

## PSYCHIATRIC CAREGIVER STRESS: CLINICAL IMPLICATIONS OF COMPASSION FATIGUE

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### SUMMARY

The capacity to work productively is a key component of health and emotional well-being. People who work in health care can be exposed to the fatigue of care. Compassion fatigue has been described as an occupational hazard specific to clinical work related severe emotional distress. In our study, we have evaluated compassion fatigue in a mental health group (47 psychiatric staff) and its relationship with inpatients (237 inpatients) affected by some psychiatric disorders. At baseline, the more significant data indicate a high percentage of Job Burnout and Compassion Fatigue in psychiatric nurses (respectively, 39.28%, 28.57%). Significant Compassion Fatigue percentage is present also in psychologist group (36.36%). Finally, in psychiatrists, the exposure to patients increased vicarious trauma (28.57%), but not job burnout. After a year of participation in Balint Groups, the psychiatric staff presented an overall reduction in total mean score in any administered scale (CBI:  $p < 0.000045$ ; sCFs: (Vicarious Trauma:  $p < 0.0288$ ; Job Burnout:  $p < 0.000001$ )). Thus, compassion fatigue causes concern among mental health professionals, and Balint Groups may represent a therapeutic strategy to help health professionals to face difficulties in challenging work environments.

**Key words:** compassion fatigue – burnout – psychiatric caregivers

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### INTRODUCTION

The capacity to work productively is a key component of health and emotional well-being. A key component of the World Health Organization (WHO) definition of health is the notion of the capacity to participate in community life, rather than the traditional narrower view of health as the absence of disease (Tanışman 2014, Chopra 2009). The Health Care Professional (HCP) (referring to all the professionals who as part of their work activities assist persons suffering from psychiatric disorders) engages their emotional experiences of empathy, of suffering and fatigue during the course of their work (Auer 2015). Several types of occupational stress have been identified, including burnout, compassion fatigue, and vicarious traumatization.

### WORK, STRESS AND MENTAL ILLNESSES

People are exposed to diverse pressure in modern life, and work-related stress has become particularly important. Work-related stress is considered to be a risk factor for many disorders, including hypertension, ischaemic heart disease, asthma and depression (Ruotsalainen 2014, Mino 2006). Several organizations increasingly recognize their obligation to employee health as marked by the rise in workplace health initiatives, particularly over the last two decades. Despite mental disorders being the leading cause of sickness absence and work incapacity in most developed countries, mental health has remained relatively ignored in the

majority of workplace health programs (Tan 2014). Charles Figley, a pioneer in the development of the definition of Compassion Fatigue argued that “*There is a cost to caring. Professionals who listen to clients’ stories of fear, pain, and suffering may feel similar fear, pain, and suffering because they care. Sometimes we feel we are losing our sense of self to the clients we serve*” (Figley 1995).

Another important aspect is that the mental illnesses, and in particular Common Mental Disorders (CMDs) such as depression and anxiety, are among the most frequent causes of occupational disability (Greenberg 2015, Wang 2008, Wang 2003). The burden of CMDs is under-recognised despite strong evidence regarding its social impact. Providing care and support to people with complex mental health needs and disabilities can be highly stressful. The impact of working in psychiatric services on staff quality of life has been assessed in terms of burnout (BO), compassion fatigue (CF), and, more positively, in relation to compassion satisfaction (CS). In this article, we will refer to compassion fatigue (CF) to indicate the stress of health workers. Although many benefits from the work we can collect, at the same time we can be suffering from some degree of caregiver stress without even knowing it. Many different symptoms can indicate that a problem has developed or is likely to arise in the future (Teater 2014). Caregiver stress can affect a person in many different ways and with many signs and symptoms: psychological (for example, being easily frustrated, sadness, guilt, detachment, depression symptoms, etc.), physical (for example, headaches, muscle tension, fatigue and exhaustion, sleep problems, etc.), and behavioural (for example, anger,

restless, difficulty with personal relationship, etc.) signs and symptoms (Gold 2014, Thomas 2004, Kahn 2003, DeMarco 2001).

## COMPASSION FATIGUE (SECONDARY TRAUMATIC STRESS)

What is Compassion Fatigue? Compassion fatigue has been described as the “*natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping, or wanting to help, a suffering persons*” (Figley 1995) and as “*...an occupational hazard specific to clinical work related severe emotional distress*” (Figley 1995). It is defined also as the formal caregiver’s reduced capacity of, or interest in, being empathic or “*bearing the suffering of clients*” (Figley 1995, 2002). Most often this phenomenon is associated with the “*cost of caring*” for others in emotional pain. Compassion fatigue is also a state of tension and preoccupation defined by intrusive imagery, numbing or avoidance, anxiety, hyper-vigilance, re-experiencing and irritability (Wright 2004, Figley 1995, 2002). Compassion fatigue is likely to result in problems such as misjudgements, clinical errors, poor treatment planning, all serious issues for effective care (Figley 2002a, Bride 2007; Adams 2008). The ‘compassion fatigue’ term is recent and it is a latest concept known in the field of traumatology as secondary traumatic stress. This concept has been around only since 1992, when Joinson, a nurse, used it in a nursing magazine to describe nurses who were worn down by daily hospital emergencies. In his book, Figley (1995) defined it as a secondary traumatic stress reaction resulting from helping or desiring to help a person suffering from traumatic events. Key elements within this model include empathic ability, empathic response, and residual compassion stress.

## COMPASSION FATIGUE VS BURNOUT

Another aspect of emotional fatigue of the worker is Burnout. The burnout term was introduced in the scientific literature in 1974 by Herbert J. Freudenberger, an American psychologist, in his classic article, “*Staff Burn-Out*”, published in the *Journal of Social Issues*. In this article Freudenberger believed that “*Burnout is a depletion or exhaustion of a person’s mental and physical resources attributed to his or her prolonged yet unsuccessful striving toward unrealistic expectations, internally or externally derived*” (Freudenberger 1974). Burnout as a phenomenon has probably existed at all times and in all cultures (Finne 2014, Kaschka 2011). The burnout term was first introduced by Christina Maslach (1982), a social psychologist, to describe a collection of symptoms including three interrelated dimensions (Maslach 2001): 1) emotional exhaustion; 2) depersonalization; 3) low personal accomplishment. In

short, burnout is a “*... state of psychological, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations*” (Pines 1993). Most often burnout has been associated with an accumulation of stressors that erode the individual’s high ideals, motivations, and commitments to a particular field, profession, career, or jobs. Compassion fatigue and burnout differ in some key aspects. Burnout is not directly related to the exposure to traumatic stress. The main difference between burnout and compassion fatigue is exposure to trauma and suffering. Anyone in any job can experience burnout, for example, in restaurants, stores, businesses and institutions. This is unrelated to trauma exposure. The onset of burnout is gradual, while compassion fatigue has a faster onset of symptoms and as a result from the exposure to a single traumatic event (Slocum-Gori 2013; Rossi 2012). Buscarino (2008) suggests that *vicarious trauma* and *job burnout* are a separate phenomenon of compassion fatigue and that both syndromes are related to working with traumatized patients.

## BURNOUT AND COMPASSION FATIGUE IN PHYSICIANS

The burnout rate seems to be even more pronounced among physicians. Several studies have indicated a high prevalence of burnout among physicians and have shown that one-third of physicians have experienced burnout at certain points throughout their careers (Veyssier-Belot 2015, Shanafelt 2015, Shanafelt 2012). Twenty-five to sixty percent of physicians report burnout across all specialties (Gazelle 2015). Overall data indicate that, in general, burnout is present in 16 – 85% of health care workers; in 48.8% of physicians; up to 40% in psychologists (Shanafelt 2015, Teater 2014, Goodwin 2013, Evans 2006, Onyett 1997, Cushway 1996). Fatigue, Compassion and Secondary Traumatization also affects other health care professionals, including those who work with patients with AIDS or cancer or who are involved in critical care or hospice care (Adams 2008). Moreover, it was found that psychiatrists had higher levels of CF compared with non-medical workers (Sodeke-Gregson 2013, Craig 2010). However, the effects of stress management at work places have been assessed, and its effects on depressive and manic symptoms have not been clarified (Habibi 2014, Murphy 1996). There are protective factors of stress of caregivers. In fact, in compassion satisfaction (CS) is the sense of pleasure derived from helping others, and the degree of support received from colleagues (Stamm 2002). CS refers to the satisfaction derived only from being able to help other people. Stamm has suggested that increasing CF “*may overwhelm the professional’s sense of efficacy and prevent him/her from experiencing CS*”. Some studies suggested that *years of professional experience* were associated with a lower risk of both CF and BO. Having

a personal history of trauma was associated with an increased risk for CF (Cunningham 2003). *Specialized trauma* training has been reported to enhance CS and reduce the levels of CF and BO. Exposure factors such as long working hours or high percentages of trauma patients have been associated with an increased incidence of CF (Sprang 2007).

## METHOD (AIM OF THE STUDY)

We conducted a study on Compassion Fatigue in caregiver workers of patients affected by Psychiatric Disorders. The aim of our study was to investigate the stress of mental health workers (particularly psychiatrists, psychologists, social workers, psychiatric nurses, and healthcare support workers) and its relationship with inpatients in Mental Health Department “Villa dei Pini”, Avellino, Italy, that provided day care and rehabilitation. We were interested in how *Compassion Fatigue* might affect the ways in which clinicians work with psychiatric inpatients. In addition, we explored the relationship between staff perception of burnout and of CF impact and scores on a Compassion Fatigue Short Scale (CFS) (Adams 2004) and a secondary scale Caregiver Burden Inventory (CBI) (Novak 1989). Finally, we evaluated the correlation between Balint Groups and compassion fatigue in psychiatric caregivers. The study was conducted involving two groups: The first group (Group I) included 237 inpatients (152 males; 85 females) who met DSM-5 diagnostic criteria (APA 2013) for Psychiatric Disorders; we have selected 3 large groups (Schizophrenia Spectrum; Bipolar I Disorders; Depressive Disorder) from all inpatients

observed in our centre: 76.95%; 237/308 inpatients. These patients were administered the following rating scales, respectively Positive And Negative Schizophrenic Symptoms (PANSS): (Kay 1987), Young Mania Rating Scale (YMRS) (Young 1978), Hamilton Depression Rating Scale (HAM- D) (Hamilton 1967). Concurrently, at all patients were administrated the Brief Psychiatric Rating Scale (BPRS) 4.0 (18 items (Overall 1962, Leucht 2005). The second groups (Group II) included 47 psychiatric staff (24 females; 23 males) (psychiatrists, psychologists, social workers, psychiatric nurses, and healthcare support workers) that returned completed questionnaires (a completion rate of 76%). All staff in this study were asked to complete anonymously at baseline and after a year the following scales: sCFs (Short Compassion Fatigue Scale); CBI (Caregiver Burden Inventory). All health professionals have participated in Balint Groups for a year. A number of worker staff group was subjected to weekly sessions of Groups Balint, in accord to recommendations of the UK Balint Society. Balint groups focused on the everyday work of clinicians, using ordinary language and the group leaders was there to divert questions of a personal nature. Data was analysed using the statistic package EZAnalyze 3.0/Excel platform. T-tests Student were used to compare the results of administrated scales in both groups before and after Balint Groups.

## RESULTS

In table 1, at baseline some epidemiological data of inpatients (Group I) are included.

**Table 1.** Group inpatients on some sociodemographic and clinical data at baseline

Psychiatric Disorder Patients (PDP: selected)	100%	Age (ys±SD)	Scales	Scores (mean total ±SD)
Schizophrenia Spectrum Disorders	48%	39.75±12.58	BPRS PANSS	72.17±22.53 80.08±15.89
Bipolar I Disorder	27%	49.55±9.94	BPRS YMRS	67.28±18.32 37.88±10.69
Depressive Disorder	25%	45.38±9.01	BPRS HAM-D	62.51±13.29 15.61±3.81
Psychiatric Disorder Patients (selected)	76.95%			
Other disorders	13.05%			
Other overall sociodemographic data at baseline (PDP)				
Married	27%		Education (yr)	11.8±4.6
Separate	16%		Employed/Student	21.3 %
Widower	51%		Pensioners	51.7%
Treated with FGAs	17.5%		Smokers	72.5%
Treated with SGAs	68.9%		Alcohol	28.5%
Treated with mood stabilizers	33.4%		Cannabis	17.8%
Clinical global impression	5.1±1.1			

Psychiatric disorder patients selected and included in this study are the 76.95% of all inpatients observed in the observational time. Other disorders included, for examples, Anxiety Disorders, Personality Disorders, etc. Schizophrenic patients represent the largest group with 48%, Bipolar Disorder group is 27%, and Depressive Disorder group is 25%. The right side of table 1, the mean scores of total balances administered in each group are shown. In table 2, the data of the workers (Group II) are presented. In this group, psychiatrists accounted 7%, while psychologists were 10%. Psychiatric nurses was the largest group (49%). On the right side

of the table 2, there is the total mean results of the scales of stress in workers (*sCFs*: *Short Compassion Fatigue Scale*; *CBI*: *Caregiver Burden Inventory*). The highest mean total result is that of nurses (41.82%) at CBI scale. The most significant data of *sCF* scale is represented by the percentage of vicarious trauma in psychologist group (36.36%); this group has also a high percentage also in job burnout (in 35.45%). The psychiatric nurses have the highest percentage in the subscale of job burnout of *CFscale* (39.28%). Finally, in psychiatrists the exposure to patients increased vicarious trauma (28.57%), but not job burnout.

**Table 2.** Group Worker Staff sociodemographic and clinical data (baseline data)

Psychiatric Disorder Patients (PDP: selected)	100%	Age (ys±SD)	Scales	Scores (mean total ±SD)
Schizophrenia Spectrum Disorders	48%	39.75±12.58	BPRS PANSS	72.17±22.53 80.08±15.89
Bipolar I Disorder	27%	49.55±9.94	BPRS YMRS	67.28±18.32 37.88±10.69
Depressive Disorder	25%	45.38±9.01	BPRS HAM-D	62.51±13.29 15.61±3.81
Psychiatric Disorder Patients (selected)	76.95%			
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Other overall sociodemographic data at baseline (PDP)				
Married	27%		Education (yr)	11.8±4.6
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Treated with FGAs	17.5%		Smokers	72.5%
Treated with SGAs	68.9%		Alcohol	28.5%
Treated with mood stabilizers	33.4%		Cannabis	17.8%
Clinical global impression	5.1±1.1			



Scales: *sCFs* (Short Compassion Fatigue Scale); CBI (Caregiver Burden Inventory)

**Figure 1.** Balint Group CBI/*sCFs* Results in Worker Staff

**Table 3.** Mean scale (CBI; sCFs: JB – VT) results Group II (Balint Groups)

	T0	T1	p	
<b>CBI</b>				
Total	34.24±18.95	26.44±13.45	0.0000045	+
Psychiatrists	30.71±16.94	27.86±12.67	0.16190	-
Psychologists	30.71±16.94	27.86±12.67	0.02570	+
Nurses	37.82±21.35	31.54±16.74	0.00280	+
Operators	24.38±15.67	18.14±12.24	0.02340	+
Social Workers	30.20±18.21	21.20±5.76	0.22900	-
<b>sCFs</b>				
<b>JB</b>				
Total	31.07±14.99	22.75±8.96	0.000001	+
Psychiatrists	19.43±6.61	16.86±5.96	0.001740	+
Psychologists	25.91±13.84	20.82±10.35	0.057700	-
Nurses	41.93±12.02	27.75±8.09	0.000020	+
Operators	22.95±9.67	19.62±7.76	0.009000	+
Social Workers	31.80±24.19	20.40±8.68	0.221100	-
<b>VT</b>				
Total	15.54±10.28	14.28±7.66	0.02880	+
Psychiatrists	13.29±4.35	10.86±3.24	0.01490	+
Psychologists	11.54±7.16	11.36±6.17	0.82630	-
Nurses	18.50±11.15	17.46±7.86	0.35840	-
Operators	13.05±8.93	11.43±7.75	0.03790	+
Social Workers	21.40±17.81	16.60±10.45	0.26503	-

### Balint Group Results in Worker Staff (Group II)

After a year of participation in Balint groups of health workers, significant results were observed.

The summary of the data are shown in figure 1 and table 3; these results indicate an overall reduction of the main total results in all scales. After one year (T0 vs T1) the CBI total mean results was statistically significant (34.24±18.95 vs 26.44±13.45;  $p < 0.0000045$ ); also the total mean results in subscale Job Burnout (JB) of sCFs was significant (31.07±14.99 vs 22.75±8.96;  $p < 0.000001$ ). In psychiatrist group the difference (T0 vs T1) was also statistically significant (JB: 19.43±6.61 vs 16.86±5.96;  $p < 0.00174$ ; VT: 13.29±4.35 vs 10.86±3.24;  $p = 0.0149$ ).

Conversely, the results obtained in the group of psychologists are not significant in both JB and CF (respectively,  $p = 0.0577$ ,  $p = 0.8263$ ).

### DISCUSSION

In this study, we sought to investigate the presence of compassion fatigue in psychiatric caregivers in relation to some inpatients with psychiatric disorders. Signs and symptoms of compassion fatigue and burnout can appear in all personal, professional and organisational categories; particularly, psychiatric caregiver are highly exposed to these symptoms. Some studies have shown that clinicians reported specific ways that burnout affects work, including empathy, communication, therapeutic alliance, and consumer engagement (Salyers 2015, Morse 2012).

Clinicians have awareness of the negative impacts on results of your works and those with higher levels of compassion fatigue were more likely to report that burnout affects how the staff work with patients/consumers. Balint groups can represent a management strategy for CF (Diaz 2015, Van Roy 2015, Garman 2002). Balint groups were initiated by Michael Balint in the Tavistock Clinic, in London, and focussed on the importance of the doctor-patient relationship as a therapeutic tool (Nielsen 2009, Benson 2005, Clarke 2002). Balint groups are groups of GPs, usually facilitated by a psychiatrist, who discuss the doctor-patient relationship and provide peer support. Any member of the caregivers can help the other member group to recall the insight of his own lost “*mindset*”, while he confronts and fights with the expectations and the care of the ‘difficult’ patient. In short, Balint Groups can help also to design better boundaries with these patients. Thus, idealistic and inappropriate beliefs may be changed by the positive feedback from colleagues (Ghetti 2009, Kjeldmand 2008).

### CONCLUSION

Compassion fatigue causes concern among mental health professionals. Psychiatrists are drawn to work with those who are mentally ill, because they value providing care to others and often overlook their own needs. The characteristics that bring people into the caring professions are the very factors that make them vulnerable to vicarious trauma and job burnout. A suitable working environment is necessary to ensure the

welfare of the worker and therefore of our patients. Balint groups can represent a management strategy of CF. Participation in a Balint group should be included in any list of helpful professional activities, along with maintenance of a balance of variety and nature of work, pacing of work, and sufficient release time. Reducing professional burnout may have secondary gains in improving quality of services and consumer outcomes.

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