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Burnout and Compassion Fatigue in a sample of Victim Support Professionals

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Abstract

Recent research has suggested a high prevalence of burnout and compassion fatigue in helping professions, such as nurses, trauma therapists and social workers. However, no study has previously explored the relationship between compassion satisfaction, burnout and compassion fatigue with Portuguese victim support professionals. The literature has reported that these phenomena have a significant impact on the physical and mental well-being of professionals and consequently defy the quality of the services provided. Thus, this study aims to explore the relationship between compassion satisfaction, burnout and compassion fatigue, personal and structural/institutional factors, which can act as buffers or triggers to the development of these experiences, in particular the practice of self-care and perceived social support from colleagues and supervisors.

The sample consisted of 92 Portuguese victim support professionals from various institutions. Participants responded to the protocol in an online platform. For data collection, the ProQOL5, COPSOQ II, DESCA and a sociodemographic questionnaire including the practice of self-care, years working within the institution and age, were used.

The results revealed low to medium levels of burnout (81.5%) and compassion fatigue (73.9%) and high levels of compassion satisfaction (77.1%) in the participants. It also found that self-care and social support act as buffers for the development of burnout and compassion fatigue, while enhancing job satisfaction and therefore compassion satisfaction.

Key Words: Compassion Satisfaction, Burnout, Compassion Fatigue, Victim Support Professionals, Social Support, Self-care

Burnout e Fadiga por Compaixão numa amostra de Profissionais de Apoio à Vítima

Resumo

A investigação tem demonstrado uma elevada prevalência de *burnout* e fadiga por compaixão em profissões de auxílio/suporte, como enfermeiros, psicólogos e assistentes sociais. Contudo, nenhum estudo terá ainda explorado a relação entre satisfação por compaixão, *burnout* e fadiga por compaixão em Profissionais de Apoio à Vítima Portugueses. Estes fenómenos têm um impacto significativo no bem-estar físico e mental dos profissionais e, consequentemente, aumentam os desafios no serviço prestado por estes. Assim, o presente estudo tem como objetivo explorar a relação entre satisfação por compaixão, *burnout*, fadiga por compaixão e os fatores pessoais e institucionais/estruturais, que atuam como proteção ou como riscos para o desenvolvimento destes fenómenos, em particular a prática de cuidados pessoais e o suporte social recebido por colegas e supervisores.

Esta investigação tem por base uma amostra constituída por 92 técnicos de apoio à vítima portugueses, pertencentes a variadas instituições. Os participantes responderam ao protocolo através de uma plataforma *online*. No presente estudo foram avaliadas dimensões dos instrumentos ProQOL5, COPSOQ II e DESCA, bem como variáveis sociodemográficas como a prática de autocuidado, anos de trabalho na instituição e idade, entre outras.

Os resultados obtidos traduzem níveis baixos a médios de *burnout* (81,5%) e fadiga por compaixão (73,9%) e níveis elevados de satisfação por compaixão (77,1%) na amostra estudada. Verificou-se, ainda, que a prática de cuidados pessoais e o apoio social atuam como amortecedores para o desenvolvimento de *burnout* e fadiga por compaixão, e amplificam a satisfação pelo trabalho e, portanto, a satisfação por compaixão.

Palavras-chave: Satisfação por Compaixão, *Burnout*, Fadiga por Compaixão, Profissionais de Apoio à Vítima, Suporte Social, Autocuidado

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Introduction

There is a cost to caring. Professionals learn that they need to put their personal feelings aside to best administer treatments, but one cannot avoid compassion and empathy (Figley, 2002a).

Professionals who provide support to individuals dealing with traumatic experiences are often exposed to their patients' suffering (Aparicio et al., 2013; Kelly et al., 2015), this chronic day-to-day practice can seriously impact the professionals' quality of life (Nimmo & Huggard, 2013) and may result in conditions known as emotional exhaustion, dissatisfaction and, ultimately, compassion fatigue or burnout (Jeon & Ha, 2012; Mairean, 2016; Newell & MacNeil, 2010) without the proper self-care (Fontin et al., 2020). Compassion fatigue is related to low compassion satisfaction, which derives from positive feelings and increases the ability of the professional to empathize with patients (Martin-Cuellar et al., 2018; Sinclair et al., 2016).

Previous analysis of compassion fatigue were focused on doctors, nurses, social workers and therapists (Fernando & Consedine, 2014; Michalopoulos & Aparicio, 2012; Sodeke-Gregson et al., 2013; Vann & Coyer, 2014) but no study as of yet has focused on the field of victim support professionals working within institutions who provide various types of support to crime victims.

The purpose of this study was to examine the prevalence of compassion fatigue, burnout and compassion satisfaction in a sample of Portuguese victim support professionals. These studies are crucial in order to, consequently, understand which actions both individuals and institutions can take to prevent the development of compassion fatigue and burnout, while stimulating the growth of compassion satisfaction.

I – Theoretical Framework

1.1. Compassion fatigue

Compassion can be characterized as an important attribute in caring and healing (Lee et al., 2019), it depicts the sensitivity to others' pain mixed with the desire to relieve that suffering (Goetz et al., 2017). Taking this into consideration it is safe to say that compassion is a requirement for all human

service providers (Figley & Figley, 2017). The ability to consider and assist those in need depends on the worker's compassion, empathy and efficiency (Figley & Figley, 2017), meaning that support victim professionals need to be deeply sensitive to the pain and suffering of their patients. As Figley and Figley (2017; p. 389) highlighted, "To be compassionate is to be effective in assessing and helping the suffering". In consequence, these professionals tend to share others' suffering, painful information and the associated emotions with shared information. (Lee et al., 2019).

When in contact with individuals that are suffering and that describe their painful situations, workers may develop compassion stress, as a result of a demand to be compassionate and effective in helping (Figley & Ludick, 2017). The stress felt by these professionals often turns into fatigue (compassion fatigue), described as mental exhaustion resulting from the effort that is associated with exposure to other people's physical and emotional suffering (Figley & Ludick, 2017). According to Sodeke-Gregson et al. (2013) there are a few terms that have the potential to describe the negative consequences of working with suffering individuals, such as compassion fatigue, secondary traumatic stress, vicarious traumatization and burnout.

The concept of Compassion Fatigue (CF) has been used since 1992 when Joinson (1992) first conceptualized the term in a nursing magazine in order to describe a state of reduced ability to feel compassion for patients due to a consequent exhaustion of sharing and "absorbing" the suffering of others. Many other authors have studied this concept, each one presenting their own definition, but never straying too far from the original one (Bride et al., 2006).

Figley (1995a, 2002b) characterizes CF as a state of biologic, psychologic and social deregulation caused by the prolonged exposure to other people's traumatic stress. Working with an individual's suffering implies the need to create a close connection between the health professional and the patient (Lago & Codo, 2010). CF is based on the feeling of empathy and connection with the person in distress and that it is closely linked to the desire to alleviate this suffering. Thus, CF is the consequence of a build-up of secondary traumatic stress resulting of "day after day of feeling cumulative stressors from delivering human services to suffering clients"

(Figley & Figley, 2017, p. 5), that can become harmful for the professional. The persistent resource to compassion and empathy creates an environment where CF can grow and take over the professional's work and personal life.

Previous studies (Adams et al., 2006; Bride et al., 2007; Stamm, 2002, 2009) argue that compassion fatigue consists of an overlap of symptoms of secondary traumatic stress and burnout. On the other hand, Figley (1995a, 2002a, 2002b) refers to empathetic engagement as the primary channel for the transmission of traumatic stress, as professionals put themselves "in the shoes" of the person in distress, sharing their feelings and thoughts. This process is necessary in order to personalize the help that the individual is requiring. Therefore, professionals risk the burden of feeling and experiencing CF, but they cannot avoid their compassion and empathy, given that they need to access the world view of the client in order to adjust their services and responses (Figley, 2002a).

Like other types of fatigue, CF tends to diminish the capacity and interest in "bearing the suffering of others" (Figley, 2002a, p. 1434). According to Galek et al. (2011), CF is a syndrome composed of five components, namely: frequent and intense encounters with clients; physical and mental fatigue states; challenges to values, beliefs and world view; exposure to traumatized clients and expectable stress responses. These components are best summarized in two main processes: "too tired to care" and "having to forgo compassion in an effort to protect oneself from despair" (Lee et al., 2019, p. 769). Professionals that develop CF might suffer from a variety of negative emotions (Mairean, 2016), namely, become less interested and competent to feel empathetic (Fontin et al., 2020) and develop an impaired ability to make decisions and care for clients (Cocker & Joss, 2016). The mentioned consequences are related with the severity of the traumatic material, the type of contact with the victim and the degree of the description of a graphic nature (Cocker & Joss, 2016).

Although compassion and empathy are imperative conditions in building a relationship between mental health professionals and clients, they can result in the development of compassion fatigue that poses a risk to the professional's well-being (Carvalho & Sá, 2011).

According to the existing literature (Adams et al., 2006), CF is a broad concept which encompasses secondary traumatic stress and burnout, so it is

clear that there are overlaps between these phenomena (Stamm, 2002, 2009).

1.2. Burnout

Burnout (BO) has been defined in a number of ways. Nevertheless, the most accepted one describes BO through three dimensions, feelings of emotional exhaustion, depersonalization, and reduced personal accomplishment (Lee et al., 2019; Maslach & Jackson, 1981; Maslach et al., 2001). Regarding the dimension of emotional exhaustion, professionals might feel depleted, overextended, and fatigued (Morse et al., 2012; Newell & MacNeil, 2010). Depersonalization, which can also be called cynicism, refers to negative and cynical attitudes towards clients and/or work in general, making responses excessively detached (Maslach et al., 2001). Cynicism is a crucial symptom of BO, especially when referring to individuals that work with victims of violence, due to the fact that, even though a certain amount of cynicism serves to relieve tension and tends to help dealing with others misery and suffering, it can become hugely dangerous given that it can turn into brutalization and contempt, which takes a toll on the type of care that is given (Pross, 2006). The reduced personal efficacy can occur when patients do not respond to the help, despite efforts, generating feelings of inefficiency and self-devaluation in professionals (Newell & MacNeil, 2010). The administrative demands and bureaucratic limitations, which are extremely present in psychology related work and within working in institutions, can also be one of the reasons as to why the feeling of reduced accomplishment might be present (Newell & MacNeil, 2010). These prompts of BO can include qualitative and quantitative overload, role conflict and ambiguity, lack of participation, and lack of social support (Shirom, 2003).

It is argued that the most idealistic workers experience more burnout, since they tend to work harder toward their goals, which can lead to exhaustion and cynicism (Angerer, 2003). It is natural for these professionals to incessantly invest emotional, cognitive and physical energy, but this dedication can cause emotional exhaustion, mental tiredness and fatigue (Shirom, 2003). Maslach et al. (2001) proposed a model focused on the compatibility among six domains present in the job environment and the professional, namely: work overload; lack of control; insufficient reward; breakdown of community; absence of fairness and conflicting values. Other

authors hypothesize that burnout can be caused by unmet job expectations and specific aspects of a worker's job experiences (Jackson et al., 1986). There are two types of expectations: achievement expectation and organizational expectation, although the existing literature highlights the first one as the most invoked when discussing causes of burnout.

Professionals that provide care to traumatized individuals, who are often victims of violence and crime, are at higher risk of developing burnout (Maslach & Jackson, 1984; Pross, 2006). Professionals that experience BO tend to have impairments regarding their emotional and physical health, an increased probability of developing depression, anxiety, sleep problems, impaired memory (Morse et al., 2012), apathy, hopelessness, irritability, uncaring and cynical attitude towards clients and a feeling of failure (Pross, 2006), as well as a deterioration of social and family relations (Zellars et al., 2000).

Stamm (2005) argued that BO incorporates the phenomenon of compassion fatigue, associated with thoughts of hopelessness and feelings of powerlessness at the level of work performed. Withdrawal as a coping strategy (Cherniss, 1980) develops as a consequence of indirect exposure to traumatic information, and additionally because of a great responsibility for handling victims in severe distress (Ben-Porat & Itzhaky, 2015).

While there are several studies that connect BO with personality and demographic characteristics, the majority of literature points to workplace variables as the primary trigger for BO (Maslach & Leiter, 2016), causing professionals to lose opportunities for a satisfying work experience and making burnout a direct cause of job dissatisfaction (Angerer, 2003).

1.3. Compassion satisfaction

A sense of satisfaction is considered a protection against the development of compassion fatigue. In fact, there is a feeling of satisfaction involved in working with trauma victims (Figley & Ludick, 2017).

The concept of Compassion Satisfaction (CS) refers to the pleasure that arises from the feeling of being able to work properly (Mangoulia et al., 2015), in this case, being able to properly help others (Mairean, 2016). Therefore, CS creates an ability to experience joy, gratification and sense of purpose in professionals that provide care (Mairean, 2016), which allows them to balance

the negative effects of caring by creating resilience (Burnett & Wahl, 2015).

Larsen and Stamm (2008) suggested that there are three elements to CS: the first is the level of satisfaction that an individual gets from their job; the second consists of how well a person feels they are doing their job, in relation to their levels of competence and control; and lastly the level of positive institutional support that a person has.

Compassion satisfaction is also found to be greatly associated with higher levels of work experience in domestic violence services, especially when professionals share the institution's values (Kulkarni et al., 2013). Also, on this line of work, it was possible to understand that, although some workers manifest secondary traumatic stress and burnout, they were capable of feelings of compassion satisfaction (Conrad & Kellar-Guenther, 2006). Somehow the positive impact of seeing victims healing and being a part of that process, expressly feeling CS, (Bell, 2003; Stamm, 2005) helps to balance the negative conditions surrounding the work with these people.

High compassion satisfaction increases the ability to empathize with patients and contributes to their recovery (Mairean, 2016; Sinclair et al., 2016). Taking into consideration the ways that compassion satisfaction can be promoted within institutions is a step forward in the direction of a positive goal that consists of enhancing workers wellness and their given services (Kulkarni et al., 2013).

1.4. Risk vs protective factors for the development of CF and BO

The impact caused by working with victims of trauma can vary depending on the individual's condition (Sodeke-Gregson, 2013). Some professionals are at greater risk of suffering from compassion fatigue and burnout than others. For example, the development of CF and BO is more common in professionals with limited social support (Adams et al., 2006, p.104). Social support is considered a vital resource in maintaining an emotional equilibrium in a response to stress (Beehr et al. 2003; Vermeulen & Mustard, 2000), while the lack of it can lead to BO.

A perceived support from family and friends during difficult times can provide the required resources to strengthen the professional's perceived ability to deal with difficulties at work (Galek et al., 2011). This also prevents a sense of isolation and allows the workers to stay in touch with positive

aspects of humanity (Yassen, 1995), providing, at the same time, people to rely on in times of need. After all, the person's emotional strengths and the social support provided by loved ones are defenses against symptoms of compassion fatigue (Figley & Barnes, 2005; Phipps & Byrne, 2003). It is clear that professionals have a need for a fulfilling personal life that will act in contrast to struggles and difficulties present in their job (Knight, 2013). The social support provided from professional colleagues, such as taking on a difficult client, comparative feedback or emotional support (Phipps & Byrne, 2003; Ray & Miller, 1994), has shown to be crucial, not just for good work environment, but also to diminish burnout and high levels of stress (Galek et al., 2011).

Burnout has a slow development, and it can take years to settle in the person's life (Maslach et al., 2001). The measures used when investigating BO have as time reference the number of years spent in the same position and the years in the same profession (Birck, 2001; Galek et al., 2011). Although in some studies the amount of casework is associated to burnout and compassion fatigue (Craig & Sprang, 2010), in others this connection was not found (Devilly et al., 2009; Schauben & Frazier, 1995). Structural factors of the workplace, such as perceived support, provision of trauma-specific training, remuneration and working for public institutions (Sodeke-Gregson, 2013) also needs to be taken into account when assessing compassion fatigue and burnout.

Another particularly important condition is self-care, which involves the use of strategies and skills to maintain personal, familial, emotional, and spiritual needs despite dealing with clients and professional challenges (Figley, 2002). Strategies such as setting realistic goals regarding workload, maintaining positive connections with others (Maslach, 2003), having moments of relaxation and coffee and lunch breaks are suggested as ways to prevent the development of burnout. The growth of individual self-care routines also helps when workers are already struggling with symptoms of compassion fatigue. In these routines there should be incorporated positive forms of self-expression, like drawing, painting and other pleasure bringing activities (Newell & MacNeil, 2010). It is possible to notice that the use of common tactics, like exercise, good quality nutrition and adequate sleep also act as buffers to the development of negative conditions provoked by work

(O'Halloran & O'Halloran, 2001; Zimering et al., 2003).

Variables such as age and perceived management support were significant predictors of compassion satisfaction (Sodeke-Gregson, 2013), nonetheless other studies have suggested that younger workers as well as older workers, with more years of experience, described higher levels of stress when compared to professionals with an ordinary work experience (Steed & Bicknell, 2001).

Further, a high level of resilience will result from the optimization of protective factors, namely self-nurturance, detachment, sense of satisfaction and social support (Figley & Figley, 2017). Eventually, the side effects of working with crime victims and consequently the exposure to trauma material, might be mitigated by cultural and individual resilience factors (Cieslak et al., 2014).

In Portugal, the research on CF is scarce, particularly with regard to compassion fatigue in professionals who deal with crime and trauma victims.

The Present Study

Previous studies have explored the relationship between Compassion Fatigue, Burnout and Compassion Satisfaction in professionals who care for victims of trauma and crime, such as nurses (Cruz & Pinto-Gouveia, 2014), palliative heath care providers (Carvalho & Sá, 2011) and trauma therapists (Canfield, 2005; Craig & Sprang, 2010; Sodeke-Gregson et al., 2013). Research has shown that these workers are more inclined to suffer from compassion fatigue and burnout than others that deal with non-trauma victims, having symptoms that are exclusive to this occupation (Beck, 2011). Such symptoms are associated with the fact that, when dealing with crime victims, these professionals are exposed to emotionally shocking material from patients (Canfield, 2005), having a high chance of also being traumatized indirectly. It is important to notice that, according to Figley (1995), the term compassion fatigue is a more appropriate way to reference secondary traumatic stress, when discussing healthcare professionals, meaning that the two concepts can be used interchangeably. Additionally, most of the above-mentioned professionals work in public settings, (e.g., public sector institutions), making the chance of suffering from burnout higher, in the sense

that these workers tend to experience more emotional exhaustion and depersonalization and less personal accomplishment (Ackerley et al., 1998).

However, no study has previously explored the relationship between compassion fatigue, burnout and compassion satisfaction with Portuguese victim support professionals, who work within institutions that deliver qualified and professional support to crime victims, at no cost.

II - Objectives

The general objective of this study is to analyze the presence of Compassion Fatigue, Burnout and Compassion Satisfaction in a sample of Portuguese victim support professionals. The path to the general aim is based in three specific goals: a) to detect the presence of Compassion Fatigue (CF), Burnout (BO) and Compassion Satisfaction (CS) in the participants; b) to analyze the influence of sociodemographic variables, such as the number of years that professionals have been working for the institution and the perceived social support, on the results of CF, BO and CS; c) to evaluate how CF, BO and CS are connected to institutional factors, such as administrative demands and bureaucratic limitations.

In summary, this study dwells on the following questions: Are Portuguese victim support professionals suffering from compassion fatigue? Is compassion fatigue related to burnout and compassion satisfaction?

III - Method

Sample

The sample is composed of 92 victim support professionals, 85 (92.4%) female and 7 (7.6%) male, with a mean age of 35 (M = 35.24; SD = 8.66). The participants were mainly single (n = 56; 60.95%) and did not have any children (n = 53; 57.6%). Regarding the educational level, 47.8% (n = 44) have their master's degree, 44.6% (n = 41) their bachelor's degree and the remaining 7.6% (n = 7) have other types of higher education. Regarding the participants' performed role, in the institution, 32.6% (n= 30) are managers, directors or coordinators, 15.2% (n = 14) are general support victim professionals (SVP), 21.7% (n = 20) are SVP who also perform the role of psychologists, 9.8% (n = 9) are social assistants, 7.6% (n = 7) are interns, 4.3%

(n = 4) are volunteers, 2.2% (n = 2) are SVP, with a degree in law, who provide juridic support, and 6.5% (n = 6) of the sample occupy other roles.

The time that the participants have been working in victim support institutions ranges from 0-2 years (n = 34; 37%) to 25-30 years (n = 2; 2.2%), including 2.5-5 years (n = 16; 17.4%), 5.5-10 years (n = 12; 13%), 10.5%-15 years (n = 12; 13%), 15.5-20 years (n= 8; 8.7%) and 20.5-30 years (n = 8; 8.7%).

Measures

A **sociodemographic and professional data questionnaire** was administered in order to gather information regarding gender, age, marital status, level of education, core education, role in the institution and the period of time during which they have been working in said institution. The participants were also questioned about their social support group, free time activities, as well as their self-care routines.

The ***Copenhagen Psychosocial Questionnaire II (COPSOQ II,*** Copenhagen Psychosocial Questionnaire; Kristensen, 2001; Portuguese Version taken from Silva et al., 2011).

The medium version of the COPSOQ II is a 76-item scale designed to measure the concept of "work stress" by trying to explain stress as a consequence of the high demands in the workplace and of low social support. The COPSOQ II has 28 scales, namely: Quantitative Demands (three items); Work Pace (one item); Cognitive Demands (3 items); Emotional Demands (one item); Influence at Work (four items); Possibilities for Development (three items); Predictability (two items); Role Clarity (three items); Recognition (three items); Role Conflicts (three items); Social Support from Colleagues (three items); Social Support from Supervisors (three items); Sense of Community at Work (three items); Quality of Leadership (four items); Horizontal Trust (three items); Vertical Trust (three items); Organizational Justice (three items); Self-Efficacy (two items); Meaning of Work (three items); Commitment to the Workplace (two items); Job Satisfaction (four items); Job Insecurity (one item); Self-rated Health (one item); Work Life Conflict (three items); Sleeping Troubles (two items); Burnout (two items); Stress (two items); Depressive Symptoms (two items) and Offensive Behaviors (four items).

The instrument is a valid and reliable tool for workplace settings (Kristensen et al., 2005), it is comprehensive and includes several psychosocial dimensions related to health, designed to be applied in occupational health professionals.

The Cronbach's alpha for dimensions such as Work Pace, Emotional Demands, Job Insecurity and Self-Rated Health were impossible to calculate since these subscales have only one item (Silva et al., 2011). The original studies suggest that the Cronbach's alpha was lower than 0.70 for seven of the scales, due to said scales having only two to three items (Kristensen et al., 2005). The investigation also revealed a good overall reliability and little overlap between the dimensions, making the COPSPQ II a valid and reliable tool for workplace assessments, analytic research, interventions and international comparisons (Silva et al., 2011; Rosário et al., 2017; Kristensen et al., 2005). The COPSOQ II is comprehensive and incorporates most of the pertinent dimensions according to several theories on psychosocial factors at work.

Only 16 out of the 28 scales were used, the following were chosen according to pertinence to the present study: Quantitative Demands (α = .76); Emotional Demands; Predictability (α = .79); Role Conflicts (α = .82); Social Support from Colleagues (α = .85); Social Support from Supervisors (α = .895); Sense of Community at Work (α = .85); Self-Efficacy (α = .71); Meaning of Work (α = .76); Job Satisfaction (α = .797); Work-Life Conflict (α = .81); Sleeping Troubles (α = .78); Burnout (α = .80); Stress (α = .66); Depressive Symptoms (α = .77); Offensive Behaviors (α = .69). The remaining scales registered acceptable internal consistency with coefficients surrounding values close to 0.70, except the ones that only had one item and the Commitment to the Workplace scale that showed a Cronbach's alpha of 0.31.

The Professional Quality of Life Scale, Version 5 (**ProQOL5**, Stamm, 2009; Portuguese Version taken from Carvalho & Sá, 2011).

The ProQOL5 is a 30-item scale organized in three dimensions related to the professional quality of life when working with individuals who are suffering and traumatized: compassion satisfaction (CS; e.g. "I get satisfaction from being able to help people."), burnout (BO; e.g. "I feel worn out because of my work as a helper.") and compassion fatigue (CF; e.g. "I am preoccupied

with more than one person I help".). The participants were asked to rate how frequently they experienced each item, over the last 30 days, using a Likert scale from 5 (very often) to 1 (never). The alpha reliabilities of the Portuguese Version (Carvalho & Sá, 2011) are α = .86 for CS, α = .71 for BO and α = .83 for CF, being close to the original reliabilities obtained with the original ProQOL (Stamm, 2009) (α = .88, .75 e .81). In the present study, CS presented a Cronbach's alpha of .89, α = .73 for BO and α = .69 for CF, revealing a good and reasonable internal consistency.

The ProQOL has been analyzed in various samples of professionals, including nurses (Young et al., 2011; Berger et al., 2015), therapists who work with trauma victims (Sodeke-Gregson et al., 2013) and healthcare providers (Mairean et al., 2016), showing to be reliable and valid as a measure of burnout, compassion fatigue and compassion satisfaction.

Scale of Social Desirability (DESCA; Alberto, Oliveira, & Fonseca, 2012).

DESCA was designed to measure social desirability and it consists of 15 items using a Likert scale ranging from 4 ("Completely agree") to 1 ("Completely disagree") to select for each question. The present instrument assesses three dimensions: "Search for Social Approval" (SSA) (e.g., "It is important that everyone else likes me"); "Social Image Management" (SIM) (e.g., "I like everyone I meet") and "Relational Dependency" (RD) (e.g., "I need people to tell me I'm doing something right so I can feel confident"). The Cronbach's alpha for internal reliability of α = .757, is acceptable. In the present study, the three subscales revealed a good internal consistency (α = .82 for SSA; α = .78 for SIM and α = .77 for RD).

Procedure

The present study was approved and distributed by two large Portuguese entities that provide victim support, the Portuguese Association for Victim Support and the Commission for Citizenship and Gender Equality. The informed consent was obtained from all the participants. The participants were informed that their participation in the study was voluntary, that the personal information was confidential and would not take part in any type of evaluation in the workplace. The participants completed all measures, in the digital platform GoogleForms, anonymously to protect their confidentiality,

in the following order: the sociodemographic and professional data questionnaire, the COPSOQ II, ProQOL_5, and DESCA. The authorizations, from the original authors, required for the use of the instruments, were acquired. This study follows the Declaration of Helsinki scrupulously, as a statement of ethical principles to provide guidance when researching human subjects. The research protocol had an average filling time of 20 minutes.

IV - Results

Descriptive Statistics of the variables under study

Mean, standard deviation, dispersion measures and internal consistency of the variables under study are described in Table 1.

Table 1. Mean, Std. Deviation, Skewness, Kurtosis and Cronbach's alpha (α) of the variables present in this study (N= 92)

	M	SD	Skewness	Kurtosis	α
CS	39.67	5.82	-,322	-,510	.89
BO	21.35	5.11	.181	-.163	.73
CF	21.37	4.93	.715	.635	.69
Quantitative D.	8.48	2.57	-.179	-.638	.76
Emotional D.	4.30	.822	-.986	.251	-
Predictability	7.03	1.98	-.230	-.359	.79
Role Conflicts	8.47	2.57	-.377	-.535	.82
S.S. Colleagues	11.53	2.61	-.596	-.286	.85
S.S. Supervisors	9.89	3.097	-.239	-.634	.90
Sense of C. Work	12.49	2.299	-.665	-.231	.85
Self-Efficacy	8.08	1.19	-.110	-.289	.71
Meaning of Work	13.24	1.69	-.608	-.741	.76
Job Satisfaction	14.90	2.90	-.276	.230	.80
Work-Life Conflict	8.77	2.83	.042	-.545	.81
Sleeping T.	5.05	2.14	.120	-1.29	.78
Burnout	6.18	1.96	-.202	-.744	.80
Stress	6.13	1.74	-.385	-.369	.66
Depressive S.	4.72	1.95	.537	-.090	.77
Offensive B.	4.40	1.14	3.94	17.03	.69
Search for Social Approval	10.85	3.42	.665	.869	.82
Social Image Management	12.74	3.06	-.439	.222	.78
Relational Dependency	10.34	2.81	-.241	-.440	.77

Note. CS = Compassion Satisfaction; BO = Burnout; CF = Compassion Fatigue; Quantitative D. = Quantitative Demands; Emotional D. = Emotional Demands; S.S. Colleagues = Social Support from Colleagues; S.S. Supervisors = Social Support from Supervisors; Sense of C. at Work = Sense of Community at Work; Sleeping T. = Sleeping troubles; Depressive S. = Depressive Symptoms; Offensive Behaviors

Regarding the descriptive statistics of the variables under study it was found that the measures have an adequate internal consistency. The preliminary analysis showed a non-normal distribution regarding some of the variables, non-parametric tests were used for those, and parametric tests were used when assessing correlations since the size of the sample was large.

ProQOL5's cut-offs in the present sample

The overall values obtained in the Compassion Satisfaction (CS), Burnout (BO) and Compassion Fatigue (CF) factors from ProQOL5, were converted to Zscores. These Zscores were then transformed into Tscores, forcing a mean of 50 and a standard deviation of 10, as recommended by Stamm (2009). This procedure allows comparisons between the values of the three dimensions and a comparison with the values obtained from ProQOL5 in other studies.

Table 2. ProQol5's Tscores cut-offs - Original version (Stamm, 2009); Portuguese version (Carvalho & Sá. 2011); Current study

		CS Original; Portuguese; Current	BO Original; Portuguese; Current	CF Original; Portuguese; Current
Percentiles	25	44; 44; 43.69	43; 42; 43.45	42; 41; 41.64
	50	50; 50;49.70	50; 50; 59.30	50; 49; 48.24
	75	57; 59; 59.15	56; 56; 55.20	56;57; 57.36

Frequencies and percentages of CS, BO and CF in the sample

By analyzing the scores obtained individually from CS, BO and CF, after the transformation of the original values into Tscores, and comparing them with the cutoff points stipulated by Stamm (2010), it was found that 77.1% of the sample reported medium to high levels of Compassion Satisfaction (n = 71), 81.5% revealed low to medium levels of Burnout (n = 78) and 73.9% of the participants demonstrated low to medium levels of Compassion Fatigue (n = 68). Nevertheless, 18.5% of the sample showed a

high level of Burnout and 26.1% a high level of Compassion Fatigue (Table 3).

Table 3. Frequencies and percentages of CS, BO and CF

	Level	*N*	%
CS	Low	21	22.8
	Medium	44	47.8
	High	27	29.3
BO	Low	28	30.4
	Medium	47	51.1
	High	17	18.5
CF	Low	31	33.7
	Medium	37	40.2
	High	24	26.1

The influence of sociodemographic variables on CS, BO and CF results

It was sought to understand the influence that sociodemographic variables such as gender, age, years working in the institution, marital status, level of education, core education and role performed in the institution had in the CS, BO and CF results. In order to analyze that the Mann-Whitney U test was used when dealing with variables like age, years working in the institution and the practice of self-care. On the other hand, when analyzing variables such as marital status, level of education, core education and role performed in the institution, the H de Kruskal-Wallis test was utilized.

The variable age was reconfigured into two groups, people with ages lower then 35 (22 to 34 years old; n = 46) and above 35 (35 to 55 years old; n = 46) taking into account the average age of the sample, as well as the variable 'years in service': < 8 (0 to 7 years; n= 55); ≥ 8 (8 to 30 years; n = 37).

Significant differences were found in the BO results due to the practice of self-care (U = 549.500; W = 2565.500; p = 0.002; d = 0.67), with a medium size effect (Cohen, 1988). Significant differences were also found in the BO results due to the practice of a healthy lifestyle (U = 546.000; W = 799.000; p =.04; d = .44) and CF (U = 518.000; W = 799.000; p = .02; d = .496), exhibiting both a medium effect size (Cohen, 1988).

No significant differences were found for age (CS: U = 929.500; W = 2307.500; p = .38; BO: U = 980.500; W = 2358.500; p = .64; CF: U = 1012. 000; W = 2390.000; p = .83) , gender (CS: U = 283.000; W = 311.000; p = .83; BO: U = 289.500; W = 317.500; p = .91; CF: U = 262.000; W = 3917.000;

p = .60), years working in the institution (CS: U = 875.000; W = 1505.000; p = .32; BO: U = 793.500; W = 2446.500; p = .10; CF: U = 891.500; W = 25440.500; p = .39), marital status (CS: X2kw(2) = .248; p = .88; BO: X2kw(2) = .316; p = .85; CF: X2kw(2) = .188; p = .91), level of education (CS: X2kw(4) = 3.182; p = .53; BO: X2kw(4) = 4.444; p = .35; CF: X2kw(4) = 2.720; p = .61;), core education (CS: X2kw(4) = 3.060; p = 55; BO: X2kw(4) = 4.776; p = 31; CF: X2kw(4) = 3.593; p = .46) and role performed in the institution (CS: X2kw(7) = 4.793; p = .69; BO: X2kw(7) = 2.859; p = .898; CF: X2kw(7) = 4.832; p = .68).

The effect of professional/institutional variables on COPSOQ results

Significant differences were found in quantitative demands (U = 718.500; W = 2371.500; p = .02; d = .48), role conflicts (U = 729.000; W = 2382.000; p = .03; d = .46) and social support from supervisors' results (U = 626.500; W = 1256.500; p = .03; d = .66) according to the time during which they have been working in said institution. These results showed a medium effect size (Cohen, 1988), while self-efficacy displayed a large effect size (U = 551.000; W = 1181.000; p <.001; d = .81), attributed to time working in the institution.

Social Support from supervisors (U = 791.500; W = 1611.500; p = .04; d = .41) and self-efficacy (U = 754.000; W = 1574.000; p = .02; d = .48), also presented significant differences due to the age variable. Both displayed a medium effect size (Cohen, 1988).

Furthermore, significant differences were detected in the burnout (U = 570.000; W = 2586.000; p = .003; d = .63), stress (U = 536.500; W = 2552.500; p = .001; d = .7) and depressive symptoms' results (U = 638.000; 2654.000; p = .02; d = .497) due to the practice of self-care. All three variables presented a medium effect size (Cohen, 1988).

Regarding specific actions present in the practice of self-care it was found that spending alone time and leading a healthy lifestyle shows significant differences, with a medium effect size (Cohen, 1988), in the variables work-life conflict (U = 463.000; W = 716.000; p = .005; d = .61) and job-satisfaction (U = 489.000; W = 2974.000; p = .009; d = .56). As for meditative and relaxation activities it revealed significant differences in stress (U = 628.000; W = 1189.000; p = .004; d = .61), burnout (U = 620.500; W =

1181.500; p = .004; d= .63) and depressive symptoms (U = 727.000; W = 1288.000; p = .04; d = .43), all three variables show a medium effect size according to Cohen (1988). Concerning social activities, it too was found to impact, in a significant way, burnout results (U = 67.000; W = 77.000; p = .035; d = .45), presenting a medium effect size (Cohen, 1988).

Significant differences were also found in stress (U = 749.000; W = 1529.000; p = .02; d = .48) and burnout' results (U = 752.000; W = 1532.000; p = .02; d = .48) results due to the practice of physical exercise, both variables presented a medium effect size according to Cohen (1988).

Correlations between CS, BO and CF, and institutional factors

To analyze the correlation between CF, BO and CS as measured by the ProQOL5, and the sixteen dimensions used from the COPSOQ, specifically, Quantitative Demands, Emotional Demands, Predictability, Role Conflicts, Social Support from Colleagues, Social Support from Supervisors, Sense of Community at Work, Self-Efficacy, Meaning of Work, Job Satisfaction, Work Life Conflict, Sleeping Troubles, Burnout, Stress, Depressive Symptoms and Offensive Behaviors, the Pearson Coefficient was used (Table 4).

The data obtained registered significant positive moderate correlations (Cohen, 1988) between CS and Social Support from Colleagues (r = .364; N = 92; p <.001), CS and Job Predictability (r = .301; N = 92; p = .004), CS and Job Satisfaction (r = .459; N = 92; p <.001). CS was positively and strongly correlated (Cohen, 1988) with Self-Efficacy (r = .538; N = 92; p <.001), as well as Meaning of Work (r = .658; N = 92; p <.001). On the other hand, significant negative moderate correlations (Cohen, 1988) were found between CS and Stress (r = -.439; N = 92; p <.001), CS and Depressive Symptoms (r = -.453; N = 92; p <.001).

As for BO it was possible to understand significant positive moderate correlations (Cohen, 1988) between this variable and Quantitative Demands (r = .335; N = 92; p = .001), BO and burnout (r = .478; N = 92; p <.001) plus BO and Depressive Symptoms (r = .497; N = 92; p <.001). BO was positively and strongly correlated (Cohen, 1988) with Work-Life Conflict (r = .526; N = 92; p <.001) and Stress (r = .534; N = 92; p <.001). While significant negative moderate correlations were also observed with Meaning of Work (r = -.411; N = 92; p <.001) and Job Satisfaction (r = -.423; N = 92; p <.001).

CF was positively correlated, in moderation (Cohen, 1988), with Quantitative Demands (r =.404; N = 92; p <.001), Emotional Demands (r = .352; N = 92; p = .001) and Sleeping Troubles (r = .365; N = 92; p <.001), plus Depressive Symptoms (r = .365; N = 92; p = .002). While also displaying significant positive strong correlations (Cohen, 1988) between CF and Work-Life Conflict (r = .561; N = 92; p <.001), CF and Burnout (r = .526; N = 92; p <.001), and CF with Stress (r = .505; N = 92; p <.001).

It was possible to observe that workers who scored high levels of BO and CF also revealed more workload, emotional demands, time and energy spent at work that affected their personal lives, exhaustion, irritability, sadness and lack of interest. Still, it is possible to see that professionals with a high sense of CS feel that they work in a good, well-informed environment, where they feel supported and helped by colleagues and supervisors, giving them good conditions and perspectives in the workplace, as well as a sense of ability in their job.

Table 4. Coefficients from Pearson's Correlation between the variables present in the ProQOL5 and the COPSOQ (N=92)

	CS	BO	CF
Quantitative Demands	-.16	.36**	.40**
Emotional Demands	-.13	.28**	.35**
Predictability	.30**	-.29**	.02
Role Conflicts	-.17	.16	.18*
Social Support from Colleagues	.36**	-.29**	-.15
Social Support from Supervisors	.25*	-.29**	-.15
Sense of Community at Work	.27**	-.27**	-.09
Self-Efficacy	.54**	-.47**	-.25*
Meaning of Work	.66**	-41**	.01
Job Satisfaction	.46**	-.42**	-.18
Work-Life Conflict	-.22*	.53**	.56**
Sleeping Troubles	-.23*	.28**	.37**
Burnout	-.29**	.48**	.53**
Stress	-.44**	.53**	.51**
Depressive Symptoms	-.45**	.50**	.37**
Offensive Behaviors	-.18	.18	.26*

Note. *p < .05

**p < .01

Correlation between the ProQOL5's, COPSOQ's and Social Desirability

As a result of the analysis done on the data, through the Pearson's correlation coefficient (Table 5), a significant positive moderate correlation (Cohen, 1988) was detected between Social Image Management and Sense of Community at Work (r = .335; N = 92; p = .001) plus Social Image Management and Self-Efficacy (r = .335.; N = 92; p = .001). Search of Social Approval also displayed a significant positive moderate correlation (Cohen, 1988) with Stress (r = .303; N = 92; p = .003). The rest of the correlations displayed weak correlations, proving that a strong Social Desirability pattern was not present in this sample.

Table 5. Coefficients from Pearson's Correlation between the variables present in the DESCA and the ProQOL5 and COPSOQ (N=92)

	SSA	SIM	RD
Compassion Satisfaction	-.27**	.14	-.21*
Burnout	.19	-.19	.16
Compassion Fatigue	.16	-.11	.15
Quantitative Demands	.03	-.29**	.10
Emotional Demands	-.14	-.22*	-.01
Predictability	.11	.21*	-.03
Role Conflicts	.11	-.21*	.09
Social Support from Colleagues	-.07	.26*	-.16
Social Support from Supervisors	.13	.16	.04
Sense of Community at Work	.095	.34**	-.05
Self-Efficacy	.01	.34**	-.12
Meaning of Work	-.8	.02	-.10
Job Satisfaction	.02	.12	-.11
Work-Life Conflict	.11	-.22*	.06
Sleeping Troubles	.02	-.08	-.01
Burnout	.06	-.20	.23*
Stress	.30**	-.17	.25*
Depressive Symptoms	0.7	-.29**	.098
Offensive Behaviors	-.09	-.08	.02

Note.

*p < .05

**p < .01

V - Discussion

Compassion Fatigue and Burnout are widely researched and discussed themes these days, since it was recognized that they can have a negative and

powerful impact on professionals' mental and physical state, as well as in the quality of service provided by them. There has been an increase of studies about burnout, compassion fatigue and compassion satisfaction, in nurses (Carvalho & Sá, 2011; Hooper et al., 2010; Sprang et al., 2007) and therapists (Canfield, 2005; Craig & Sprang, 2010; Sodeke-Gregson et al., 2013). However, there is still scarcity in the investigation of these phenomena on professionals who work in institutions designed to help and provide services to crime victims, connecting CS, BO and CF to the environment present in the workplace, alongside other structural factors, such as quantitative demands, sense of community at work, predictability and social support from both colleagues and supervisors. Thus, the present study seeks to assess the prevalence of these phenomena in a sample of victim support professionals, working within public institutions, and the way that work environment influences CS, BO and CF.

The results obtained suggest that the results found for the three dimensions of the ProQOL5 are similar to those attained in the original version (Stamm, 2009) and the Portuguese version (Carvalho & Sá, 2011). It was possible to verify that 77.1% of the sample presented medium to high levels of CS (N = 71), 81.5% revealed low to medium levels of BO (N = 78) and 73.9% of the professionals showed low to medium levels of CF (N = 68). The support victim professionals in this study did not show significant levels of BO and CF, unlike in some other studies regarding professionals who work with crime and trauma victims (Fontin et al., 2020; Sodeke-Gregson et al., 2013). It was also noted that the participants showed high levels of CS, which is in line with other studies (Fontin et al., 2020; Hinderer et al., 2014).

It was also sought to explore the influence of the sociodemographic variables on the results of CS, BO and CF. No significant differences were found in the CS, BO and CS results due to sociodemographic variables, as reported in the original version (Stamm, 2010) and the Portuguese version (Carvalho & Sá, 2011). This means that there is no connection between levels of CS, BO and CF and variables, such as age, gender and years working in the institution. Considering that the difference between the number of women (92.4%; N = 85) and men (7.6%; N = 7) is vastly large, these results must be interpreted with caution.

In the present study, the association between age, years of service and

stress, with high levels of BO associated to younger professionals and in the beginning of their career was not detected, which differs from other studies (Baird & Jenkins, 2003; Maslach & Jackson, 1981; Maslach & Leiter 2008; Sodeke-Gregson et al., 2013). It seems as though the combination of high levels of CS and the practice of self-care, present in these participants, played a role in preventing the development of BO, regardless of age.

The results obtained in the variables BO, stress and depressive symptoms differ significantly depending on the practice of self-care. Professionals that have a consistent practice of self-care activities exhibited low levels of BO, stress and depressive symptoms, it seems as the practice of self-care acts as a preventive measure that can be both used in an individual way or within the institution (Fontin et al., 2020; Newell & MacNeil, 2010; Sanchez-Reilly et al., 2013). The practice of self-care and the development of individual coping strategies are useful to develop resilience to CF in order to deal with the feeling of loss and pain, that these types of professionals often encounter at work, since these activities bring them joy and a sense of tranquility (Figley & Ludick, 2017; Newell & MacNeil, 2010; Rothschild, 2006; Saakvitne, 2002). Real expectations regarding workload, client care, the utilization of breaks, adequate rest and relaxation and keeping close connections with friends and family, help professionals to maintain their personal and emotional needs while attending to the demands of their clients (Figley, 2002b; Maslach, 2003; Stamm, 1999). Also, maintaining physical health, having a balanced diet, doing exercise and using positive forms of self-expression serve as buffers to the effects of BO and CF (Hesse, 2002; O'Halloran & O'Halloran, 2001; Pearlman, 1999; Zimering et al., 2003). Without proper self-care, victim support professionals, can easily develop BO, negative working behaviors and a diminished positive work experience (Fontin et al., 2020).

Additionally, it is possible to comprehend, through the results obtained, that social support from colleagues and supervisors is related to low levels of BO and high levels of CS. Support from coworkers and supervisors include actual help, such as assisting with excess work, taking on a difficult client, emotional support, comfort, humor and feedback (Maslach, 2003b). Help from colleagues reduces stress and BO (Greenglass et al., 1997) by altering the appraisal stressors, changing coping patterns or affecting self-perceptions

(Galek et al., 2011). Social support is a vital resource in response to occupational stress (Beehr et al., 2003), leading to a better a mental health (Cohen et al., 1997) and decreasing the effects of BO (Lakey & Cohen, 2000). On the other hand, the lack of social support within an institution can also lead to BO, therefore, organizations should create a warm and friendly environment, where workers feel valued and feel like they can rely on colleagues when necessary (Newsome et al., 2012; Radey & Figley, 2007). Thus, social support is a protective factor (Figley & Figley, 2017) and involves a positive work environment where professionals care for each other and demonstrate it (Figley & Ludick, 2017).

The current study registered a high prevalence of CS among professionals who work with victims of violence (Hooper et al., 2010; Poulin et al., 2013). It can serve as a buffer to the consequences of stressful emotional states, diminishing the probability of these professionals developing high levels of secondary traumatic stress (Berger et al., 2015; Hinderer et al., 2014; Sodeke-Gregson et al., 2013), and reducing the likelihood of experiencing CF (Figley & Ludick, 2017). Additionally, there is a clear connection between CS and resilience among trauma responders (Burnett & Wahl, 2015). CS revealed a connection with job predictability, both social support from colleagues and supervisors, sense of community at work, meaning of work, job satisfaction and perceived self-efficacy. Thus, the research (Sodeke-Gregson et al., 2013) highlights that such variables act as predictors for high levels of CS while acting as preventives for CF.

It was also found, in the present study, a connection between job predictability, social support from colleagues and supervisors, sense of community at work, meaning of work, job satisfaction and perceived self-efficacy with low levels of BO. Thus, it is possible to verify the influence of security, sense of self-worth in the role performed and a supportive work environment in the prevention of the development of BO, in the present participants (Ben-Porat & Itzhaky, 2015; Roe, 2002). Complementarily, the influence of variables such as role conflicts, lack of social support, the large number of labor cases and intense emotional demands on the growth of BO and stress did not emerge in this sample. This reinforces the preponderant role of self-care, personal and institutional support, the feeling of security, among others, in the prevention of BO (Craig & Sprang, 2010; Leiter et al., 2014;

Maslach & Leiter, 2016; Shirom, 2003).

VI - Conclusion

The present study aimed to detect the presence of Compassion Fatigue, Burnout and Compassion Satisfaction, the influence of sociodemographic variables and the connection of these phenomena with institutional factors, in a sample of Portuguese victim support professionals. According to the results obtained, high levels of Compassion Fatigue and Burnout were not found among the participants. In contrast, Compassion Satisfaction was vastly present in the sample, as well as a sense of importance on maintaining self-care activities and receiving social support in the workplace. It seems as Compassion Satisfaction serves as a protective factor for the development of Burnout and Compassion Fatigue in Portuguese victim support professionals. The data, in the present study, suggests that there are low to medium values of BO and CF in Portuguese victim support professionals. Nevertheless, there are variables that can help to minimize BO and CF and consequently, increase CS. More precisely, using the various personal and social resources and self-care, these professionals deal effectively with work stressors, including those related to the traumatic feelings and narratives of the people they care for and support (Figley & Ludick, 2017).

Thus, the present work is a pioneering study in Portugal with victim support professionals that provides a contribution for the understanding of the relationship between the phenomena of Compassion Satisfaction, Burnout and Compassion Fatigue with variables such as self-care and institutional factors in particular social support from colleagues and supervisors. In this regard, the results provide support for the elaboration of strategies aimed at combating BO and CF, by an increase of feelings of CS.

Nevertheless, the current study presents some limitations. The first limitation refers to the predominance of women compared to the number of men. Still, the low percentage of men (N = 7; 7.6%) compared to women (N = 85; 92.4%) is due to the larger number of women working in victim support institutions. The second limitation concerns the variables explored in the present study, which were analyzed at a single moment in time, therefore it is not possible to notice causal relationships. The third limitation involves a lack of a comparison group. Lastly, the usage of a more focused instrument to

measure Burnout in more depth, constitutes a final limitation.

Future research is needed to assess more rigorously Burnout in support victim professionals and on how to promote a more satisfactory work environment.

Despite the limitations mentioned, this study shows the importance of providing support and institutional well-being, as well as promoting self-care and informal care, to victims' support professionals and promote job satisfaction.

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Attachments

Attachment A – Sociodemographic Questionnaire

Gender: Feminine
Masculine
Other

Age:

Marital Status: Single
Married
Divorced
Widow

Level of education completed:

Basis degree:

Do you have kids: Yes
No

How long have you been working in the organization (in years):

What is your main activity at the institution:

Activities performed in your spare time:

Who are the people (without naming names, indicate the type of relationship, for example, friend, spouse) you can count on in difficult times:

Do you practice self-care? Yes
No

If you answered yes, what kind of activities do you perform?