EMPATHIC DISTRESS FATIGUE RATHER THAN COMPASSION FATIGUE? INTEGRATING FINDINGS FROM EMPATHY RESEARCH IN PSYCHOLOGY AND SOCIAL NEUROSCIENCE

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How selfish soever man may be supposed, there are evidently some principles in his nature, which interest him in the fortunes of others, and render their happiness necessary to him, though he derives nothing from it except the pleasure of seeing it.
—Adam Smith, 1853, p. 3

KEY CONCEPTS

- Compassion fatigue is introduced as a form of pathological altruism since it is altruistically motivated and gives rise to symptoms of burnout.
- Empirical findings are discussed that dissociate different forms of vicarious responses.
- We conclude that the term compassion fatigue should be replaced by the term empathic distress fatigue.

ALTRUISM, WHICH IS usually defined as an unselfish concern for the welfare of others, was identified early on by scientists and philosophers such as David Hume, Adam Smith, and Auguste Comte as a crucial component of our social interactions (for reviews on this topic, see Batson, Fultz, & Schoenrade, 1987; Wispé, 1986). However, despite the strong positive connotation of altruism in our society, there are also downsides to altruism, which can be subsumed under the umbrella term of pathological altruism. Depending on how the term is defined, many different forms of pathological altruism exist, ranging from
Williams syndrome to politically motivated suicide (discussed in Chapters 9 and 15, respectively). In their chapter on codependency (Chapter 4), Michael McGrath and Barbara Oakley define pathological altruism in general as “the willingness of an individual to place the needs of others above him- or herself to the point of causing harm—whether physical, psychological, or both—to the purported altruist.” In this chapter, we begin by describing compassion fatigue—a form of burnout—as an example of how an excess of altruism in caregivers may result in suffering and actually lead to decreased levels of helping. After reviewing definitions of the concepts related to empathy and compassion, we discuss how these concepts have been studied scientifically in the fields of social and developmental psychology and social neuroscience. Finally, we propose an integrative model and argue that compassion fatigue should instead be renamed empathic distress fatigue. We close the chapter by outlining suggestions for promoting prosocial behavior while circumventing pathological altruism in the form of compassion (or empathic distress) fatigue.

**Compassion Fatigue as a Form of Pathological Altruism in Caregivers**

Compassion asks us to go where it hurts, to enter into places of pain, to share in brokenness, fear, confusion, and anguish. Compassion challenges us to cry out with those in misery, to mourn with those who are lonely, to weep with those in tears. Compassion requires us to be weak with the weak, vulnerable with the vulnerable, and powerless with the powerless. Compassion means full immersion into the condition of being human.

—McNeill, Morrison, & Nouwen, 1982, p. 4

Baumeister and Vohs (2007) provide a cogent definition of compassion as “the emotion one experiences when feeling concern for another’s suffering and desiring to enhance that individual’s welfare.” Typically, compassion involves two components: the affective feeling of caring for a suffering person, and the motivation to relieve the other person’s suffering. In this regard, the term compassion fatigue, first introduced by Joinson (1992), describes a state of reduced capacity for compassion as a consequence of being exhausted from absorbing the suffering of others² (Figley, 2002; Sabo, 2006). We argue that compassion fatigue can be regarded as a manifestation of pathological altruism for the following reasons:

- The source of compassion fatigue is altruistic: Caregivers with compassion fatigue were initially motivated by the prosocial aim of alleviating the suffering of others by means of their empathic care.
- The consequence of this form of altruism, however, is pathological, since compassion fatigue negatively affects the caregiver’s mental and physical health (see also Chapter 11).

To better understand the nature of compassion fatigue, the following section will describe the negative consequences of compassion fatigue for clinicians and give an account of its causal mechanisms.

Compassion fatigue, or burnout, has been reported to be very frequent in caregivers, with prevalence rates ranging from 40% to 80% and to have adverse effects on the people who experience it (for a recent review, see McCray,
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Cronholm, Bogner, Gallo, & Neill, 2008). Shanafelt and colleagues (2002) assessed the prevalence and effects of burnout by mailing clinicians anonymous surveys, such as the Maslach Burnout Inventory (Maslach & Jackson, 1981) along with questions regarding patient care practices and depressive symptoms. This cross-sectional study showed that 76% of the responding medical residents reported symptoms of burnout in the domains of high depersonalization (e.g., “I’ve become more callous toward people since I took this job.”) and emotional exhaustion (e.g., “I feel emotionally drained from my work.”). Furthermore, Shanafelt and colleagues reported that half the residents who feel burned out suffer from depressive symptoms. The adverse effects of compassion fatigue on clinician’s health were substantiated by a longitudinal study in which burnout was shown to predict mood disorders and poor general health in physicians (Hillhouse, Adler, & Walters, 2000). In addition to negative effects on the caregivers, burnout has also been associated with an increase in self-reported medical errors (West et al., 2006) and suboptimal patient care practices (Shanafelt et al., 2002). These and similar studies suggest that the consequences of compassion fatigue are wide-ranging and affect the caregivers’ health and interaction with patients. In light of these alarming consequences, the question arises as to why caregivers are sometimes overwhelmed by compassion.

Schulz and colleagues (Schulz et al., 2007) argued in their review that, more than all other factors, including the patient’s disability and the time spent caregiving, it is the perceived suffering of the patient that leads to depressive symptoms in the caregiver. This suggests that empathy for a patient lies at the very root of compassion fatigue. Similarly, Figley (2002) described empathy as one of the main sources of compassion fatigue. This might seem counterintuitive at first glance, since compassion and empathy are said to promote prosocial behaviour. To unravel this paradox, we reexamine here the definitions that have been used to describe empathy and its consequences and review empirical findings from different fields supporting these conceptual distinctions. We show that by differentiating these concepts, a new integrative model arises that can account for mechanisms underlying compassion fatigue. This model suggests that, rather than compassion fatigue, it is empathic distress that underlies the negative consequences of caregivers who are exposed to others’ suffering.

Definitions of Empathy and Related Concepts

Broadly speaking, empathy occurs when observing or even simply imagining another person’s affective state triggers an isomorphic affective response. Importantly, the person experiencing empathy is aware that the source of his or her emotional response is the other person’s affective state (for comprehensive reviews, see Batson, 2009b; de Vignemont & Singer, 2006; Eisenberg, 2000; Hoffman, 2000; Singer & Lamm, 2009; Singer & Leiberg, 2009). As outlined by Singer and Lamm (2009), empathy
is a vital first step in a chain of emotional responses that lead towards feelings of compassion, empathic concern, or sympathy. There is a crucial distinction between empathy as opposed to compassion, empathic concern, and sympathy. Empathy refers to “feeling with”—it involves vicariously sharing the same feeling with another person. The other forms of vicarious affective responses refer to “feeling for” and are not necessarily isomorphic to the target’s affective state. Empathizing with someone else’s sadness implies that we also feel sad. Having compassion, sympathy, or feelings of empathic concern for someone who is feeling sad or distressed does not necessarily mean that we are also feeling sad or distressed. Instead, it means we have feelings of concern for the other (“feeling for”), as well as a motivation to alleviate the other’s suffering. Feeling compassion can also imply that we have positive feelings related to love for the suffering other. As we discuss in more detail below, a number of social and developmental psychological studies have shown that these other-oriented feelings motivate prosocial behavior (see Batson et al., 1987 and Eisenberg, 2000 for a review). However, these prosocially motivated and other-oriented feelings of compassion, sympathy, or empathic concern are not the only way of responding to others’ suffering. Empathizing with others may also give rise to so-called feelings of empathic or personal distress. In this case, empathizing with the suffering of another person leads to strong feelings of distress and aversive emotions in the observer. It has been suggested (Batson, O’Quin, Fultz, et al., 1983; Eisenberg et al., 1989) that, in contrast to compassion, sympathy, and empathic concern, which are all three other-oriented emotions that promote prosocial behavior, empathic distress and personal distress are aversive and self-oriented emotions that often lead to withdrawal behavior motivated by the desire to protect oneself from negative emotions.

The different steps involved in an empathic response can be illustrated by the following example: Upon hearing that a friend of ours is sad because her grandmother is dying, our first reaction would be empathy, which means that we would share the feeling of sadness and thereby know what our friend is going through. Empathy is the first step connecting us with the affective and motivational states of the other. In the next step, we would either transform this empathic response into compassion or empathic distress depending on our disposition, personality, emotion regulation ability, and the situation. If we reacted with compassion, we would feel pity or concern for our friend and, motivated by this other-oriented feeling, act in a prosocial way by trying to alleviate our friend’s suffering. However, if we reacted with empathic distress, which is a self-oriented response linked to withdrawal, we would be overwhelmed by our own sadness and try to avoid the aversive situation by leaving our friend alone with her sadness. In the following, we will discuss empirical evidence for such distinctions, first from social psychology, then from developmental psychology, and finally from social neuroscience.

**Empirical Evidence from Social Psychology**

To understand from a social psychological perspective how empathy and prosocial behavior are linked, Batson and his colleagues (1987) postulated and tested two core hypotheses:

1. Since the feeling of empathic concern is other-oriented, it should give rise to prosocial motivation. In other words, people who experience
empathic concern should strive to relieve the suffering of the person in need.

2. The experience of empathic distress is self-oriented. Therefore, people who experience empathic distress should primarily be motivated to reduce their own negative affect. This can be done either by avoiding the distressing situation altogether or by alleviating the other person's suffering.

Batson proposed that the relation between empathy and helping could be investigated by manipulating the ease with which the observer can escape witnessing the suffering of another person. He reasoned that people who respond to others' suffering with personal distress should primarily seek to reduce their own negative affect. So, when someone is suffering as a result of witnessing a distressing situation in which escape is easy, the primary motive of reducing one's own negative affect should result in the person leaving the situation without providing help (in the above example, one would avoid seeing the sad friend or change the subject whenever she speaks of her dying grandmother). However, if a person experiences distress in response to suffering in a situation that is not easy to escape from (for example, when hearing the distressed friend sob at night when sharing a hotel room), the distressed person should help the person in need, since the vicariously induced distress can be reduced by alleviating the other's suffering. Conversely, people who experience empathic concern for the person in need should help irrespective of whether it is easy or difficult to escape since their primary motivation is prosocial and other-oriented. Based on this theoretical framework, Batson and colleagues were able to test how empathy is related to prosocial motivation. They expected to observe low levels of helping when people experienced personal distress and when it was easy to escape witnessing the suffering of the other, since withdrawal would be an adaptive first response to protect oneself from the vicariously experienced negative affect. Conversely, people who experience personal distress but do not have the opportunity to escape the suffering stimuli easily, should provide help, since this is the most efficient way to reduce their own negative feelings. Furthermore, in this framework, the ease of escape should not matter for persons who experience empathic concern, since they would be motivated by the desire to help the needy person in all situations. So, helping rates should always be high in people who experience empathic concern.

To test their hypothesis, Batson and colleagues used a paradigm in which subjects watched another person receive electric shocks in an ostensible learning experiment. After a few trials, subjects were given the opportunity to relieve the other person's suffering by taking the remaining shocks themselves. In one experiment, the researchers manipulated the participant's emotional response to the person receiving shocks by using an emotion-specific misattribution technique (Batson, Duncan, Ackerman, Buckley, & Birch, 1981). Subjects who reported reacting with more empathic concern to the suffering person as a consequence of the experimental manipulation showed high rates of helping in both the easy and the difficult escape condition. However, subjects whose dominant response to the suffering was distress showed lower helping rates in the easy escape condition compared with subjects in the difficult escape condition or subjects with high empathic concern. In another experiment, Batson and colleagues (1983) showed that subjects who reported being more distressed from observing suffering helped significantly less in the easy escape condition than in
the difficult escape condition. Furthermore, the general pattern of results supported Batson’s claim: Subjects who reported more empathic concern showed comparatively high levels of helping in both the easy and the difficult escape condition. This and many more experiments (for review, see Batson, 2009a) confirm the hypothesis that empathic concern acts as a precursor of altruistic motivation, whereas personal distress leads to a self-oriented response. As will be outlined in the next paragraph, parallel research in developmental psychology has extended these findings to children.

**Empirical Evidence from Developmental Psychology**

In the domain of developmental psychology, Eisenberg and colleagues (1989) studied how children’s responses to needy others differed from adult’s reactions. One of their studies used a paradigm similar to that developed by Batson and colleagues; it focused on the easy escape condition, since it best differentiates between altruistic and selfish motives. In addition to measuring subjects’ individual rates of helping behavior, Eisenberg and her colleagues also recorded facial expressions and heart rate while subjects watched a video clip of a hospital scene depicting a woman and her two injured children, who were suffering from the consequences of a car accident. After viewing the film, subjects reported their emotional reactions and were given the opportunity to offer help to the woman in the film by assisting her with some household tasks (in the case of adults) or to help the injured children by gathering together homework materials (in the case of children). In line with the hypothesis that sympathy promotes prosocial behavior, this experiment showed that, for adults, self-reports and facial expressions of sympathy predicted helping. Interestingly, children’s verbal reports of distress and sympathy were not related to their prosocial behavior, suggesting that children’s capacity to report self-experience may be underdeveloped. However, children’s facial display of distress tended to be negatively related to their helping behavior: Children who showed more facial signals of distress tended to help less. Taken together, the general pattern of results supports the claim that empathic concern promotes helping, whereas personal distress is linked to a self-oriented motivation. Several other developmental psychological studies have confirmed with various measures (ranging from facial and behavioral to physiological reactions to the distress of others) that children’s increased empathic concern is positively correlated with higher helping rates (for a review, see Eisenberg, 2000).

**Empirical Evidence from Social Neuroscience**

As pointed out in previous paragraphs, to predict prosocial motivation, it is crucial to differentiate between the different reactions that follow empathy. Social neuroscience has recently significantly advanced our understanding of the different neural substrates of empathy, particularly through functional magnetic resonance imaging (fMRI; for recent reviews, see Decety & Lamm, 2009; Singer & Lamm, 2009). In these studies, brain responses were acquired while participants were receiving painful stimulation themselves or were empathizing with others in similar situations. Guided by the assumption that empathy would
be very strong for one's partner, Singer and colleagues (2004), for example, invited couples to participate in an experiment in which the woman's brain activity was measured by means of fMRI while her partner was sitting next to the scanner. During the measurement, either the female or the male partner received painful stimulation through electrodes that were attached to the back of the hands. An arrow indicated who would be stimulated next and whether the stimulation would be painful or nonpainful. Interestingly, this study revealed that certain parts of the neural "pain matrix" show increased activation in both conditions; that is, in the direct experience and in the observation of pain. More specifically, the brain areas that were activated more strongly during the experience of pain and empathy for pain were the anterior insula (AI) and the anterior cingulated cortex (ACC), which both play a crucial role in processing bodily and feeling states (see also Singer, Critchley, & Preuschoff, 2009). These findings have been replicated (Bird et al., 2010; Hein, Silani, Preuschoff, Batson, & Singer, 2010; Singer et al., 2006, 2008) and corroborated by several other empathy-for-pain studies that also found increased activation of AI and ACC when subjects merely observed pictures, photographs, or videos depicting body parts, faces, and people in painful situations (Cheng et al., 2007; Gu & Han, 2007; Jackson, Brunet, Meltzoff, & Decety, 2005; Jackson, Meltzoff, & Decety, 2006; Lamm, Batson, & Decety, 2007; Morrison, Lloyd, di Pellegrino, & Roberts, 2004; Morrison, Peelen, & Downing, 2007; Saarela et al., 2007; Singer et al., 2006). Importantly, a recent meta-analysis by Lamm and colleagues (2011) across nine independent fMRI studies on empathy for pain showed consistent involvement of a core network involving AI and ACC in self-pain and empathy for pain (Figure 28.1). The routes leading to activation of this core network, however, differ depending on the type of paradigm used. More specifically, a neural

**FIGURE 28.1**
Schematically depicted shared networks for pain as experienced by oneself as opposed to one's empathy for the pain being experienced by another. Activation related to empathy for pain in another is depicted checkered, whereas activation related to the direct experience of pain in the subject him- or herself is shown with stripes. Overlapping activation between both conditions (also checkered) is localized in the anterior cingulate cortex (ACC) and the anterior insula (AI). MI, medial insula; PI, posterior insula
circuitry processing somatic features was involved along with the AI and ACC when pictures of body parts or faces in painful situations were shown to induce empathy. In contrast, the above-mentioned paradigms, which involved a real-life situation with the suffering person being present in the scanner environment while abstract cues indicated when and to whom pain would be inflicted, induced activation in networks involved in inferring abstract mental states of others, that is, networks involved in Theory of Mind and mentalizing.

Although neural correlates of empathy have been observed in numerous studies and across different paradigms, empathic brain responses have also been found to be modulated by multiple factors (for a recent review, see Hein & Singer, 2008). There are situations in which stimuli that usually lead to empathy fail to induce increased responses in empathy-related brain networks. For example, Singer and colleagues (2006) investigated how empathy and its neural underpinnings depend on the perceived fairness of people suffering pain. In their study, the participant who was subsequently being scanned first played an economic game with two other volunteers, who in fact were confederates, and who behaved either fairly or unfairly. This manipulation induced the participant to like the fair confederate and dislike the unfair confederate. In a second step, the subject who was scanned, and the two other participants who were seated next to the scanner received painful or non-painful stimuli. First, Singer and coworkers confirmed the existence of a shared neural representation for self-experienced pain and the observation of pain in fair players in the AI and the ACC. Interestingly, only female subjects also showed increased activation in these regions when witnessing unfair players receiving pain, suggesting that women empathized with both fair and unfair players in pain. In contrast, men showed significantly less activation in the AI when witnessing unfair players as opposed to fair players receiving pain. Notably, the reduction in the men’s empathic neural response toward unfair players was accompanied by a rise in activation in the nucleus accumbens, a region that has previously been linked to reward-processing (for recent reviews, see Knutson & Cooper, 2005; Schultz, 2000). This link between activation in a reward-processing area and punishment was further supported by the observation that activation in the nucleus accumbens in men correlates positively with their self-reported desire for revenge.

The observation that the readiness to empathize crucially depends on the nature of the social relation has received additional support from a recent study in which Hein et al. (2010) report that male soccer fans show a greater empathic response in the left AI when witnessing the pain of a fan of their own favorite team (in-group) as compared to a fan of a rival team (out-group). Intriguingly, the intensity of activation in the insula predicted the amount of altruistic helping later on. In contrast, the intensity of nucleus accumbens activation observed when watching out-group members suffering pain was associated with a reduction of empathic brain responses in AI and correlated with reduced helping for the out-group member. In other words, when empathy-related activation in AI while seeing someone else suffering was high, neural activation in the nucleus accumbens was low, whereas nucleus accumbens activation was elevated when activation in the AI in response to another person’s suffering was low. These findings corroborate the suggestion that empathy motivates prosocial behaviour, and an absence of empathy accompanied
Empathy motivates prosocial behavior, and an absence of empathy accompanied by *schadenfreude*—reflected in elevated activation in nucleus accumbens—predicts a lack of helping.

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Another study relevant to the present chapter showed that empathic brain responses can be modulated as a function of the observer’s experience. Cheng and colleagues (2007) compared the neural response of volunteers who observed needles being inserted into different body parts. Some volunteers were physicians who practice acupuncture, whereas others were naïve participants with no experience in practicing acupuncture. The results showed that naïve participants showed activation in the neural network related to empathy in response to the stimuli, whereas physicians did not. One potential explanation is that the physicians were able to either not engage in any empathic response or to inhibit their empathic response toward the patient’s pain at an early stage.

The question arises as to which neural networks are actually involved when people adopt a loving attitude toward others, particularly in light of the potential dissociation of empathic distress and empathic concern. Although findings in this realm are not yet as abundant as in the domain of empathy for pain, the evidence for distinct neural structures converges: Bartels and Zeki studied romantic love (2000) and maternal love (2004) by means of fMRI and found overlapping activations for both types of love in the middle insula, the dorsal part of the ACC and the striatum (comprising the putamen, globus pallidus, and caudate nucleus). Similar activation patterns were reported by Beauregard and colleagues (2009), who observed increased activations in the middle insula, the dorsal ACC, the globus pallidus, and the caudate nucleus when their participants adopted a stance of unconditional love toward pictures of individuals with intellectual disabilities compared to just looking at these pictures. Converging evidence for the involvement of the striatum in feelings of love comes from another study that shows that activation in the caudate nucleus is linked to seeing a beloved person (Aron et al., 2005). Furthermore, Vrticka et al. (2008) report increased ventral striatum activation in response to smiling faces. As reviewed by Zeki (2007), the reported areas are linked to reward processing and are awash with oxytocin and vasopressin receptors—neuropeptides that play a crucial role in attachment and bonding (see Depue & Morrone-Strupinsky, 2005, for a review). Interestingly, increases in middle insula activation were also reported to be more pronounced in expert as compared to naïve meditators who were listening to distressing sounds while they were in a compassionate state (Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008). The finding that the middle insula is up-regulated in response to aversive stimuli during loving-kindness meditation is promising since it suggests that these meditation techniques are efficient in activating neural networks of love and positive emotions, even in light of distressing stimuli. However, much more research is necessary to substantiate which neural networks are involved in positive social emotions such as love and compassion.

**An Integrative Model**

Looking at the different studies presented in this chapter, it might at first seem confusing that, despite empirical evidence from psychology revealing that
Compassion is a necessary precursor for prosocial behavior, the same behavior has been linked to compassion fatigue and burnout in caregivers. We suggest that this confusion can be resolved by taking a close look at the definition of empathy and its related concepts. As outlined above and illustrated in Figure 28.2, one should distinguish between empathy, which denotes sharing someone's feelings ("feeling with"), and the consequences of empathy, which can take at least two different paths.

As illustrated by the upper path in Figure 28.2, empathy can result in feelings of concern, compassion, or sympathy for another person. The other-oriented focus of the compassionate response is essential, because it prevents the empathizer from identifying with the suffering. In other words, the compassionate person responds with feelings of love and concern to the observed suffering, while at the same time being able to regulate their own negative feelings caused by an empathic response and being aware that it is the other person who is suffering. Empirical evidence for the importance of self-other distinction in determining which path an empathic response will follow was reported by Lamm and colleagues (2007). In their study, which combined behavioural measures with fMRI, participants viewed video clips depicting patients who reacted to a medical treatment with painful or nonpainful facial expressions. The behavioural results show that participants reported higher personal distress when they imagined themselves in the patient's situation (self-perspective), whereas participants reported more empathic concern when they cognitively differentiated between the patient and themselves (other-perspective). Likewise, Eisenberg (2000) underlines that the realization of being different from the suffering person without being indifferent toward him or her is an important prerequisite for the development of prosocial behaviour. In other words, the compassionate person has the capacity to help because he or she is not overwhelmed by distress, but instead guided by feelings of concern, love, or affection toward the other.

This view on compassion is very close to the Buddhist notion of loving kindness (a feeling of warmth and caring toward oneself and others, Salzberg, 2002), because both share the same core emotions of positive affect and feelings of love and concern. The crucial difference between these two concepts is that, whereas loving kindness is experienced towards nonsuffering beings, compassion is felt for suffering beings. As will be discussed below, initial evidence suggests that compassion (or loving kindness) can even
have beneficial effects on the empathizing person's health, leading to a win–win situation in which both parties benefit: The suffering person profits from the help he or she receives, and the empathizing person profits from the feelings of warmth he or she experiences.

As shown in the lower path of Figure 28.2, empathy may also give rise to aversive emotions of empathic or personal distress. In this case, the empathizing person is overwhelmed by the vicariously induced negative emotions that are threatening the self. Note that, in contrast to a compassionate response in which the observing person does not identify with the suffering, the self–other distinction becomes blurred during empathic distress as the observer is overwhelmed by the experience of negative emotions. As outlined in the section above, this distinction is supported by the behavioural results reported by Lamm and colleagues (2007). Furthermore, the fMRI data of this study show that adopting the self-perspective leads to increased activation in brain areas involved in the processing of threat or pain, such as the amygdala. This suggests that the different experiences related to whether one adopts a self-focused or other-focused perspective are accompanied by distinct neural responses. Since identifying with the suffering of others induces empathic distress, the empathizing person will most likely try to reduce these harming feelings and attempt to withdraw from the difficult emotional situation, even if that means losing the opportunity to provide help. This withdrawal response may in fact be very adaptive, given that the studies described above on burnout in caregivers show that being overwhelmed by others' distress can have detrimental consequences for the mental and physical health of the affected person.

With this model in mind, we propose that the term compassion fatigue is slightly misleading, since it suggests that caregivers are tired of feeling too much compassion, whereas the definition we use implies that the feeling of compassion should actually protect against burnout. Therefore, we argue that the term compassion fatigue should be replaced by empathic distress fatigue, since the nature of burnout described in caregivers closely resembles the state of empathic distress. Both, burnout in caregivers and empathic distress, are characterized by the experience of negative emotions, which lead to a self-oriented response with the desire to alleviate one's own distress and both have negative effects on health. So, instead of abstaining from empathic responses altogether, physicians and caregivers in general should aim at maintaining high levels of empathy and learn how to transform empathy into compassion and loving kindness before being trapped by empathic distress. It is important to note here that the schematic model depicted in Figure 28.2 does not make any prediction about whether feelings of empathic distress and compassion can also be developed and experienced simultaneously while being exposed to a suffering person. It is plausible to assume that we can experience a
mixture of both feelings at the same time and that it is rather a question of which path is predominantly activated that will determine whether negative or positive outcomes will be observed in the long run.

The importance of a compassionate approach in physician–patient interactions is indisputable and was nicely illustrated in a study by Fogarty and colleagues (1999). The researchers showed women with breast cancer short videotapes about the treatment before the women saw the physician. One video contained an “enhanced compassion” segment in which the physician says: “You know you have a very bad disease, but we are going to take care of you.” Fogarty and colleagues report that women who saw the “enhanced compassion” video were less anxious than women who saw the control video. This finding underpins how crucial a compassionate approach is for a good physician–patient interaction. Given the high prevalence and the adverse effects of burnout among caregivers, the question arises as to how one can maintain a high level of compassion, and by this, profit from the beneficial effects that a health profession can entail (for a discussion of the positive effects of caregiving, see Post, 2005). Recently, there has been growing research interest in the question of how compassion might be promoted. Although solid findings in this area are still scarce, certain streams of research on meditation suggest that mindfulness and loving-kindness training can have beneficial effects on the mental and physical health of those who practice it. Meditation training based on mindfulness, loving kindness, or both, have been shown to have beneficial effects on markers of immune function (Davidson et al., 2003), reduce negative affect and stress (see Chiesa et al., 2009 for a recent review), decrease illness symptoms, and finally, to increase positive affect (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008). Importantly, the beneficial effects of meditation also extend to caregivers. Shapiro and colleagues (2005) have found that mindfulness-based stress reduction in healthcare professionals decreases perceived stress and promotes self-compassion. A recent review by Irving and colleagues suggests that various other studies found empirical evidence showing that mindfulness-based training improves physician’s mental and physical health (Irving, Dobkin, & Park, 2009).

Conclusion

In summary, despite the scarcity of studies that allow for causal inference (for a review, see Toneatto & Nguyen, 2007), accumulating evidence suggests that certain forms of meditation offer effective ways of circumventing compassion fatigue in caregivers by promoting an attitude of empathic concern and compassion that is associated with a skillful use of adaptive emotion-regulation mechanisms and a clear self–other distinction that makes one less vulnerable to the repeated experience of distress and suffering.

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could never lead to burnout, whereas engaging in empathic states alone can lead to unbearable suffering. In addition, we would like to thank Regula Ott for her help with the figures.

Notes

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2. In addition to the phrase compassion fatigue, terms such as secondary traumatic stress and burnout are also used to describe the negative consequences of intense emotional engagement with patients (for review, see Najjar, Davis, Beck-Coon, & Carney Doebbeling, 2009; Thomas & Wilson, 2004). For simplicity, we will use these three terms interchangeably in this chapter.

3. Although these concepts can be further differentiated, these terms are often used synonymously (Batson, 2009b). Whereas Eisenberg (2000) primarily uses the term sympathy, Batson (2009a) rather refers to empathic concern. Since it would be beyond the scope of this chapter to introduce the fine-graded differences, we will use the three terms interchangeably.

References


