

Work-related factors that may influence compassion fatigue and compassion satisfaction in mental health professionals.

This paper provides a Commentary on:

Singh, J., Karanika-Murray, M., Baguley, T., & Hudson, J. (2020). A Systematic Review of Job Demands and Resources Associated with Compassion Fatigue in Mental Health Professionals. *International journal of environmental research and public health*, 17(19), 6987. <https://doi.org/10.3390/ijerph17196987>

Key Points

- While many mental health professionals experience compassion satisfaction through their jobs, compassion fatigue (secondary traumatic stress and burnout) is also common at some level, and therefore needs addressing.
- Research evidence on the effectiveness of individual-level interventions to help healthcare providers deal with workplace trauma is inconclusive and research on upstream factors is more limited.
- Work-related factors, such as workload, support from co-workers and supervisors, and relevant training, may have an impact on the development of compassion fatigue.
- Shifting the focus from solely individual-level interventions to also intervening at the organisation level addressing upstream factors may be beneficial.

Abstract

Background: Empathy is an essential therapeutic skill in mental health care, but the emotional strain of working with people who have experienced trauma has the potential to increase the risk of developing compassion fatigue. A systematic review investigated work-related factors in the development and mitigation of compassion fatigue in mental health professionals. **Aim:** The aim of this commentary was to critically appraise the methods used within this systematic review and expand upon the findings in the context of clinical practice. **Methods:** The Joanna

Briggs Institute Critical Appraisal Checklist was used to critically appraise the review. **Results:** While many mental health professionals experience compassion satisfaction through their jobs, compassion fatigue is also common. There is a broad range of factors in the work environment that may influence compassion fatigue, including workload, co-worker and supervisor support, and relevant training. **Conclusion and implications to practice:** Shifting the focus from solely individual-level interventions to also intervening at the organisation level addressing upstream factors may be beneficial. However, further better-quality studies and longitudinal research are needed to confirm the importance and role of these factors.

Key words: compassion fatigue, compassion satisfaction, professional burnout, secondary traumatic stress, work-related factors

Teaser text

Empathy is a necessary skill in mental health care. However, hearing about and caring for others' suffering can be emotionally and physically draining. It can also traumatise those working in helping professions.

Researchers looked at the literature to collect, summarise, and evaluate research evidence on work-related factors that can help mental health professionals deal with suffering. This commentary examined the quality of this evidence review. It also explains how the findings relate to real-life working practice. The authors of this commentary used a specialised assessment tool to determine the quality of the review and its findings.

Findings show that many mental health professionals get pleasure and positive feelings out of their jobs. While others feel emotionally and physically exhausted and traumatised. Workload, support from colleagues and managers, and getting relevant training can affect whether or not mental health professionals can deal with others' suffering. This suggests that it is not enough to ask mental health professionals to care for themselves, but workplaces should also provide

supportive work environments. We need better-quality and long-term research to confirm the importance and role of these factors.

Background

Empathy is an essential therapeutic skill in mental health care, but it can be viewed as a double-edged sword (Russel & Brickel, 2015). On the one hand, it enables mental health professionals (MHPs) to understand their clients' feelings and build a strong therapeutic relationship (Rogers, 1961). It drives MHPs to feel compassion towards their clients facilitating care (Goetz et al., 2010). On the other hand, the emotional burden of 'feeling' other people's suffering on the long-term can come at a great cost to the mental health of those who are able to empathise (Figley, 1995). It has the potential to increase the risk of developing secondary traumatic stress (STS; Stamm, 1999) with symptoms of posttraumatic stress disorder, as well as burnout (Maslach, 1981).

The Professional Quality of Life model (ProQOL; Stamm, 2010) posits that work-, client-, and person-related environmental factors have an impact on the extent to which healthcare professionals experience compassion satisfaction (CS) or compassion fatigue (CF) when providing care. CF in this model is a combination of burnout (feelings of extreme emotional/physical exhaustion leading to reduced productivity and depersonalisation/cynicism; Maslach, 1981) and STS (experiencing traumatic stress as a result of exposure to a traumatised individual; Figley, 1995). Those working in helping professions, such as nursing, psychotherapy, or social work, often experience compassion fatigue, although prevalence levels differ in different professions, perhaps due to the intensity of training received (Ondrejková & Halamová, 2022). Indeed, a recent scoping review by Garnett et al (2023) on CF in healthcare providers revealed that more than half of the participants in all included studies reported high or moderate levels of CF in a variety of different countries, such

as Spain, Greece, and Taiwan. Additionally, a Canadian study found that about a third of psychotherapists reported high levels of STS (Laverdière et al., 2019).

CF can lead to a number of problems, including psychological conditions (e.g. anxiety, depression, mood disorders), addictions (e.g. smoking, alcohol, gambling), reduced ability to empathise, and ultimately a reduction in one's ability to provide optimal care (Mathieu, 2011). Much of the research has focused on individual characteristics, such as emotional intelligence, trauma history, coping and attachment style, self-care (Salloum et al., 2015; Valavanis., 2019; Gleichgerrcht et al., 2013). Therefore, interventions have largely focused on individual-level change, such as psychoeducation (Berger & Gelkopf, 2011), cognitive behaviour therapy (Partlak Günü, sen et al., 2022), motivational messages (Goktas et al., 2023), and mindfulness (Pérez et al., 2022) without considering the broader work-related factors in mitigating CF. Singh et al. (2020) conducted a systematic review aimed at identifying work-related factors that influence both the development and mitigation of compassion fatigue among mental health professionals.

Aim of commentary

This commentary aims to critically appraise the methods used within the review by Singh et al (2020) and expand upon the findings in the context of clinical practice.

Commentary approach

This critical review utilises a RaCES (Rapid Conversion of Evidence Summaries) project methodology. The commentary is a collaborative work between academics, health and care professionals, and people with lived experience converting systematic reviews into evidence summaries to build research capacity in health and care professionals, develop professional networks, and inform practice using the latest scientific evidence. The Joanna Briggs Institute

Critical Appraisal Tool (JBI; Aromataris et al, 2015) for systematic reviews and research syntheses was used to evaluate the review.

Methods of the review by Singh et al (2020)

The review conducted a comprehensive literature search using a range of electronic databases (Web of Science, SCOPUS, PsycINFO, Science Direct, PubMed), to search for peer-reviewed articles prior to January 2020 without time restriction. Hand searches of the references of included studies was also performed. Only English language articles were considered.

Based on the inclusion criteria, studies were included if at least half of their participants were clinical psychologists, counsellors, psychotherapists, psychiatric social workers, psychiatric nurses who worked in organisational settings or other professionals who worked in related allied mental healthcare services. Studies with medical practitioners were excluded (e.g. psychiatrists) due to their mental health training and philosophical approach. The review included any design of quantitative studies with validated measures of compassion fatigue (including the quantitative part of mixed methods studies) that investigated the role of work-related and/or preventative factors of compassion fatigue.

It was unclear how many researchers screened titles, abstracts, and full texts. Uncertainties around eligibility were resolved by discussions with an additional researcher. It was unclear who extracted the data from included studies. The Crowe Critical Appraisal Tool (CCAT Version 1.4; Crowe, 2013) was used to assess the quality of included studies. All studies were assessed by the first reviewer with a small random subset ($n = 5$) independently assessed by three other reviewers. Inductive content analysis was used to analyse the data.

Results of the review by Singh et al (2020)

Study characteristics

Database searches identified a total of 806 articles. After screening titles and abstracts, 157 articles were retained for full-text screening, which identified 15 studies for inclusion in the systematic review. Studies were conducted in a range of different countries, the United States (6), Australia (1), Greece (1), United Kingdom (2), Italy (1), Belgium (1), Israel (1), and Canada (1). Additionally, there was one multisite study (Germany/Austria/Switzerland). All studies were quantitative cross-sectional in design (including five prevalence studies). Eight studies were conducted between 2004 and 2013. The remaining seven studies took place between 2015 and 2019. Included studies used the Professional Quality of Life Scale Version 5 (ProQOL 5) or a previous version of the scale. A total of 3356 participants took part in the studies and included a range of professionals: counsellors, mental health social workers, mental health social work doctoral students, mental health nurses, employee assistance professionals, correctional officers, psychotherapists, and frontline mental health professionals. Only nine studies reported participants' age, which ranged from 36.9 to 59.9 years ($M=47.1$, $SD=7.5$). Just under half of the participants were female. The authors noted the use of a theoretical framework to guide investigation in nine studies.

The authors deemed six studies as 'poor', five studies as 'average', two as 'good', and two as 'very good' based on quartile ranks calculated by the authors from the scores/percentages. Inter-rate reliability showed moderate degree of agreement.

Data synthesis

Prevalence findings (five studies, total N=886; Table 1.)

Compassion fatigue - Burnout

A total of 214 (24.2%) participants in five studies experienced burnout at some level: high (6.6%; n = 58), medium (6.8%; n = 60), and low (10.8%; n = 96) levels of burnout.

Compassion fatigue - Secondary traumatic stress

A total of 178 participants (19.8%) in five studies experienced secondary traumatic stress (STS). Of these, 1.8% (n = 16) reported high levels of STS, 7.4% (n = 65) medium levels, and 10.6% (n = 94) low levels.

Compassion satisfaction

A total of 179 (20%) participants in five studies reported a total prevalence of compassion satisfaction (CS) at different levels. Of these, 5.33% (n = 47) experienced high levels, 10.1% (n = 89) average levels, and 4.8% (n = 42) low levels of CS.

Table 1. Prevalence of compassion fatigue (STS and burnout) and compassion satisfaction

Total N=886 in 5 studies	Compassion Fatigue - STS	Compassion fatigue - Burnout	Compassion satisfaction
Total	24.2% (n=214)	19.8% (n=178)	20% (n=179)
High	1.8% (n=16)	6.6% (n=58)	5.33% (n=47)
Moderate	7.4% (n=65)	6.8% (n=60)	10.1% (n=89)
Low	10.6% (n=94)	10.8% (n=96)	4.8% (n=42)

Findings in relation to the JD-R model

While the review authors reported to set out to conduct an inductive content analysis to examine the role of work-related factors in the development and mitigation of compassion fatigue (CF; burnout, STS) in MHPs, they made the decision during the process to map the findings onto

the Job Demands-Resources Model (JD-R; Demerouti et al, 2001; *Table 2*) used in occupational health psychology. Furthermore, some additional findings were also reported independently of the JD-R model. These included findings regarding the prevalence of CF (burnout, STS) and CS (see above and *Table 1*); as well as the association between STS and burnout. CS was also investigated as an outcome in relation to job resources, which we also included in *Table 2*.

The link between job demands and compassion fatigue

‘Workplace trauma’, ‘workload’ and ‘therapeutic settings’ were categorised as job demands. History of workplace trauma, perceived risk for the future, prediction of clients’ aggressive behaviour, and stress/mental strain as a result of engaging with traumatic clients were found to be associated with increased burnout in six studies. This latter along with involvement in recovery efforts from large-scale traumatic events were statistically significantly linked to increased STS.

Quantitative aspects of workload, such as working hours and number of patients on night shift were predictors of burnout. However, those who worked weekends and had to work more than expected were statistically significantly less likely to experience STS. Qualitative aspects of workload, including having traumatised clients on case load, was associated with increased STS.

Finally, working in inpatient care compared to a community mental health centre was positively linked to both burnout and STS, and using CBT was statistically significantly associated with higher levels of burnout, but not with STS.

The link between job resources and compassion fatigue

Work-related factors classed as job resources were ‘support from co-workers’, support from supervisor’, and ‘organisational support and resources’. Congenial relationships with colleagues, collaborative effort, perceived competence of staff to cope with patient-aggression,

and a sense of belongingness in the workplace were statistically significantly and negatively associated with burnout. Emotional support from colleagues were statistically significantly and negatively associated with both burnout and STS.

Supervisor support, namely support from line manager and regular supervision/consultation with line manager were statistically significantly associated with reduced burnout and STS. A trusting relationship between employee and supervisor had a statistically significant negative association with burnout.

Finally, organisational support and resources that statistically significantly reduced both burnout and STS were the use of evidence-based practices and the degree of working through trauma. Adequate information to work effectively with traumatised clients also made a positive difference, although statistical significance is unclear. Mental health professionals who were provided with employee assistance and received customised training to work with traumatised clients reported statistically significantly lower levels of burnout.

The link between job resources and compassion satisfaction

Emotional support from colleagues, a sense of belongingness and community, and trauma training statistically significantly increased CS. Moreover, support from supervisor/management, evidence-based practice, and training and practice in transpersonal therapy were linked to higher levels of CS, although it is unclear whether these results were statistically significant.

Table 2. Findings of the data synthesis in relation to compassion fatigue (burnout, STS) and compassion satisfaction.

Job demands			
	Compassion Fatigue		
	Burnout	STS	Compassion Satisfaction

Workplace trauma (7 studies)	History of workplace trauma (85)↑	-	-
	Perceived risk for the future (86)↑	-	-
	Prediction of aggressive behaviour of clients (87)↑	-	-
	Stress/mental strain from engaging with traumatic clients (77, 81, 88)↑* F = 24.38, p < 0.001	Stress/mental strain from engaging with traumatic clients (77, 81)↑* F = 10.39, p < 0.01	-
	X	Involvement in recovery efforts from large-scale traumatic events (e.g. 9/11) (78)	-
Workload (4 studies)	Quantitative aspects of workload (e.g. working hours, # of patients on night shift) (84)↑	Incongruent workload expectations (90)↓* R = -0.45, p < 0.01	-
	-	Qualitative aspects of workload (e.g. traumatised clients on case load)↑	-
	X	Quantitative aspect - work on weekends (84)↓* β = -0.57, p < 0.01	-
Therapeutic setting (2 studies)	Inpatient care (compared to community MH centre) (80)↑	Inpatient care (compared to community MH centre) (80)↑	-
	Therapeutic practice in CBT (compared to other orientation) (89)↑* r = 0.20, p < 0.001	X	-
Job resources			
Support from co-workers (5 studies)	Congenial relationships F (4, 169) = 9.64, p < 0.001 (84)↓*	-	-
	Collaborative effort F (4, 169) = 3.76, p < 0.05 (84)↓*	-	-
	Emotional support from colleagues↓*	Emotional support from colleagues ↓*	Emotional support from colleagues ↑*

	IRR = 0.93, p < 0.05 (85)	IRR = 0.87, p < 0.001 (85)	$\beta = 5.33, p < 0.001$
	Perceived competence of staff to cope with patient-aggression \downarrow^* $r = -0.22, p < 0.01$ (87)	-	-
	A sense of belongingness in the workplace \downarrow^* $\beta = -0.35, p < 0.001$ (83)	-	A sense of belongingness in the workplace \uparrow^* $\beta = 0.35, p < 0.01$ (83)
	-	-	A sense of community in the workplace \uparrow^* $r = 0.40, p < 0.01$ (90)
	-	-	Staff always working as a team \uparrow^* M = 32.9, SD = 9.4 compared to less frequent teamwork M = 22.3, SD = 7.5), F (4, 169) = 7.40, p < 0.001 (84)
Support from supervisors (2 studies)	Support from the line manager \downarrow IRR = 0.90, p < 0.01 (85)	Support from the line manager \downarrow^* IRR = 0.92, p < 0.05 (85)	Support from the supervision or management (85)
	Regular supervision \downarrow IRR = 0.87, p < 0.001 (85)	Consultation with the line manager \downarrow^* IRR = 0.92, p < 0.05 (85)	-
	Trust between supervisor and employee \downarrow^* $\beta = -1.2$ 95% CI (-2.038, -0.382) (86)	-	--
Organisational resources and support (6 studies)	Services provided by employee assistance professionals \downarrow^* F = 4.01, p < 0.05 (77)	-	-
	Customised training to work with traumatised clients \downarrow^* $\beta = -0.09, p < 0.05$ (80)	-	Trauma training \uparrow^* M = 43.8, SD = 5.2 than without M = 41.4, SD = 6.6; t (499) = -4.42, p < 0.001 (80)
	Adequate information to work	Adequate information to work effectively	-

	effectively with traumatised clients ↓ (76, 78)	with traumatised clients ↓(76, 78)	
	Use of evidence-based practices ↓* β = -0.12, p < 0.01(80)	Use of evidence-based practices ↓* β = -0.09, p < 0.05 (80)	Use of evidence-based practices ↑(82, 85, 89)
	The degree of working through trauma ↓* r = -0.21, p < 0.05 (82)	Advocating working through trauma but not practicing it ↑* F (2, 91) = 4.84, p < 0.01 (82)	-
	-	-	Training and practice in transpersonal therapy ↑ (89)

STS: Secondary Traumatic Stress; CBT: Cognitive Behaviour Therapy; MH: mental health; SD: standard deviation; M: mean; * reported to be significant correlation; X: no association observed; -: Not investigated. ↑: higher level; ↓: lower level

Association between Secondary Traumatic Stress and Burnout

Five studies found and reported a correlation between STS and burnout although the strength of the correlation varied (*Table 3*).

Table 3. Association between Secondary Traumatic Stress and Burnout

Study	Statistics	Direction and strength of correlation	Scales used
88	r = 0.47, p < 0.01	Positive, moderate	ProQOL (burnout and STS subscales)
82	r = 0.819, p < 0.001	Positive, strong	ProQOL (burnout and STS subscales)
82	Not reported	Positive, very strong	ProQOL (burnout and STS subscales)
83	Not reported	Positive, moderate	ProQOL (burnout and STS subscales)
84	Not reported	Positive, moderate	ProQOL (burnout and STS subscales)
81	r = 0.62, p < 0.01	Positive, moderate	STSS and ProQOL (burnout sub-scale)
*90	<i>STS/emotional exhaustion:</i> r = 0.59, p < 0.01 <i>STS/cynicism:</i> r = 0.39, p < 0.01	Positive, moderate	MBI and ProQOL (STS sub-scale)

	<i>STS/reduced personal achievement:</i> ($r = -0.21, p < 0.01$)		
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* This study was not amongst the five studies mentioned above (81–84,88); ProQOL: Professional Quality of Life Scale; STSS: Secondary Traumatic Stress Scale; MBI: Maslach Burnout Inventory.

Association between compassion satisfaction and components of compassion fatigue

Four studies reported the relationship between CS and components of CF (STS and/or burnout;

Table 4).

Table 4. Association between compassion satisfaction and components of compassion fatigue

Components	Statistics	Direction and strength of correlation	Study
Compassion satisfaction and <i>STS</i>	Ranging between -0.16 and -0.28	Negative, weak	81, 83, 84, 90
Compassion satisfaction and <i>burnout</i>	Ranging between -0.47 and -0.66	Negative, moderate	81, 83, 84, 90

Commentary

Critical appraisal of the review by Singh et al (2020)

Table 5. Critical appraisal using the JBI critical appraisal checklist for systematic reviews and research syntheses (delete the tool which is not relevant)

JBI critical appraisal checklist items	Responses
1. Is the review question clearly and explicitly stated?	No
2. Were the inclusion criteria appropriate for the review question?	Unclear
3. Was the search strategy appropriate?	No
4. Were the sources and resources used to search for studies adequate?	Yes
5. Were the criteria for appraising studies appropriate?	No

6. Was critical appraisal conducted by two or more reviewers independently?	No
7. Were there methods to minimize errors in data extraction?	Unclear
8. Were the methods used to combine studies appropriate?	No
9. Was the likelihood of publication bias assessed?	No
10. Were recommendations for policy and/or practice supported by the reported data?	Yes
11. Were the specific directives for new research appropriate?	Yes

The review by Singh et al (2020) met only three of the 11 criteria of the JBI checklist for systematic reviews and evidence synthesis (Aromataris et al., 2015 (*Table 1*)). The review question was ambiguous affecting the inclusion criteria and data synthesis method. This made it difficult to determine whether the review achieved its objectives without re-organising the findings. There were some inconsistencies and a lack of clarity regarding the inclusion and exclusion criteria for professional roles. A broader inclusion criterion to encompass others working in the field would have allowed for greater diversity and relevance across global contexts. The search strategy did not include alternative terms for compassion fatigue that are commonly used in the literature, such as burnout (Maslach & Jackson, 1981) and secondary traumatic stress (Bride et al., 2007) introducing potential selection bias. While a suitable risk of bias tool was used (CCAT Version 1.4), the authors made some changes to the categories (poor, average, good, very good) without further explanation what these meant. The tool guidance warns that “*Any changes made to the categories, items, or item descriptors, no matter how small, may compromise the validity and reliability of the scores obtained*” (Crowe, 2013, p. 2). The creators of the tool also state that the items do not have equal importance and, therefore, it is not appropriate to add up scores and create categories (Crowe, 2013). Additionally, studies were assessed by one reviewer with only a small random subset (n = 5) independently assessed by other reviewers (rather than the preferred two independent reviewer

assessing all studies), and it was unclear from the reporting who performed data extraction. These issues may have led to systematic errors and bias. Publication bias was not assessed or considered, again potentially impacting on the validity of the findings. While there was a mention of a review protocol, the lack of registration at a prospective register of systematic reviews affected transparency of the review process.

Changes in the data synthesis method was mentioned within the report and the authors claimed that they performed a hybrid deductive/inductive approach. The aim of a hybrid approach to data analysis, where inductive and deductive analyses are combined, is to first map the data onto an existing framework through deductive data analysis, which serves to test the applicability of a model in a particular area or population (Braun & Clarke, 2021). Further inductive analysis ensures that the complexity of the data is captured and themes that do not fit the framework are not forced onto the model (Delve et al., 2024). In this review, the authors planned to inductively analyse the data but instead changed to a deductive approach using a model (JD-R) identified by the review authors during the analytic process. Furthermore, the analysis type used, inductive content analysis (Thomas, 2006), is an analysis method for qualitative data, and therefore not appropriate to use with quantitative data. Vote counting and narrative synthesis may have been a more appropriate analytical approach to take.

Due to the above limitations of the review, the lack of clarity about the quality issues of included studies, the evidence regarding the role of work-related factors in the development and mitigation of compassion fatigue is limited.

In the review, the data was mapped onto the JD-R model (Demerouti et al., 2001; *Figure 1 and Figure 2*), which is a general model of burnout as opposed to CF, and the model does not account for STS and compassion satisfaction. Therefore, this model did not adequately represent CF, which is a combination of burnout and STS as theorised by Stamm (2010) in her

model of PQoL (Figure 3). As all included studies used a version of the PQoL questionnaire, which was developed based on PQoL model (Stamm, 2010) that is specific to healthcare professionals, it may have been more appropriate to map the data onto this model to test its applicability among MHPs (deductive analysis; Figure 4) and through further analysis to demonstrate the importance of work-related factors in the development of both CF and CS and in the mitigation of CF (inductive). Using this more suitable model, all the findings can be linked up with the model.

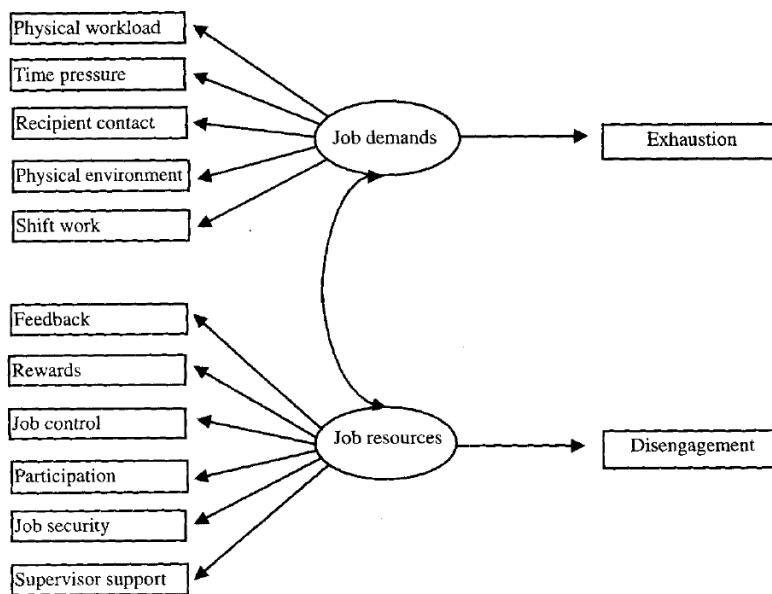


Figure 1. The Job Demands-Resources model of burnout (Demerouti et al., 2001).

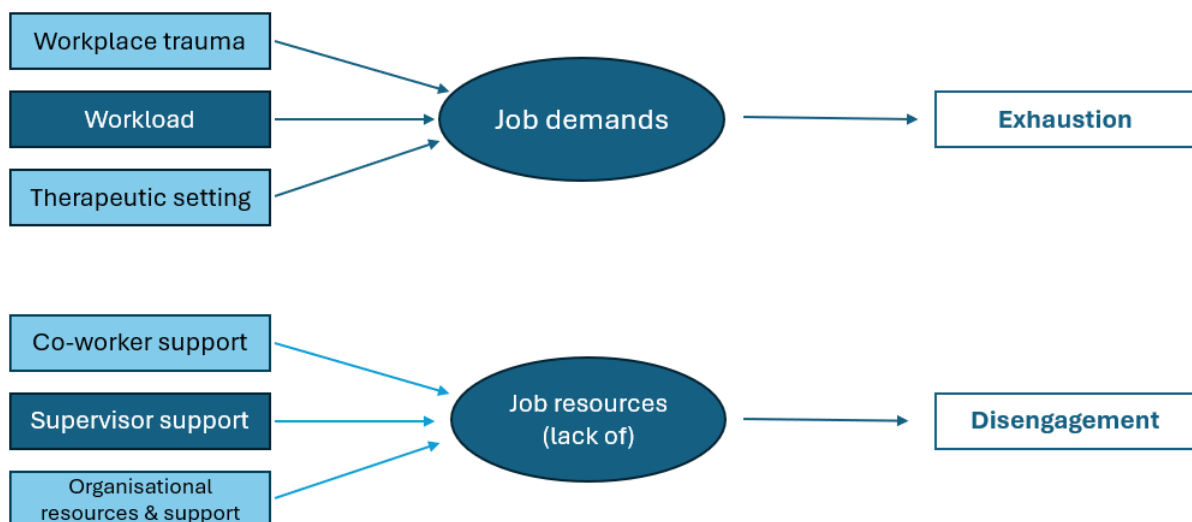


Figure 2. Graphical representation of the findings of the data synthesis mapped onto the JD-R model based on the report by Singh et al (2020). (The items ‘Workload’ and ‘Supervisor support’ correspond to ‘Physical workload’ and ‘Supervisor support’ of the original model, respectively. However, ‘Workplace trauma’, ‘Therapeutic setting’, ‘Co-worker support’, and ‘Organisational resources and support’ (providing trauma-relevant training and information) did not correspond with any of the items on the JD-R model.)

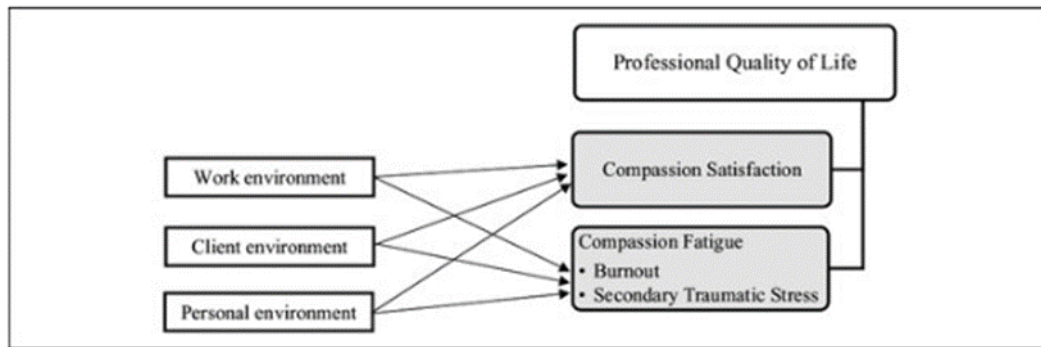


Figure 3. Professional Quality of Life model – compassion satisfaction and compassion fatigue (Stamm, 2010).

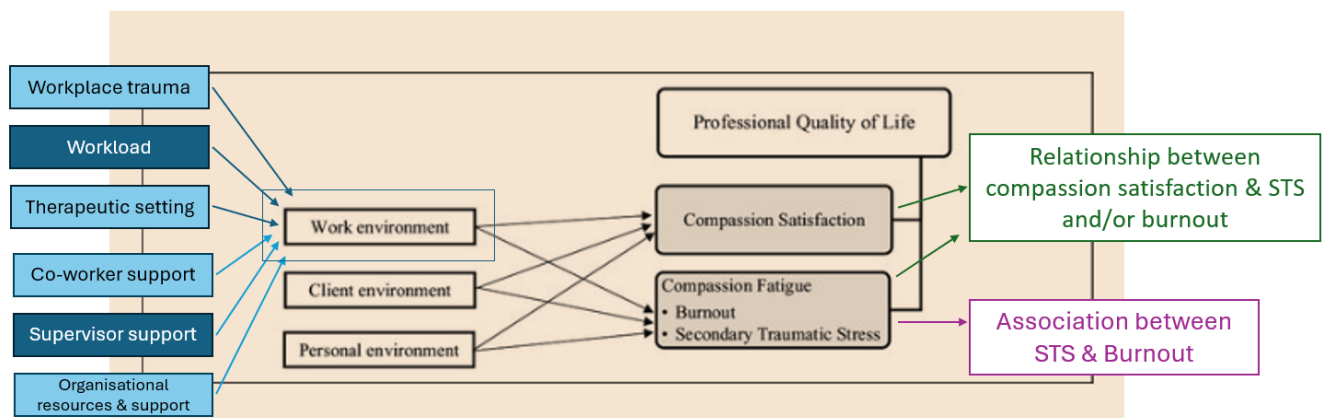


Figure 4. Findings of the review mapped onto the PQoL model. (STS: secondary traumatic stress)

Prevalence data from five included studies indicate that while many mental health professionals seem to experience compassion satisfaction through their jobs, compassion fatigue, both in the form of STS and burnout, is also common at some level, and therefore needs addressing. Mapping the results onto the PQoL model (Stamm, 2010), it is possible to clearly highlight the

broad range of factors in the work environment that may influence CF and their importance to practice and policy over individual-level factors, which was the original aim of the review. In line with other research (Jovanović et al., 2016; Hamaideh, 2011; McFadden et al., 2015; Kiratli & Duran, 2024), the findings of this review indicate that levels of workload, availability of work-based social support, supervision and training are linked to the development of CF in mental health professionals. However, much of the research has focused on individual-level interventions helping healthcare providers deal with workplace trauma. While this work is important, the effect of these interventions is inconclusive due to inadequate research evidence (Patole et al., 2024). On the other hand, reasonable workload, positive relationships, and support from managers and colleagues within the workplace has been found to improve CS (Kiratli & Duran, 2024). Therefore, shifting the focus from solely individual-level interventions to also intervening at the organisational level addressing upstream factors may be beneficial. Better workload management, interventions to promote supportive collegial relationships, increase in relevant training and supervision, and monetary interventions to provide a supportive working environment and achieve better staff retention may be some of the central factors to reduce CF (STS and burnout) and increase CS.

However, further better-quality studies and longitudinal research are needed to confirm the importance and role of these factors. Future systematic reviews should ensure that appropriate frameworks and analysis methods are used to synthesise quantitative data from primary studies, in addition to reviewing the qualitative literature to dig deeper into how work-related factors influence compassion fatigue. Finally, as the reduction of CF is not equivalent to increasing CS, it could be beneficial to include CS as an outcome of focus, as well.

Relevance for clinical practice

Based on the findings, those managing mental health professionals could consider managing workload, promoting supportive collegial relationships, providing relevant training and supervision, and monetary interventions to create a supportive working environment as means of reducing compassion fatigue and increasing compassion satisfaction in their staff.

CPD reflective questions

- What are the main differences between the Job Demands-Resources model of burnout and the Professional Quality of Life model?
- How could the work setting (e.g. community, hospital) influence the development of compassion fatigue?
- What work-related factors do you experience that impact your mental health?

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