

## DEALING WITH WEAR: CARE AND PALLIATIVE MECHANISMS FOR COMPASSION FATIGUE

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### **Abstract**

The Compassion Fatigue concept is common in the sci-entific literature of International Social Work, although surprisingly nonexistent in Spanish literature. Fatigue can be defined by compassion as a state of exhaustion and biological, psychological and relational dysfunction, the result of immediate or prolonged exposure to compassionate stress and as the final result of the progressive and cumulative process resulting from pro-longed, continuous and intense contact with clients or clients. patients, the use of oneself and exposure to stress.

The maintenance of the wear can lead to severe pictures typical of secondary traumatization or the onset of Burned Professional Syndrome (Burnout). In any case, if a social work professional experiences this phenomenon, their ability to empathize, connect and help their clients is severely diminished. Paradoxically, compassion fatigue is, on the one hand, necessary and inevitable if good practice is developed; on the other, dangerous and disabling if it is not compensated by other mechanisms. Compassion fatigue can not be prevented but it can and must be palliated consciously. Increasing the ability to recognize and minimize the impact of attrition is a responsibility of the professional and the organization in which he works. Finally, the work raises what to do about this phenomenon and how to take care of yourself, professionally and institutionally.

**Keywords:** Social work; compassion fatigue; professional wear; help relationship; self-care.

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### **A. INTRODUCTION**

The investigation of the processes and mechanisms of professional burnout that have been developed within the framework of Social Work in Spain, have revolved almost exclusively on the phenomenon of Burnout Syndrome, (Campos et al., 2017).

The bi-directionality that Feundenberger (1974) raised when describing and conceptually defining the Burnout Syndrome has been one of the most significant sources of confusion when it comes to apprehending the concept, investigating the phenomenon and defining its scope. The author describes the syndrome as the response to chronic work stress, which is evidenced by the negative attitude and feelings directed towards the people with whom one works, towards one's professional role and the perception of emotional exhaustion. Feundenberger (1974) indicates that this type of phenomenon is observable in the group of workers who are in

direct contact with people and, later, broadens this perspective to any type of professional. The excessive breadth and scope of this idea of wear and tear, the inaccuracy and confusion existing in the scientific literature in this regard (Campos et al., 2015) and the profusion of the concept from the disclosure of Maslach's works (1986) has facilitated the spread of a single perception of the phenomenon of professional burnout in all professions that, such as Social Work, focused on the context of helping relationships.

Clinical practice and empirical evidence have revealed the fact that this broad and generic view of burnout is neither the only possible nor, in certain contexts of professional activity, the most appropriate. However, for decades it has been the hegemonic idea that has guided research on the impact of burnout on the practice of Social Work in Spain. Based on the evidence that burnout occurs in the practice of Social Work professionals (Adams et al., 2006), We consider that it is necessary to equip oneself with alternative theoretical and practical perspectives to the dominant theses about attrition.

The development of helping relationships with the people we work with in different contexts implies the development of competencies and capacities linked to the management of our empathic capacity and the development of an aid alliance (Corbella & Botella, 2003). This is why, by working with our listening skills, linking ourselves to people who suffer psychically, physically or emotionally, for which a known price is paid: physical exhaustion, emotional exhaustion and exhaustion of professional capacities and skills. Understanding what happens to our clients, understanding the meanings of their situations and linking ourselves to their discomfort generates pain in the professional. In other words, bonding hurts (Borges et al., 2019).

## **B. METHOD**

This research is a type of descriptive research that uses literature to get data, and then analyzed based on the theoretical basis used to frame the analyzed data. The theoretical foundation used is Dealing with Wear: Care and Palliative Mechanisms for Compassion Fatigue .

## **C. RESULT AND DISCUSSION**

### **Sources of professional discomfort**

We are interested in highlighting the phenomenon of professional burnout from a relational point of view. Thus, we consider that an effective support relationship requires the development of a relationship of trust between the professional and the client. This relationship is built through the deployment of two factors: First, our ability to empathize with the customer. Under normal conditions, it is about our psychophysiological ability to understand from the cognitive and emotional point of view what happens to our client (Bermejo, 2012). Second, the development of an alliance for change between the professional and the

client. This includes four dimensions: emotional ties between the two and mutual trust, respect and interest in the process of change, an active commitment to the process and a sense of association to achieve a common goal (Corbella & Botella, 2003). Without the development and engagement of empathy, person-centered social work is impossible (Adams et al., 2006).

Thus, empathy and alliance will be the generators of three significant sources of wear and tear. First, it is necessary to counteract our spontaneous empathic reflex. This is thoughtless and unconscious, it translates into an unbalanced listening to the narratives that people tell us and that are flooded with problems, discomfort, disability or pain. In these narratives, our empathic capacity is triggered as a first reflection and is translated into the tendency to listen and empathize, preferably, to that or that story in which we perceive personal, cultural or gender ideological resonances, in which there are good and bad guys, victims and victimizers. It is understandable that, as professionals who are sensitive to people who suffer, we tend to empathize with the loser, or with the one who apparently takes the worst part. Since good listening is not judgment, correcting this unintended tendency requires wear-and-tear effort.

Second, active listening and empathy involve developing a conscious empathic attitude. The empathic attitude implies a conscious and voluntary predisposition to understand the position of the other, the speech of the other and the meaning that the other gives to his speech, his emotions and his experiences.

To develop an apprehension of meanings, professionals must perceive and experience some of the discomfort that people feel. Active listening activated by a predisposition and an empathic attitude implies perceiving in oneself part of the other's discomfort. Experiencing part of the other's pain generates wear and tear. It was Figley (1995), who first coined the term Compassion Fatigue referring to the "feeling of deep empathy and pity for another who is suffering, accompanied by a strong desire to alleviate pain or solve its causes". A third source of burnout is related to the necessary emotional distance, due to the paradoxical tension between empathy and epathy. The concept of epathy (González de Rivera, 2004) refers to our ability to control the empathic reaction through the active exclusion of feelings induced by others. The practice of epathy protects us from the affective flood and from being carried away by the emotions of the parties through a form of intentional control of interpersonal subjectivity.

Therefore, an adequate professional practice requires the deployment of our empathic capacity, the alliance of help and the emotional distance necessary for the effectiveness of the relationship. It is evident that this paradoxical tension between emotional closeness and emotional distance generates more wear and tear in a context of interaction with people, couples, families or groups that experience situations of physical, psychological, relational or emotional suffering.

### **Diverse perspectives on burnout.**

We have carried out a review on national-based bibliographic sources, focusing on Spanish journals whose subject is specific to Social Work and Social Services: Alternatives, Notebooks of Social Work, Azarbe, Social Education, Humanism and Social Work, Community, Atlántida, Ehquidad, Portularia , Social Work and Health, Social Work Magazine, Social Work Documents, Social Work today, Social Policy and Social Services Magazine, Global Social Work and TS Nova. Given the limitation of the universe of journals, it was not necessary to go to the available databases. We have carried out searches by entering the following keywords: <secondary trauma>, <compassion fatigue>, <empathy burnout>, <professional burnout>, <burnout> and <self-care>, also generating AND and OR searches in the cases from compassion fatigue and empathy burnout. Although we were aware that the concept of compassion fatigue, of our special interest, would probably not be reflected, the results obtained in relation to the search have been less than expected. There are no works related to the concepts of trauma, traumatization, Secondary trauma, empathy burnout, empathy, compassion, or compassion fatigue. We have detected six studies directly related to the phenomenon of burnout, two that address burnout and two related to self-care. Having seen the results and reviewed the bibliography, we have not selected any of the documents found. This has forced us to turn to indirect sources related to national-based journals related to medicine, psychology and nursing. In them we have observed that the range of documents is wide and diverse. However, they did not provide information on the most important authors who have investigated and described the phenomenon of compassion fatigue, nor did they appear in Spanish journals on research references within the framework of Social Work practice. This has forced us to inevitably track down the databases that, in the field of social sciences and Social Work, are valued as being of recognized prestige: Web of Science, SCOPUS, EBSCOhost, PsycARTICLES Sciencedirect. The results show that the phenomenon of compassion fatigue, clearly differentiated from the concept of burnout, is sufficiently collected in the main Anglo-Saxon social work journals. We develop the results obtained below

Psychotraumatology is the discipline that has focused its efforts with the most relevance in investigating and knowing the scope and impact that help relationships exert on the physical, mental and emotional balance of the professionals who exercise these roles (de Madrid, 2002). The antecedents of the study of the impact of the helping relationship on professionals can be found in the works of C. Figley (1995), who studied these consequences for the first time with nurses who treated veterans of the Vietnam War in the 1960s. According to the author, these professionals had feelings of guilt and remorse for not having been able to "save" their patients. Joison (Jiménez et al, 2004) used the term compassion fatigue to refer to the harmful effect of continued exposure of nurses to their patients' stories of pain and suffering. One might wonder what compassion fatigue is and what harmful effects it has on those who experience it. Compassion fatigue has been defined as "the state of exhaustion and biological, psychological and social dysfunction, the result of prolonged exposure to compassion stress and all that it evokes" (Sorensen et al., 2017) . For Figley (2002), "compassion fatigue, like any other form of fatigue, reduces our ability or our interest in bearing the suffering of others." If a professional experiences such a phenomenon, their ability to empathize, connect and help their clients is

seriously diminished. Figley (2014), considers compassion fatigue as the natural emotional behaviors and reactions derived from knowing a traumatic event experienced by a significant person, that is, an indirect traumatization of rapid and sudden onset as a consequence of helping those who experience the trauma in a direct and / or primary way.

The latest published works abandon the restricted vision provided by psychotraumatology and broaden the concept of compassion fatigue, understanding it as the progressive and accumulated result of intense contact with people who suffer and due to exposure to stress, and which includes all patients. professionals who develop a helping relationship (Dekel and Baum, 2010). We have traced the concept of compassion fatigue in scientific journals in the "Social Work" category of the Web of Science and Scopus. The tracking of publications highlights the handling of the concept of compassion fatigue in the world of Anglo-Saxon Social Work ( *Compassion Fatigue* ). We have traced the issue of burnout in the issues of Social Work scientific journals for the last ten years, finding only references to the topic of burnout, and none related to compassion fatigue or, failing that, Secondary Traumatic Stress. That is why we affirm that the concept of compassion fatigue or empathy exhaustion is non-existent in the scientific literature on social work in Spain. The common denominator of all the proposals regarding its definition rests on the concept of empathy, not on the concept of trauma.

It is evidence that in an open and living system such as the help system formed by the social worker and his client, there is a permanent exchange of information, relationships and mutual influences. Depending on the characteristics of the context of intervention for change (Cardona & Campos, 2009), the helping relationship is biased by a set of relationships and intense emotions that affect all participants in the process, and that are manifested through anxiety, stress and emotions expressed and felt by all participants. The physiological dimension (Labrador, 2009) linked to the stress and anxiety of the disorders that are experienced when one is immersed in an intense and sometimes toxic relational and emotional context, allows us to approach the set of key ideas: the work that social workers develop generates an inevitable physical and mental exhaustion given the nature of the context and the emotions in which they develop: conflict, tension, stress and emotional pain. Consequently, developing the role of social worker carries a cost related to the erosion and wear of skills and competences.

### **Signs of Compassion Fatigue**

Unlike burnout, understood as the result of a cumulative and chronic process related to working conditions, compassion fatigue can appear as an acute, sudden and immediate process after a helping relationship with a client. Campos Méndez (2015), following Figley (1995; 2002), and Sabo (2011), refer to a sudden onset (acute) in which we can identify three moments: 1. Compassionate Discomfort, with the appearance of causes that provoke the shift towards malaise; 2. Compassion Stress in progressive increase, exceeding tolerance thresholds and, 3. Compassion fatigue. Together, the signs of compassion fatigue are structured along three axes

that coincide with those of secondary traumatic stress: hyperarousal, avoidance and re-experimentation.

These are structured in five dimensions of the personal and professional life of the social worker:

1. **Somatic reactions** focused on exhaustion and loss of strength, lack of energy, decreased efficiency, reduced performance, loss of resilience, slower and more costly physical recovery, increased physical complaints, accident prone, insomnia, pain from head, upset stomach, muscle tension, rapid heart rate, fluctuating body temperature and back pain.
2. **Relational reactions** such as insensitivity and indifference, inability to address or alleviate suffering, and lack of enjoyment with leisure activities.
3. **Emotional reactions** such as loss of enthusiasm and apathy, desensitization, intense anger or irritability, desire to leave, emotional overflow, feelings of lack of joy in daily activities, feeling of emptiness or hopelessness towards the future, state of depression or sadness most of the time part of the time, fear and anxiety about events, feelings of paralysis, lack of motivation, compulsions such as drinking, eating and spending excessively.
4. **Spiritual reactions** such as lack of spiritual awareness, disinterest in introspection, impoverished judgments, decreased discernment and questioning of spiritual beliefs.
5. **Cognitive reactions** such as boredom and disinterest in clients, disorganization, decreased attention, reduced ability to concentrate, recurring dreams and nightmares, and concentration problems.

### **Compassion fatigue and other forms of burnout**

Associated with the “costs of care” to other people who suffer and suffer, numerous terms used have made possible a certain theoretical-conceptual confusion (Caro et al., 2017). As Figley has already pointed out (Figley, 1995, 2002, Figley & Bride, 2007, Figley, 2014), various terms have been used to refer to wear, which describes the current meaning of compassion fatigue. We refer to the concepts of secondary traumatic stress (traumatic stress derived from contact with the victim or the traumatic event), Post-traumatic Stress, Vicarious Traumatization, Countertransference and also the well-known Burnout Syndrome (Sorensen et al., 2017 ), as well as emotional contagion (Fernández-Pinto et al., 2008). With the exception of burnout, all of them are manifested in activities related to people who are victims of a traumatic event. Secondary traumatic stress occurs in relatives or close people of the person who suffers a traumatic event as a consequence of the proximity of the relationship and also as the impact it generates on the professionals of the helping relationship when observing or listening to the story of a primarily traumatized person (Hensley, 2008). Vicarious traumatization refers to a transformation of cognitive schemata and belief systems that result from empathic engagement with the traumatic experiences of clients ( Newman & Gamble, 1995). And finally, compassion fatigue, is defined by Figley (1995), as suffering (no traumatization) produced in the professional as a result of their work in a support service for people with a suffering or dysfunction, not necessarily traumatized.

At times, compassion fatigue has been considered a subtype of burnout syndrome. Various authors (Najjar et al, 2009) consider compassion fatigue to be a unique form of burnout, in which the cause of discomfort is not as closely related to work stressors as to the empathic response that professionals who work with empathy provide. Sabo (2006, 2011) describes burnout syndrome as a gradual process resulting from the responses we give in our work environment, while compassion fatigue has an acute onset that results from caring for people who are suffering, a product of the experience of taking charge, empathically, of the discomfort of the other, being only present in professions related to helping relationships. Compassion fatigue is the natural, predictable, treatable, and alleviable consequence of working with suffering people; It is the emotional residue resulting from exposure to work with those who suffer the consequences of traumatic events.

### **Evaluation of Compassion Fatigue**

Instruments for measuring compassion fatigue are scarce. In 1995 C. Figley and BH Stamp constructed the *Compassion Fatigue and Satisfaction Test* (Self-administered Compassion and Satisfaction Fatigue Questionnaire; (Figley & Stamm, 1995). The evolution of this instrument is materialized today in the information on the review of the previous work by Figley and Stamm (1995) developed by Stamm, Larsen and Davis (2002). As a result, today we have the *Professional Quality Life Scale, ProQOL*, version V (Stamp, 1997) which is made up of 30 items that are distributed in three sub-scales: secondary traumatic stress, burnout and compassion satisfaction. The dimension of Satisfaction by Compassion collects the measurement of satisfaction

generated in professional by doing the job well. The secondary traumatic stress dimension measures the effects of exposure to trauma or stressful situations by the professional, while the burnout dimension measures the exhaustion experienced through the expression of negative ideas and feelings of hopelessness and depersonalization.

Internal consistency reliability estimates for the subscales are reported with a Cronbach's alpha of 0.87 for the compassion satisfaction scale, 0.72 for the burnout scale, and 0.80 for the secondary trauma fatigue scale of the compassion (Bride et al., 2007).

The latest advances in the mediation of compassion fatigue can be found in the works of Zamponi, Viñuela, Rondoni, Tauber and Main (2009). The Inventory of Attrition by Company (IDE) consists of 27 items with a Cronbach's Alpha of 0.7 that are organized in three dimensions. The first dimension refers to Professional Involvement, that is, the degree of involvement of the professional in the relationship between professional and client, considering that good professional practice means a reasonable and safe degree of involvement. The second dimension refers to Personal Care, that is, to what extent the professional has personal and technical resources to face the risks and psychophysical wear and tear derived from the helping relationship. The third factor refers to the degree of

Vulnerability, reflecting the extent to which the professional is perceived to be affected by their professional practice, manifesting and recognizing themselves at a relational, psychic, physical and emotional level. Based on the scores obtained and a combination of scores for each dimension, the IDE identifies four possible profiles: Profile I, optimal empathic functioning, without the risk of contracting Empathy Burnout Syndrome; Profile II, Normal empathic functioning, without risk of contracting empathy burnout syndrome; Profile III, Normal empathic functioning, at risk of developing empathy burnout syndrome, and Profile IV, Dysfunctional Empathic Functioning. In our opinion, and unlike the ProQOL scale, the empathy attrition construct is more defined in the Empathy Attrition Inventory. The dimensions of which they are composed facilitate not only the knowledge of the level of wear in any of its four profiles, but also the knowledge of which is the most significant dimension in order to assess wear. In pragmatic terms, knowing the manifestation of wear in each one of the dimensions facilitates the application of concrete measures that point to the difficulties identified in each dimension.

### **General Model of Resilience to Compassion Fatigue**

The works of Figley (2006; 2014), insist on the search for an interpretation model of compassion fatigue that allows determining which variables it depends on. In this process, it has been considered that the phenomenon of fatigue depends on the behavior of six factors. The general model of resilience to compassion fatigue described by Figle (2014), is made up of the following factors and the unique relationship between them:

1. Exposure to the suffering client: The more exposure to the suffering client, the greater the empathic response, the greater the residual compassion stress, the lower the resilience to compassion fatigue.
2. Empathic ability: is the degree to which the professional can accurately predict the emotion exhibited by the client and expose emotions to the client that reflect effective services and with results.
3. Concern for the client: it is the interest in the welfare and success of the client. Motivates the professional to seek the best therapeutic response.
4. Therapeutic response: it is the one that the professional uses to allow the client to a) have more will to change, b) have less fear, c) be more optimistic about the outcome of the intervention, d) feel supported. However, by giving the appropriate therapeutic response, the worker experiences vicarious distress from the client that burdens the professional, in a measurable way, as Residual Compassion Stress.
5. Self-regulation: is the degree to which the professional can effectively manage the cause and impact of stress and separate work of personal life; feel fresh every day thanks to the worker's ability to self-regulate.
6. Compassionate satisfaction and support: it is the degree to which a professional feels a high level of personal satisfaction from working with their clients and perceives a high level of support and respect from co-workers.

7. Compassionate residual stress: experienced by professionals as stress reactions to the client's difficult situation and the concern to do all that one can to help the suffering client. In addition to the therapeutic response, self-regulation and satisfaction from compassion and support also affect the level of residual compassion stress.
8. Resilience to compassion fatigue: it is the speed and degree of total recovery from an adversity of the professional after having experienced a significant increase in the volume of stress. The model suggests that it is a function in four different variables: residual compassion stress, prolonged exposure to clients, effective management of traumatic memories (if any), and new life stressors.

Prolonged exposure to clients is the number of clients assigned versus the time per day to provide services multiplied by the number of months performing these tasks.

The effective management of traumatic memories is the satisfaction, self-reported, managing the number (if any) and the intensity of memories of the past trauma. The greater the satisfaction in handling memories, the greater the resilience to compassion fatigue. It is important not only to predict resilience to compassion fatigue, but also to predict how well the practitioner uses lessons from past trauma to help clients who are experiencing similar trauma and to adjust to trauma.

New Life Stressors: Events typical of the development of the life cycle or unforeseen events that cause personal and family crises that affect professionals as people.

## C. CONCLUSION

As an inherent phenomenon of the helping process, compassion fatigue is not preventable. Its existence and manifestation reflects the development of a good relational engagement and an adequate use of our empathic capacity. However, this does not mean that we cannot take conscious actions to minimize their effects.

Bride, Radey and Figley (2007), point out that the prevalence of compassion fatigue is the result, always unbalanced, of the balance between compassionate satisfaction and compassion fatigue. Compassionate Satisfaction is related to the subjective perception of a job well done, the emotionally significant connection with our clients and the satisfaction of the professional's own psycho-emotional needs. However, it is known that this balance, of leaning dangerously towards a significant increase in compassion fatigue, increases the risk of emotional disconnection, the danger of making erroneous judgments or of poorly organizing and process of change. From this perspective, the cost of caring must be offset by self-care. We can understand by self-care as "those activities carried out by individuals, families or communities, with the purpose of promoting health, preventing disease, limiting it when it exists or re-establishing it when necessary." (Ginés & Carvalho, 2010), having an institutional, personal or community dimension. If this compensation is not given, compassion fatigue will prevail over compassion satisfaction. Bride, Radey and Figley (2007), propose that alleviating compassion

fatigue, that is, balancing the structural imbalance that will always exist between satisfaction and fatigue, means developing four areas (Borges et al, 2019).

- a. **Development of positive relationships** with clients, that is, permanently activating the empathic response and the dimensions of the help alliance. In short, it is about working well, consciously well. They also aim to meet the professional's needs such as satisfaction with the relationship provided or recognition from colleagues.
- b. **Non-specific self-care** related to the maintenance of recognized standards of self-care that define the lifestyle (rest, sleep and eat well, maintain relationships and networks, hobbies, etc.). It is necessary to frequently monitor compliance with the (conscious) self-care plan and update it periodically.
- c. **Intentional self-care** linked to the permanent review of professional practice and its impact on oneself, resorting to supervision, review of practice, participation in professional forums, study, biophysical balance (food, exercise, rest and pleasure).
- d. **Stress management strategies** through the care and development of hobbies, relaxation, yoga, conscious meditation ( *mindfulness* ), artistic expressions, therapeutic writing, etc.

To conclude, we want to emphasize the positive dimension of compassion fatigue. This reflects a clear commitment of the professional with respect to her client and her own and appropriate practice. It is necessary and inevitable if good practice is developed; it is disabling if it is not compensated by other mechanisms: positive relationships, self-care and stress management strategies. Compassion fatigue cannot be prevented but can and should be consciously alleviated. Increasing the ability to recognize and minimize the impact of burnout is a responsibility of the professional and the organization in which they work.

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