational and structural issues such as bureaucratic and finan-

Whenever possible, individual supervisions should be offered regularly to helping professionals.

cial constraints, high workload and work intensity, and insufficient staff resources may also be required as these issues may impact negatively both on individuals and organisations [75, 76]. Supervisors, organisation managers and leaders may also need support in regards to compassion fatigue, which could be obtained from peers and compassion fatigue specialists [15]. Organisations and managers play an essential part in preventing compassion fatigue in their work environment, but helping and social professionals may have an equally important responsibility for taking measures to mitigate the risks of compassion fatigue. *Individual strategies* have been suggested in the literature to combat compassion fatigue, starting with increasing the self-awareness of compassion fatigue among helping professionals through education [1, 66, 70, 71, 77]. Some authors have recommended developing personal skills in resiliency [1, 33, 62, 64, 70], which can be defined as the «process of coping with or overcoming exposure to adversity» [49]. Having the ability to be more resilient may help an individual to better cope with stressful and distressing events experienced within the work environment, allowing him or her to have a positive stress response [1]. Among other protective factors, development of self-care and self-compassion strategies seems to be central and has been advocated by many clinicians and researchers [7, 12–14,

25, 28, 30, 43, 50, 60, 66, 68, 69, 72–74, 77–80]. Self-compassion entails having an «empathic response and curiosity to one's own mistakes and faults» [25]. Self-care strategies that have been suggested in the literature include developing an adequate and healthy work-life balance by setting clear boundaries between work and personal life [1, 7, 12, 43, 69, 71], having regular healthy activities such as sports, arts or narrative work such as keeping a journal [1, 26, 31, 60, 68, 71, 73, 81], developing personal resources in spirituality and meditation [1, 26, 28, 50, 60, 73, 79], building and maintaining a healthy and supportive social network at home and at work [59, 81–83]. The use of humour, a vast and complex phenomenon, has been suggested by some authors to lessen or prevent symptoms of compassion fatigue [82], but the beneficial role of humour has been questioned by other authors who advocated a cautious use of humour when engaging in trauma work, as it may be perceived as inappropriate to the contextual setting [84].

Over the last two decades, models of interventions to assist helping and social professionals to mitigate the risk of or to treat compassion fatigue have been developed. In the late 1990s, a local programme in the USA, the Accelerated Recovery Program (ARP) for compassion fatigue, was designed in the field of mental health to help professionals who were secondarily exposed to trauma material in their work to combat compassion fatigue [85, 86]. The ARP's goals focused on the delivery of comprehensive tools to assess compassion fatigue symptoms and triggers, and the elaboration of a self-care plan [86]. The ARP was further developed and became the Certified Compassion Fatigue Specialist Training (CCFST), which gave promising results in reducing compassion fatigue among participants [87]. Other interventions targeting «compassion fatigue/secondary traumatic stress» have been tested across the globe (in the USA, Mexico, New Zealand) in various disciplines (professional educators, emergency and oncology nurses, military healthcare providers). Various methods were used to enhance and consolidate individuals' resiliency and coping resources [29, 49, 64, 88], to acquire knowledge and skills for practicing effective self-care [89], and to use practices to reduce stress and negative emotions such as mindfulness techniques [90] and brief structured meditation sessions [91]. Different statistical methods were used in these studies, and the impact of the interventions on participants varied across the studies, from a significant reduction in «compassion fatigue/secondary traumatic stress symptoms» [29, 49, 64, 88, 91] or an increase in «compassion satisfaction» [64, 91] to no significant effect on compassion fatigue/secondary

traumatic stress symptoms [89, 90]. Because of potential budget restrictions and chronic lack of human resources in helping professions, organisation managers and leaders may feel reluctant to release their staff to attend to such programmes, but offering professional development for them may constitute a skill-building strategy in the longer run that might increase staff work performance and staff retention [15].

The degree of success of the interventions used in the studies mentioned above may depend on the pathogenesis of compassion fatigue. In its early conceptualisation, developed mainly in the field of psychotraumatology [6], compassion fatigue was considered to be the consequence of experiencing helplessness, fear, horror, «mental defeat» in traumatic experiences in general, emotions that are highly important in the pathogenesis of posttraumatic stress disorder. In the following years, clinicians in the medical and nursing fields have further developed the concept of compassion fatigue by characterising it as the consequence of an affectionate and caring attitude, rather than as the result of a traumatic experience [7, 25], although there is no definitive evidence that this phenomenon results from an extraordinary compassionate attitude. For Boyle et al., compassion fatigue can occur when the «compassion energy» that healthcare providers expend with their patients surpasses their «ability to recover from this energy expenditure», causing «significant negative psychological and physical consequences» [7]. From that perspective, the interventions aimed at combating compassion fatigue may need to be adapted to professionals' roles and missions, as well as their work environment, which may shape or define, among other factors, the pathogenesis of compassion fatigue.

Limitations of the review

First, this literature review may be incomplete. The detailed data analysis included only published original articles that were identified from five databases, missing potentially relevant information on the topic from other sources. Furthermore, a publication bias may have occurred in this literature review [35]: studies with inconclusive or negative results may have been unpublished and therefore overlooked in this review; the language restriction (English and French) may have led to an incomplete overview of the existing literature on the topic; relevant information from low-income countries may have been overlooked since the vast majority of the studies included in this review were conducted in upper-middle- and high-income countries (see table 2). Secondly, a major difficulty was the conceptual ambiguity and inconsistent definitions

of compassion fatigue in the existing literature. As there is no clear definition of the phenomenon, conducting epidemiological research with a systematic review based on the prevalent literature may not have been the most appropriate methodology to answer our research question. A reflection of this limitation in our research was that half of the recommendations suggested to combat compassion fatigue came from authors' or experts' opinions, which may be considered a low level of evidence [9]. In association with the heterogeneity of the screening instruments used to detect compassion fatigue across studies, the lack of a consensual definition of compassion fatigue may have contributed to the heterogeneity in the results of the analysed studies, limiting their comparability and interpretation. Thirdly, there were limitations to the validity and the generalisability of the studies. Internal validity of descriptive studies may have been limited by the use of self-questionnaires in cross-sectional surveys, which brings a risk of biases such as recall bias or information bias. Internal validity of experimental studies may also have been limited by the relatively small participant sample size. Regarding generalisability, relevant information on the topic almost exclusively came from researches in middle- and high-income settings, and so suggested recommendations from this literature review may not be applicable or feasible in resource-constrained settings that are usually overwhelmed by workload [71].

Implications for further research

Solid evidence on compassion fatigue has been admittedly difficult to come by because of the inconsistent definition and concept of the term, the conceptual confusion and overlapping with other occupational hazards (secondary traumatic stress, vicarious traumatization), and the heterogeneity of the instruments developed to screen for compassion fatigue. More homogeneity at the level of study design and methodology (e.g., sampling, setting of inclusion and exclusion criteria, data extraction and analysis) may be required to allow a comparison between studies on the topic, although the combined use of various research designs (e.g., studies other than controlled trials) has been recognised to be useful for designing successful public health interventions [92]. The lack of longitudinal studies that would ascertain the causal associations between compassion fatigue and risk factors suggested in the literature requires more scientific evidence. Further research is needed in the future to address these problems, which may have hindered the development of appropriate interventions aimed at combating compassion fatigue [7, 30, 63].

Conclusions and recommendations

Clinicians and researchers from various disciplines (mostly nursing, medicine, social sciences and psychology) in developed countries have developed and studied over the last two decades programmes and interventions aimed at mitigating the risks of compassion fatigue. It is believed that compassion fatigue may be the consequence of interactions between this syndrome and professional, organisational and individual risk factors, although their causality has yet to be proved. The findings of this review indicate that compassion fatigue can be combated. It requires, however, that helping organisations and professionals take essential steps to increase their (self-)awareness of compassion fatigue through education, debriefings and supervisions, and equip helping professionals with adequate knowledge and skills that will enhance their coping and resiliency resources. It also requires development and nurture of self-care and self-management strategies, and promotion of organisational and structural changes that will mitigate work environment constraints.

Despite the taxonomical conundrum in the construct of compassion fatigue and the need for more scientific evidence on the topic, clinicians and researchers acknowledged the necessity of (self-)protecting helping professionals from the deleterious effects of compassion fatigue, as they may not only severely and durably affect the mental and physical health of individuals, but also impact negatively on their supportive network (peers, family and friends) [39]. Furthermore, when trained individuals have no choice left but to leave their profession because of the consequences of compassion fatigue, this constitutes an enormous loss of resources and potential for healthcare services for other helping professions and organisations [71].

In conclusion, successfully combating compassion fatigue may require redefinition of our own perceived role and mission as a helping professional, including changes in our ways and levels of expectation to fulfil them. This change in our work culture may need to happen early in our professional education, before we acquire maladaptive behaviours and inappropriate mechanisms to cope with stress factors in our work environment [93]. Whereas it has been suggested that

individuals who are overly perfectionist, conscientious and self-giving are most susceptible to compassion fatigue [63], it may be necessary to «recalibrate» our thinking by acknowledging that the use of compassion and empathy can provide us with a high level of professional fulfilment, but at the same time can be profoundly hurtful if left unchecked. Furthermore, experiencing compassion fatigue should not be considered as a professional or personal failure as we are all susceptible to it [56]. To cite an analogy used by some authors, when working with traumatised and suffering people, «there is no lead shield for the professional to step behind in order to avoid absorbing radiation from the patient's X-rays» [94]. This reframing of our thinking may be particularly challenging, as some of us may believe that working under emotional, psychological and physical stress is a normal part of our job, and that accepting help from others may be a sign of our own clinical incompetence or weakness [76]. Patient/client care must remain central to our work, but it may be equally important to acknowledge and integrate into clinical practice our own needs and limits by setting realistic goals and boundaries [39]. Finally, blaming individuals for not having successfully shielded themselves from compassion fatigue is not helpful, and organisations and employers need to proactively support their employees through professional and organisational measures aimed at combating compassion fatigue [79]. Strategies to address occupational hazards are usually focused on individual measures such as providing better education to staff. However, helping organisations such as healthcare services may need to develop in parallel innovative and sustainable measures aimed at improving structural and organisational conditions in their work environment [93].

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The full list of references is included in the online version of the article at www.sanp.ch

Correspondence:
Francis Vu, MSc
Policlinique Médicale
Universitaire (PMU)
Rue du Bugnon 44
CH-1011 Lausanne
[francis.vu\[at\]chuv.ch](mailto:francis.vu[at]chuv.ch)