



Compassion Fatigue Recovery Pathways Among Community Health Professionals

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Abstract

Community health professionals routinely work at the intersection of illness, poverty, bereavement, family crisis, chronic disease, violence, social vulnerability, and limited service resources. Repeated exposure to the suffering of patients and families can create substantial emotional demands and may contribute to compassion fatigue, secondary traumatic stress, burnout, and diminished professional quality of life. Recovery is frequently framed as an individual responsibility centered on rest or self-care, although occupational evidence indicates that managerial support, workplace conditions, resilience, peer relationships, and organizational practices are also relevant. This simulation-based study develops a multidimensional recovery framework for community health professionals experiencing elevated compassion-fatigue indicators.

A hypothetical cohort of 450 professionals was divided equally among three recovery pathways: integrated individual–team–organizational recovery, peer and supervisory support, and usual or predominantly self-directed support. Professional quality of life was conceptually assessed using the domains of compassion satisfaction, burnout, and secondary traumatic stress represented in the Professional Quality of Life framework. The simulation produced a standardized recovery index beginning at 42 points across all pathways. At eight weeks, the integrated pathway reached a simulated score of 77, compared with 65 for peer and supervisory support and 50 for usual support. These numerical results are synthetic and do not constitute observed intervention effects.

Earlier systematic and meta-analytic evidence confirms that compassion fatigue is an important concern among health professionals, although terminology and intervention evidence remain heterogeneous. The study proposes that recovery programs should address workload regulation, psychologically safe supervision, peer processing, recovery time, mindful self-regulation, professional recognition, and access to confidential support rather than relying exclusively on personal resilience. The findings provide a testable framework for future longitudinal and intervention research among community-based health workforces.

Keywords: compassion fatigue; community health professionals; secondary traumatic stress; burnout; compassion satisfaction; professional quality of life; occupational well-being; resilience; peer support; recovery



1. Introduction

Community health professionals occupy a distinctive position within health systems because their work often occurs close to the everyday realities of patients and families. Community nurses, outreach professionals, counselors, health educators, case managers, social-care personnel, and related frontline workers may encounter terminal illness, domestic hardship, disability, bereavement, financial insecurity, treatment failure, neglect, and repeated preventable suffering while simultaneously working with constrained resources. These encounters can create meaningful professional satisfaction, but sustained exposure to distress can also generate emotional exhaustion and secondary stress. Compassion fatigue has consequently become an important concept in research on professional quality of life among helping occupations. Cocker and Joss's systematic review specifically included health-care, emergency, and community-service workers and found that the intervention literature was still limited and methodologically heterogeneous.

Compassion fatigue should not, however, be treated as a simple synonym for ordinary job stress. The literature has used overlapping concepts including burnout, secondary traumatic stress, vicarious traumatization, and compassion fatigue, sometimes with insufficient conceptual distinction. Sinclair and colleagues' meta-narrative review identified important inconsistencies in the way compassion fatigue had been conceptualized within health-care literature and questioned assumptions that compassion itself is inherently depleting. This conceptual caution is important because poorly defined outcomes can lead to equally poorly targeted recovery interventions.

The Professional Quality of Life framework provides one widely used approach for examining the positive and negative consequences of helping work. Its domains include compassion satisfaction, burnout, and secondary traumatic stress, allowing occupational well-being to be considered as more than the absence of fatigue. The 2010 ProQOL manual provides guidance on administration and interpretation of these related dimensions. A professional may therefore experience meaningful satisfaction from helping others while simultaneously experiencing considerable occupational strain, making multidimensional assessment preferable to a single global fatigue score.

Recovery strategies have often emphasized individual coping, mindfulness, resilience, relaxation, and self-care. These approaches may be valuable, but research also indicates that professional fatigue is influenced by the working environment. Hunsaker and colleagues reported that lower manager support was associated with greater burnout and compassion-fatigue indicators among emergency nurses, whereas stronger support was associated with greater compassion satisfaction. Harker and colleagues similarly found that greater resilience predicted lower psychological distress, burnout, and secondary traumatic stress among human-service professionals, while mindfulness was associated with lower psychological distress and burnout. These findings indicate that both individual capacities and organizational conditions deserve attention.

The present study develops a recovery-pathway model specifically suited to community-oriented health work. Because no original participant dataset was supplied, the analytical section uses synthetic data and does not claim real-world prevalence, efficacy, or causal effects. The central proposition is that recovery may be more sustainable when it combines personal regulation strategies with collegial support, reflective supervision, manageable workload, recovery opportunities, and organizational



responsibility. The proposed framework is intended to support future prospective studies rather than substitute for them.

2. Objectives of the Study

2.1 To Identify the Core Dimensions of Compassion-Fatigue Recovery

The first objective is to establish a conceptually coherent recovery model that distinguishes secondary traumatic stress, occupational burnout, and compassion satisfaction rather than treating them as interchangeable outcomes. Existing research shows that these domains can coexist and may be influenced by different professional and organizational conditions. Cavanagh and colleagues' systematic review and meta-analysis identified substantial variation in compassion-fatigue findings across health-care studies and highlighted the importance of validated measurement.

Recovery is therefore defined in the present study as an improvement in professional functioning and emotional sustainability rather than merely a short-term reduction in subjective tiredness. The proposed framework incorporates restoration of psychological detachment from work, reduction of secondary stress reactions, improvement in perceived support, stronger boundary management, and maintenance or restoration of compassion satisfaction.

2.2 To Compare Alternative Recovery Pathways

The second objective is to compare three hypothetical recovery arrangements: an integrated recovery pathway, a peer and supervisory support pathway, and usual or predominantly self-directed support. The integrated pathway intentionally distributes responsibility across the professional, the immediate team, and the organization. This approach reflects evidence that both personal and environmental factors are associated with professional quality of life. Hunsaker and colleagues identified managerial support as relevant to compassion fatigue and burnout, while Harker and colleagues found resilience and mindfulness to be associated with more favorable psychological outcomes.

The comparison is not intended to imply that every professional requires a formalized intervention after emotionally demanding work. Instead, the model investigates whether professionals with elevated compassion-fatigue indicators might recover more effectively when individualized strategies are complemented by accessible supervision, peer connection, protected recovery opportunities, and workload review.

2.3 To Develop an Organizationally Responsible Recovery Framework

The third objective is to reduce excessive reliance on narratives that position distress exclusively as a failure of individual resilience. Community health professionals may operate under high caseloads, limited staffing, repeated exposure to traumatic circumstances, administrative pressure, insufficient recovery time, and difficult boundary conditions. A worker-focused intervention cannot fully correct structurally generated occupational strain.

The study therefore conceptualizes recovery as a shared organizational responsibility. Individual practices such as mindfulness, self-compassion, sleep protection, exercise, and reflective practice may contribute to recovery, but organizations must simultaneously consider supervisory quality, role clarity,



manageable exposure, psychological safety, recognition, access to confidential support, and opportunities to recover after particularly demanding events.

3. Review of Literature

3.1 Conceptual Development and Professional Quality of Life

Figley's early work contributed substantially to the discussion of secondary stress among helping professionals and described compassion fatigue as a potential consequence of sustained empathic engagement with traumatized or suffering individuals. Later research expanded the construct across nursing, emergency services, social work, counseling, oncology, and other health-related fields. Cavanagh and colleagues' 2020 systematic review confirmed the widespread use of compassion-fatigue measures among health professionals but also documented considerable heterogeneity in prevalence estimates and associated variables.

The conceptual boundaries remain debated. Sinclair and colleagues' meta-narrative review concluded that the construct had been used inconsistently and raised concerns regarding the assumption that compassion itself necessarily becomes depleted. This observation is important for recovery research because intervention targets should be based on clearly specified mechanisms. A professional experiencing chronic workload-related burnout may need workload and organizational change, whereas one experiencing intrusive responses after repeated exposure to trauma may require a different form of psychological support.

The ProQOL framework addresses some of this complexity by assessing compassion satisfaction alongside burnout and secondary traumatic stress. Compassion satisfaction represents the positive meaning and fulfillment that can arise from helping others. From a recovery perspective, this is important because successful occupational support should not merely suppress negative symptoms; it should also preserve a sustainable sense of professional purpose.

3.2 Occupational Predictors and Protective Resources

Hunsaker and colleagues investigated compassion satisfaction, compassion fatigue, and burnout among emergency-department nurses and identified managerial support as an important work-related factor. Lower manager support predicted less favorable professional-quality-of-life outcomes, whereas stronger managerial support was associated with higher compassion satisfaction. Although emergency nursing differs from community health practice, the finding is transferable at the organizational level because both environments depend heavily on teamwork, role support, and rapid responses to emotionally demanding situations.

Hegney and colleagues examined compassion satisfaction and compassion fatigue in relation to anxiety, depression, and stress among registered nurses, demonstrating that professional quality of life interacts with broader psychological distress rather than existing as an isolated workplace phenomenon. Zhang and colleagues' correlative meta-analysis likewise demonstrated relationships among compassion satisfaction, compassion fatigue, burnout, stress, and related professional variables in nursing populations. These findings support multidimensional assessment during recovery.

Protective resources have also received attention. Harker and colleagues reported that resilience predicted lower psychological distress, burnout, and secondary traumatic stress among human-service



professionals, and that mindfulness predicted lower distress and burnout. Alharbi and colleagues similarly examined relationships among personal characteristics, coping, resilience, and compassion-fatigue dimensions among critical-care nurses. Such evidence supports resilience-building but does not justify transferring full responsibility for occupational stress to individual workers.

3.3 Intervention Evidence and the Recovery Gap

Intervention evidence available through 2020 remains promising but inconsistent. Cocker and Joss reviewed interventions designed to reduce compassion fatigue among health-care, emergency, and community-service workers and identified only thirteen relevant studies, most involving nurses. The authors emphasized substantial methodological variation and the need for stronger research designs. This limitation is particularly important for community-health services because organizational structures, exposure patterns, and available support can differ considerably from hospital environments.

Delaney's 2018 pilot study evaluated an eight-week Mindful Self-Compassion program for nurses and reported favorable changes in compassion-fatigue and resilience-related outcomes. Duarte and colleagues also reported reductions in compassion fatigue and burnout following a mindfulness-based intervention among oncology nurses. These studies support further investigation of mindful self-regulation as one component of recovery.

Evidence nevertheless cautions against assuming uniform intervention effects. Pehlivan and Güner's 2020 randomized study reported that compassion-fatigue resiliency programs did not significantly change several targeted outcomes, although compassion satisfaction improved in intervention groups. The unresolved research gap is therefore not simply whether one self-care technique works, but how individual recovery practices interact with supervision, workload, peer support, professional meaning, and organizational conditions over time.

4. Research Methodology

4.1 Research Design and Simulated Sample

The study uses a simulation-based longitudinal comparative design. A hypothetical sample of 450 community health professionals was created and divided equally among three recovery conditions: integrated recovery pathway ($n = 150$), peer and supervisory support pathway ($n = 150$), and usual/self-directed support pathway ($n = 150$). The simulated population conceptually represents community nurses, outreach clinicians, counselors, case managers, community health workers, health educators, and related professionals regularly exposed to emotionally demanding service encounters.

Eligibility for a future empirical study would require active employment in community-oriented health or human services and an elevated but non-emergency professional-quality-of-life risk profile. Professionals experiencing acute psychiatric crisis, imminent self-harm risk, severe functional impairment, or another condition requiring individualized clinical treatment would need appropriate confidential clinical assessment rather than routine participation in a workplace recovery protocol.

Baseline equivalence was assumed for simulation purposes. All three groups began with a standardized recovery index of 42 on a 0–100 illustrative scale. The index does not correspond to a validated clinical threshold and is used only to visualize longitudinal recovery. A real study would retain



validated instruments separately and would not replace their established scoring systems with this composite measure.

4.2 Recovery Pathways and Intervention Components

The integrated recovery pathway is organized at three levels. At the individual level, participants would receive structured education concerning compassion fatigue, psychological detachment from work, sleep and recovery habits, boundary management, brief mindful self-regulation, and recognition of signs requiring professional help. Evidence from mindfulness and self-compassion studies suggests that such approaches may benefit selected professional well-being outcomes, although results should not be assumed to generalize across all settings.

At the team level, the model includes regular reflective peer meetings and psychologically safe supervision. These sessions are designed to normalize discussion of emotionally demanding work without requiring workers to disclose private clinical information publicly. Supervisors would receive guidance on recognizing workload overload, responding constructively to distress, and differentiating supportive supervision from performance surveillance. The relevance of manager support is supported by Hunsaker and colleagues' findings.

At the organizational level, the pathway includes workload review, protected recovery after exceptional cases, escalation mechanisms for sustained overload, access to confidential counseling, meaningful recognition, and periodic assessment of professional quality of life. These structural elements are included because compassion-fatigue recovery is unlikely to be sustainable when unchanged workplace conditions repeatedly reproduce the same exposure pattern.

Table 1: Proposed Compassion-Fatigue Recovery Framework

Recovery domain	Proposed component	Intended mechanism	Evaluation indicator
Individual awareness	Education on burnout, secondary traumatic stress, and compassion satisfaction	Improve recognition and reduce delayed help-seeking	Knowledge and self-recognition
Self-regulation	Brief mindfulness, self-compassion, recovery routines	Improve emotional regulation and psychological detachment	Perceived recovery and distress
Peer support	Structured reflective peer sessions	Reduce isolation and normalize professional processing	Peer-support rating
Supervisory support	Regular psychologically safe supervision	Improve role support and early identification of overload	Supervisor-support score
Workload recovery	Caseload review and protected recovery after high-intensity exposure	Reduce repeated overload	Workload manageability



Professional support	Confidential counseling or occupational mental-health referral	Provide appropriate escalation	Referral utilization
Recognition and meaning	Constructive recognition and reflection on valued work	Protect compassion satisfaction	Compassion-satisfaction score

4.3 Measurement Strategy and Statistical Plan

A future empirical study could use the Professional Quality of Life Scale to measure compassion satisfaction, burnout, and secondary traumatic stress. The ProQOL manual describes the scale structure, scoring, and interpretation framework and is widely used in helping-profession research. Additional measures could include validated perceived-stress, resilience, supervisory-support, sleep-quality, and psychological-distress instruments depending on study resources.

The study also proposes exactly five pathway-experience questions: “I have enough opportunity to recover after emotionally demanding work”; “I can discuss difficult cases with a supportive colleague or supervisor”; “My workload allows me to maintain appropriate emotional boundaries”; “I know where to obtain confidential professional support if work-related distress becomes difficult to manage”; and “My organization treats professional well-being as a shared responsibility rather than solely an individual responsibility.” These items are proposed for research development only and have not been psychometrically validated.

For an empirical longitudinal study, mixed-effects regression would be appropriate for repeated outcome measurements across baseline and follow-up. Group-by-time interaction terms could determine whether recovery trajectories differ among intervention pathways. Baseline workload, professional role, years of experience, trauma exposure, prior mental-health treatment, shift patterns, supervisory support, and organizational characteristics should be examined as possible confounders or moderators. Attrition analysis would also be necessary because professionals experiencing the greatest strain may be least able to complete workplace well-being programs.

5. Analysis

5.1 Comparative Simulated Recovery Outcomes

The synthetic dataset begins with an equivalent recovery-index value of 42 across all three pathways. At week two, the integrated pathway reaches 51, the peer-supervision pathway reaches 47, and usual support reaches 44. The modeled separation continues through week four and week six, suggesting a gradual rather than instantaneous recovery process.

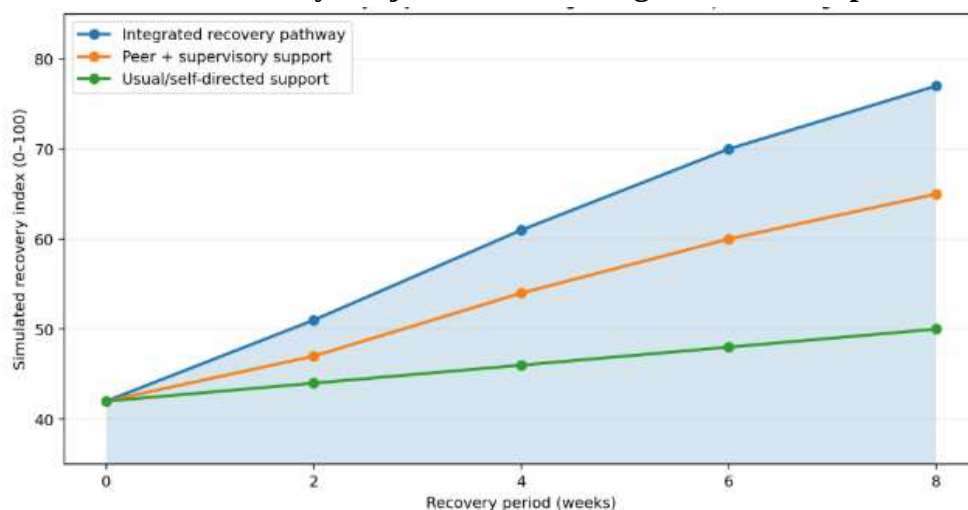
By week eight, the integrated pathway reaches a simulated recovery index of 77, compared with 65 under peer and supervisory support and 50 under usual/self-directed support. The 35-point improvement in the integrated pathway is not an empirical effect estimate. It was constructed to illustrate a hypothesis that recovery may be stronger when personal coping resources are reinforced by team and organizational changes.

Table 2: Simulated Eight-Week Recovery Outcomes

Outcome indicator	Integrated recovery pathway (n = 150)	Peer + supervisory support (n = 150)	Usual/self-directed support (n = 150)
Baseline recovery index	42	42	42
Week-4 recovery index	61	54	46
Week-8 recovery index	77	65	50
Simulated improvement from baseline	+35	+23	+8
Professionals reporting adequate supervisory access	84%	79%	43%
Professionals reporting adequate recovery time	71%	55%	32%
Simulated high secondary-stress risk at week 8	18%	28%	43%
Simulated high compassion satisfaction at week 8	69%	58%	45%

5.2 Recovery Trajectory Over Time

Graph 1: Simulated Recovery Trajectories Following Elevated Compassion Fatigue





5.3 Recovery, Compassion Satisfaction, and Residual Risk

The analysis also distinguishes recovery from simple symptom reduction. In the integrated pathway, simulated compassion satisfaction rises alongside improvement in the recovery index. This reflects the proposition that occupational recovery can involve renewed professional meaning rather than merely a reduction in fatigue. The ProQOL framework explicitly recognizes compassion satisfaction as a distinct positive dimension of helping work.

Residual risk nevertheless remains in all three pathways. Even the integrated condition retains a simulated subgroup with elevated secondary-stress indicators at week eight. This feature is deliberate because no organizational wellness program should imply that all clinically significant distress can be resolved through peer support, mindfulness, or workload adjustments. Some professionals may require individualized mental-health care, extended leave, occupational accommodations, trauma-focused treatment, or other services appropriate to their circumstances.

6. Discussion

6.1 Recovery Requires More Than Individual Self-Care

The main implication of the proposed model is that compassion-fatigue recovery should not be reduced to advice that professionals become more resilient on their own. Resilience and mindfulness can be valuable psychological resources, and empirical research among human-service professionals has associated them with lower psychological distress, burnout, and secondary traumatic stress. Mindful self-compassion interventions have also produced promising results in selected nursing studies. These findings justify including personal recovery practices within a broader program.

However, an exclusive focus on self-care can unintentionally obscure workplace causes of distress. A professional may practice mindfulness while remaining exposed to an unmanageable caseload, inadequate supervision, repeated traumatic cases, chronic staffing shortages, or poor organizational recognition. In such circumstances, individual techniques may improve momentary coping without addressing the conditions repeatedly generating fatigue.

The integrated framework consequently treats self-care as one layer of recovery rather than its entirety. Its expected advantage arises from aligning personal skills with psychologically safe teams and responsive organizational systems. This position is consistent with findings that manager support is associated with more favorable professional-quality-of-life outcomes.

6.2 Supervisory and Peer Relationships as Recovery Infrastructure

Community health work frequently involves professional isolation. Staff may travel between homes, outreach locations, community centers, or dispersed service areas and may have fewer opportunities for informal case processing than colleagues working continuously within a large clinical team. Formal opportunities for reflective supervision can therefore become particularly important.

Supportive supervision should not be interpreted as compulsory emotional disclosure. Professionals differ in how they process difficult experiences, and psychologically safe supervision must protect privacy, professional autonomy, and confidentiality. Its purpose is to provide an accessible setting in which workload concerns, boundaries, emotional reactions, and referral needs can be discussed without automatically being interpreted as performance weakness.



Peer support can complement but not replace formal organizational mechanisms. Informal collegiality may reduce isolation, yet complex distress should not be shifted onto coworkers without boundaries or training. Programs should therefore establish clear pathways for confidential professional support while retaining peer connection as a preventive and recovery resource.

6.3 Intervention Uncertainty and Organizational Accountability

Strength of the proposed framework is its refusal to assume that every compassion-fatigue intervention will be effective. Cocker and Joss found a limited and heterogeneous intervention literature, while Pehlivan and Güner's randomized study reported no significant benefit for several major outcomes despite improvements in compassion satisfaction. This mixed evidence means that organizations should evaluate programs rather than introduce them symbolically and assume success.

Interventions should therefore include measurable outcomes such as secondary traumatic stress, burnout, compassion satisfaction, perceived support, sickness absence where ethically and analytically appropriate, staff retention, workload, and access to support. Participation in well-being measurement should be handled carefully because workers may fear that responses could influence performance assessment. Confidentiality and separation between clinical support information and routine human-resources evaluation are essential.

Organizational accountability also requires attention to intervention failure. If professionals complete resilience training while workload and exposure remain unchanged, limited improvement should not automatically be interpreted as failure of employee engagement. Recovery programs should create feedback mechanisms through which persistent distress can trigger review of staffing, workload distribution, supervision, recovery time, and service design.

7. Conclusion

Compassion fatigue among community health professionals is best approached as a multidimensional occupational-health issue rather than a simple consequence of insufficient personal resilience. Existing research demonstrates important relationships among secondary traumatic stress, burnout, compassion satisfaction, psychological distress, resilience, mindfulness, and supervisory support. At the same time, conceptual reviews caution against treating compassion fatigue as an uncomplicated or uniformly defined construct.

The present simulation proposes three alternative recovery pathways and illustrates why an integrated individual–team–organizational model deserves empirical testing. Under the hypothetical assumptions, the integrated pathway produced the strongest eight-week recovery trajectory, followed by peer and supervisory support and then usual/self-directed support. These values are synthetic and should not be presented as intervention-effect estimates.

The conceptual contribution lies in shifting recovery from an exclusively worker-centered model toward shared responsibility. Professionals can be supported in developing self-awareness, boundaries, mindful regulation, and recovery routines, while teams can provide reflective peer relationships and safe supervision.

Future research should test the proposed framework through longitudinal, cluster-randomized, quasi-experimental or mixed-method implementation designs. Studies should assess not only short-term



reductions in fatigue but also sustainability of professional quality of life, compassion satisfaction, workforce retention, service functioning, and organizational conditions. Such evidence would allow community health systems to move from generic well-being initiatives toward recovery pathways that are measurable, ethically responsible, and responsive to the realities of sustained caring work.

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