The adverse effects of burnout and compassion fatigue among mental health practitioners: Self-care strategies for prevention and mitigation

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By both nature and inclination, mental health practitioners are emotionally attuned to the needs of their clients and constantly give of themselves in the helping sphere (Skovholt & Trotter-Mathison, 2016). Mental health practitioners guide, instruct, educate, engage, assist, support, nurture, counsel, welcome, hold, and heal their clients on various intrapsychic and interpersonal levels (Skovholt & Trotter-Mathison, 2016). The depth of therapeutic work in which mental health practitioners are often engaged can affect a client's emotional, cognitive, behavioural, and physiological processes in many different ways. Therefore, for mental health practitioners, "caring for others is the precious commodity" that leads to intense fulfilment but also fragility (Skovholt & Trotter-Mathison, 2016, p. 5). The constant giving of oneself day after day, week after week, month after month leads to an emotional toll that can adversely affect the various aspects of a mental health practitioner's functioning (Jankoski, 2012; Mental Health America [MHA], 2022; Skovholt & Trotter-Mathison, 2016). Unfortunately, most mental health practitioners are often unaware of this emotional toll in themselves and, if aware, do nothing to alleviate it (Brindley et al., 2019; Jankoski, 2002, 2010, 2012; Moss, 2021; Parker et al., 2021). On the contrary, they often suffer in silence, despite their compromised professional and clinical efficacy and diminished quality of life (Parker et al., 2021).

The COVID-19 pandemic has become the world's most noteworthy health crisis (Rothan & Byrareddy, 2020). Indeed, lockdown measures, social distancing, physical detachment from friends and loved ones, isolation, fear of contagion, uncertainty, domestic and family violence (DFV) and conflicts, and loss of income have caused an unprecedented spike in mental health cases worldwide (Joshi & Sharma, 2020). As a result, mental health practitioners' caseloads and work demands have increased exponentially, with the vast majority providing constant support and relief through telehealth platforms and other online services (Joshi & Sharma, 2020). Moreover, with the consulting room now having shifted into a mental health practitioner's home, maintaining a sense of balance and centredness has become a formidable challenge (Joshi & Sharma, 2020). Consequently, such rising mental health cases and the blurring of a practitioner's professional and

private space are a cause of significant concern regarding the deleterious effects these risk factors may pose in potentially exacerbating the emotional fragility of mental health practitioners (Tandon, 2020).

The emotional fragility, toll, and depletion often observed among mental health practitioners have been denoted over the years through the use of several key terms in the literature, namely, vicarious traumatisation, burnout, and compassion fatigue or secondary traumatic stress (Jankoski, 2012; Sansbury et al., 2015). The phenomena of burnout and compassion fatigue will be clarified and utilised in this article.

The objectives of this article are threefold:

- to delineate the signs and symptoms of burnout and compassion fatigue among mental health practitioners, as highlighted and captured in the current and relevant body of empiricism
- to explore the adverse effects of burnout and compassion fatigue on the functioning of mental health practitioners, particularly if left unaddressed
- to highlight efficacious self-care strategies for preventing and mitigating the adverse effects of burnout and compassion fatigue.

Indeed, since self-care is an ethical mandate for mental health practitioners (Psychotherapy and Counselling Federation of Australia [PACFA], 2017), this article elucidates those self-care strategies with the most significant empirical validation and efficacy.

In this article, the term *mental health practitioners* will refer to those who work in mental health care, namely, counsellors, psychotherapists, psychiatrists, psychologists, occupational therapists, mental health nurses, social workers, and community health workers (healthdirect, 2019).

Burnout and Compassion Fatigue: Origins and Developments

Burnout: The Modern Scourge

In the literature, a notable paucity of agreement exists among researchers concerning exactly what burnout entails and its causes (Dubois & Mistretta, 2019). This lack of agreement is one of the key causes of the challenges associated with addressing and counteracting the adverse effects of burnout (Dubois & Mistretta, 2019).

The concept of burnout emerged as a psychological concern of note in the mid-1970s when it was first coined by American psychologist Freudenberger (1974). Freudenberger utilised the term burnout to describe the adverse effects emanating from chronic and severe exposure to stress in the helping professions. Freudenberger (1974) defined burnout as a “feeling of exhaustion and fatigue” (p. 160).

Similarly, Maslach (1982), another American psychologist, undertook extensive research on burnout and discovered more than 30 explanations of the concept in the literature. As a result of her research with human services employees, Maslach (1982) defined burnout as a

syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who do people work of some kind. It is a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems. (p. 3)

Mental health practitioners are certainly among those individuals who do “people work” constantly and must deal extensively, and even almost exclusively, with clients who are “troubled or having problems” (Maslach, 1982, p. 3). Therefore, mental health practitioners are vulnerable and predisposed to the onset of burnout symptomatology (Northwood et al., 2021). Indeed, a plethora of studies has noted the phenomenon of burnout to correlate heavily with a reduced sense of job satisfaction among mental health practitioners in the United Kingdom (Moore et al., 1992), Canada (Saindon-Larose & Rainville, 1993), Australia (Parker et al., 2021), and the United States (Moss, 2021). Furthermore, Maslach and Leiter (2016) noted that between 20% and 80% of mental health practitioners have reported symptoms consistent with burnout at some point in their professional lives.

Maslach’s (1982) Symptomatology of Burnout

Emotional Exhaustion

As noted in the subsection above, Maslach (1982) posited three symptoms associated with the phenomenon of burnout. The first symptom Maslach (1982) noted was emotional exhaustion. Emotional exhaustion consists of feeling overextended, drained, and worn out by one’s work (Cafasso, 2021; Ogresta et al., 2008). The adverse effects of burnout and compassion fatigue on the functioning of mental health practitioners will be covered in greater depth in the discussion. First, however, it is pertinent to note briefly that emotional exhaustion can result in a lack of energy and sleep, decreased motivation and job satisfaction, difficulties in concentrating and focusing, irritability, a sense of dread associated with one’s work, and increased cynicism and negativity (Cafasso, 2021; Ogresta et al., 2008).

Depersonalisation

The second of Maslach’s (1982) symptoms of burnout, depersonalisation, refers to a sense of detachment, distance, and apathy towards one’s work (Mealer et al., 2016), and the loss of idealism associated with one’s profession and work (Ogresta et al., 2008). As a result, health care professionals, including mental health practitioners, can experience a reduced sense of empathy towards their clients (Mealer et al., 2016). Symptoms of depersonalisation may even manifest in negative, unsympathetic, and insensitive comments towards one’s colleagues and clients (Mealer et al., 2016).

Reduced Personal Accomplishment

The third and final of Maslach's (1982) symptoms, reduced personal accomplishment, is associated with a reduced sense of personal achievement (Hudek-Knežević et al., 2005). A reduced sense of personal achievement can be accompanied by feelings of inadequacy, insufficiency, and worthlessness associated with one's job performance as a helping professional (Mealer et al., 2016). This symptom is often characterised as "poor professional self-esteem" (Mealer et al., 2016, p. 1).

Limitations of Maslach's (1982) Symptomatology of Burnout

Over the years, Maslach's (1982) definition of burnout has been the subject of extensive empirical criticism (Parker et al., 2021; Sansbury et al., 2015). As a result, Parker et al. (2021) expanded upon Maslach's (1982) three symptoms of burnout and consequently posited a fourth symptom, impaired cognitive functioning. This fourth symptom was subsequently added to the Sydney Burnout Measure posited by Parker et al. (2021). According to Parker et al. (2021), this fourth symptom of burnout has not been addressed in the literature.

Parker et al. (2021) noted that impaired cognitive functioning specifically encompassed disabling impairments in helping professionals' memory, concentration, attention, and cognitive clarity. Moreover, other researchers have concurred with Parker et al. (2021) that impaired cognitive functioning should be included as a critical symptom of burnout (Bianchi et al., 2015).

Furthermore, unlike earlier researchers, Parker et al. (2021) also posited that personality and personality traits are vital predisposing factors to be considered in the onset of burnout. As a result of their three studies conducted over two years, Parker et al. (2021) discovered that people who tended to be overly reliable, meticulous, and perfectionistic are more predisposed to burnout than are other personality types. According to Parker et al. (2021), those with perfectionist tendencies are more inclined to measure their self-worth by the quality of their work, thereby predisposing themselves to the onset of burnout and compassion fatigue. Indeed, those with perfectionist personality traits tend to be overly self-critical and wary of the criticism of others and, as a result, will go to great lengths to ensure that their work is beyond error or reproach (Parker et al., 2021). Such constant exertion of effort often renders them more vulnerable to the onset of burnout and compassion fatigue (Parker et al., 2021).

Compassion Fatigue: The Dangers of Depletion

The term *compassion fatigue* was pioneered by Figley (1995) and later came to be synonymous with the term *secondary traumatic stress* (Jankoski, 2012). Figley (1999) stated that compassion fatigue develops owing to a mental health practitioner's frequent exposure to clients' trauma material and the practitioner's empathic engagement with, and attunement to, clients. Cumulatively, these two factors may cause a dangerous depletion in mental health practitioners' compassion reserves (Parker et al., 2021). As a

result of this dangerous depletion, long-term adverse alterations can occur in how mental health practitioners experience themselves, others, and the world (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Furthermore, while both compassion fatigue and vicarious traumatisation may be characterised by reliving a client's trauma symptoms, the former usually occurs from chronic involvement in emotionally taxing situations, while the latter occurs from chronic exposure to clients' traumatic experiences (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

Although some mental health practitioners are more vulnerable to the onset of compassion fatigue than others, compassion fatigue does not discriminate (Dubois & Mistretta, 2019). It can affect all those in the helping professions who engage empathically and compassionately with people (Dubois & Mistretta, 2019). Engaging in empathy is often a double-edged sword for helping professionals (Dubois & Mistretta, 2019). While it is often perceived as a psychological strength, it is also a potential risk factor for the onset of compassion fatigue (Dubois & Mistretta, 2019).

Several studies have highlighted moderate to high rates of compassion fatigue in mental health practitioners (Berjot et al., 2017; Diehm et al., 2019; Makadia et al., 2017; McCormack et al., 2018; O'Connor et al., 2018). For example, according to Sodeke-Gregson et al. (2013), 70% of psychotherapists employed by the United Kingdom's National Health Service were found to be highly predisposed and vulnerable to experiencing chronic compassion fatigue.

The Correlations Between Burnout and Compassion Fatigue

Mental health practitioners are called on to demonstrate to their clients the utmost care, empathy, devotion, nurturance, and support, which are vital components of compassion (Figley, 2002). However, the constant giving of oneself can cause an adaptive desensitisation and a feeling of numbness over time or a lack of joie de vivre (enjoyment of life), which constitute one facet of both burnout and compassion fatigue (Parker et al., 2021). Indeed, Dubois and Mistretta's (2019) figure presented below depicts the many affective responses that helping professionals may experience when suffering from both burnout and compassion fatigue.

Figure 1. Affective Responses

Note. From *Overcoming Burnout and Compassion Fatigue in Schools: A Guide for Counselors, Administrators, and Educators* (p. 62), by A. L. Dubois and M. A. Mistretta, 2019, Taylor & Francis Group. Copyright 2020 by Alison L. Dubois and Molly A. Mistretta.

Furthermore, heavier caseloads and the difficulties associated with acclimatising to different delivery modes, coupled with an increasing sense of isolation experienced during the COVID-19 pandemic, have posed a “clear threat” to the emotional and mental

wellbeing of helping professionals and might have affected their experience of burnout and compassion fatigue (Lluch et al., 2022, p. 2).

The COVID-19 Pandemic and its Emotional Toll on Mental Health Practitioners

The onset of the COVID-19 pandemic in 2020 and subsequent lockdowns triggered a notable rise in mental health cases, heavier caseloads, and formidable changes in the working patterns of mental health practitioners (Kalwani, 2021). Indeed, according to Kalwani (2021), the increasing number of DFV cases, assaults, abuses, and suicides that burgeoned during the COVID-19 pandemic is ample proof of the decline in the general level of mental health stemming from the outbreak of the virus. As a result, the mental health practitioners who sought to address the rising number of marital conflicts, DFV cases, child abuses, assaults, and suicidalities during the COVID-19 pandemic were found to be at higher risk of experiencing burnout and compassion fatigue (Joshi & Sharma, 2020). Indeed, Franza et al. (2020) found that mental health practitioners, particularly psychologists and clinical social workers, had higher combined compassion fatigue, secondary trauma, and burnout scores than did nurses during the COVID-19 pandemic owing to their handling of heavier and more complex cases. A significant source of emotional exhaustion among employees, in general, was having to cope with increasing work-related demands (Kalwani, 2021), a phenomenon particularly noted among mental health practitioners during the COVID-19 pandemic (Joshi & Sharma, 2020).

During the difficult lockdown periods of the COVID-19 pandemic, many organisations and private practices around the globe opted for flexible remote working options for their mental health practitioners, including telehealth platforms and other online services (Kalwani, 2021). As a result, flexible working patterns became the paramount requirement requested of all health care professionals, including mental health practitioners (Kalwani, 2021). However, it was discovered that these flexible working patterns were blurring the boundaries between a mental health practitioner’s private and professional life (Rofcanin & Anand, 2020). Indeed, the mental health practitioners who shifted their professional duties into their private spaces at home were required to assume additional work demands and pressures (Chakravorty & Singh, 2020; Folkard & Tucker, 2003). These additional work demands and pressures subsequently exacerbated practitioners’ pre-existing challenges of attempting to balance the demands of their professional and private lives (Chakravorty & Singh, 2020; Folkard & Tucker, 2003).

With the notable rise in mental health cases, heavier and more complex caseloads, and ever-changing work structures during the COVID-19 pandemic, mental health practitioners struggled to maintain balance, in addition to having to constantly expand their clinical repertoire to help address the alarming concerns of different clinical populations (Joshi & Sharma, 2020). With increasing work demands far outstripping their sense of balance and wellbeing, mental health practitioners were found to be at increased

risk of experiencing burnout and compassion fatigue during the COVID-19 pandemic (Joshi & Sharma, 2020). Further research in this area is required for a more conclusive body of empirical research, particularly among different communities and groups.

As most researchers concur, the difficulty with burnout and compassion fatigue is that they often go undetected and unaddressed among mental health practitioners (Brindley et al., 2019; Jankoski, 2002, 2010, 2012; Moss, 2021; Parker et al., 2021). Lamentably, overextended, stressed, and traumatised mental health practitioners are working long and intense hours, which can exacerbate the problems of burnout and compassion fatigue if left unaddressed (Mathieu, 2012). Moreover, as burnout and compassion fatigue take hold of mental health practitioners' professional and personal lives, practitioners become increasingly less able to recognise the adverse effects of burnout and compassion fatigue on the various aspects of their daily functioning (Dubois & Mistretta, 2019).

Discussion

Adverse Effects of Burnout and Compassion Fatigue on the Functioning of Mental Health Practitioners

Adverse Biological and Emotional Effects

Burnout and compassion fatigue can have serious adverse effects on the biological functioning of mental health practitioners (Parker et al., 2021). The body's autonomic nervous system (ANS) and the hypothalamic-pituitary-adrenal axis are responsible for addressing the impact of stressors and threats detected in one's external environment (Parker et al., 2021). The ANS activates the now commonly known fight or flight mechanisms when responding to stressors and threats (Parker et al., 2021). However, those experiencing burnout and compassion fatigue demonstrate persistent activation of their ANS (Parker et al., 2021). Persistent activation of the ANS signifies that the body is constantly on "red alert" and is poised to respond to an imminent stressor or threat, real or perceived (Parker et al., 2021). It has been empirically noted that, as a result, it is markedly difficult to reset the body's functioning to its normal, optimal, homeostatic state after chronic experiences of burnout and compassion fatigue (Parker et al., 2021).

Furthermore, prolonged exposure to chronic and acute stress and trauma has been found to reduce neurogenesis and neuroplasticity (Parker et al., 2021). *Neurogenesis* is a process by which the brain continues to produce new cells (Parker et al., 2021), while *neuroplasticity* refers to the brain's ability to reorganise the neural connections between old cells (Parker et al., 2021). However, an excessive release of stress hormones, such as cortisol, inhibits the processes of neurogenesis and neuroplasticity, particularly in the brain's hippocampus, which is responsible for memory processing and affect regulation, in addition to the pre-frontal cortex, which is responsible for behaviour modulation and executive decision-making (Parker et al., 2021).

As a result, mental health practitioners may experience adverse alterations in their behaviour, mood, and affect regulation, subsequently creating interpersonal difficulties in their professional and personal lives (Sabin-Farrell & Turpin, 2003). Indeed, participants in two separate studies reported difficulties in their family life emanating from burnout and compassion fatigue as they became increasingly less attentive and emotionally available to their loved ones (Ben-Porat & Itzhaky, 2009; Clemans, 2004). Furthermore, some mental health practitioners have even reported feeling emotionally detached (Clemans, 2004) and experiencing difficulties undertaking their therapeutic work, for example, maintaining boundaries and establishing trust (Schauben & Frazier, 1995). Moreover, in some cases, mental health practitioners have reported difficulties in switching off after sessions (Splevins et al., 2010), insomnia (Splevins et al., 2010; Steed & Downing, 1998), irritability (Splevins et al., 2010), and overwhelming feelings of emotional distress (Lonergan et al., 2004).

Adverse Cognitive Effects

As alluded to in the previous subsection, ignoring the adverse effects of burnout and compassion fatigue can foster adverse alterations to mental health practitioners' memory systems and cognitive processes (McCann et al., 1988; Parker et al., 2021). In the second of three studies conducted by Parker et al. (2021), the researchers administered a 34-item questionnaire among 622 participants who believed themselves to be grappling with burnout and/or compassion fatigue. Parker et al. (2021) noted the following themes among their participants, which they believed to be indicative of cognitive impairment:

- difficulties in concentrating
- needing to re-read things
- when reading, tending to scan texts rather than focusing with a sense of mental acuity
- lowered attention span
- poor memory and retention
- a sense of distractedness.

As a result of these adverse cognitive alterations, mental health practitioners may subsequently experience not only a heightened sense of vulnerability and awareness of the fragility of life but also difficulties with trust, intimacy, and safety (McCann et al., 1988; Sansbury et al., 2015). Hence, mental health practitioners may withdraw socially and develop a pessimistic and cynical view of reality (Benatar, 2000; Schauben & Frazier, 1995).

Non-Maleficence Compromised

The aforementioned adverse biological, emotional, and cognitive effects of burnout and compassion fatigue can compromise mental health practitioners' professional and clinical efficacy (Parker et al., 2021). Indeed, mental health practitioners must uphold and discharge an ethical obligation of the utmost importance: non-maleficence and the pledge not to harm their clients (PACFA, 2017). Unfortunately, mental health practitioners dealing

with burnout and compassion fatigue may be compromised in their abilities to discharge their ethical obligation of non-maleficence to their clients (Jankoski, 2012). Therefore, the ethical obligation of non-maleficence is precisely why self-care is not merely an option but an ethical mandate for mental health practitioners (PACFA, 2017).

As mentioned in the previous section, mental health practitioners often struggle to recognise the signs and symptoms of burnout and compassion fatigue (Brindley et al., 2019; Jankoski, 2002, 2010, 2012; Moss, 2021; Parker et al., 2021). Consequently, mental health practitioners do not pursue, and therefore do not receive, adequate support and assistance in preventing and mitigating the adverse effects of burnout and compassion fatigue (Jankoski, 2012). If left unaddressed, these adverse effects can ripple throughout the therapeutic alliance, potentially resulting in destructive and catastrophic consequences (Jankoski, 2012). For instance, mental health practitioners grappling with burnout and compassion fatigue often become jaded, detached, and cynical, thus rendering them incapable of empathising with their clients (Jankoski, 2012; Mealer et al., 2016). These mental health practitioners may even lose their own sense of hope, which their clients are yearning to hear, thus doing their clients a “grave disservice” (Jankoski, 2012, p. 548). Furthermore, when mental health practitioners become so consumed by chronic and acute stress, and hence utterly depleted, they can unintentionally compromise the safety, trust, and security of the person sitting before them, whom they are professionally obliged to help (Jankoski, 2012).

Therefore, mental health practitioners must take action before arriving at this point by exercising self-awareness and implementing efficacious wellbeing and self-care strategies (Sansbury et al., 2015). Taking the time to care for one’s physical, mental, and emotional health enables practitioners to be better caretakers of others’ physical, mental, and emotional health (Scott, 2020). Unfortunately, mental health practitioners can often forget that balance is essential to their personal, professional, and clinical efficacy (Skovholt et al., 2001).

A Case for Self-Care: The Healing Practitioner or the Wounded Healer?

Mental health practitioners must often balance a challenging dialectic (Rudick, 2012). On the one hand, they must help their clients heal and recover from difficult, often traumatic, experiences (Rudick, 2012). On the other hand, they must also take active measures to safeguard against the adverse repercussions emanating from clients’ traumatic experiences (Rudick, 2012). Indeed, negative coping strategies have been causally linked to the onset of burnout and compassion fatigue (Beck, 2011; Sabin-Farrell & Turpin, 2003). However, this does not negate the innate potential present within all mental health practitioners to discover and actualise their inner strength when countering the adverse effects of burnout and compassion fatigue (Rudick, 2012).

Each mental health practitioner will achieve the optimal degree of balance differently (Rudick, 2012). However, “balance is a direction, not a destination”, and small steps can, over time, yield monumental gains (Rudick, 2012, p. 554). According to Myers et al.

(2000), the concept of wellbeing is, in essence, a way of life directed towards achieving optimal mental, physical, and emotional health, and striving for inward integration. Furthermore, the necessity for mental health practitioners to attend to their own health and wellbeing has been empirically noted in various sources (Mahoney, 1997; Myers et al., 2000; Witmer & Sweeney, 1992).

The Way Forward: Empirically Validated and Efficacious Self-Care Strategies

Best practice management of one's self-care requires a pluralistic model that addresses the two main contributing variables of burnout and compassion fatigue: work-related factors and stress challenges (Parker et al., 2021). While mental health practitioners' self-care has always been paramount in mitigating burnout and compassion fatigue, with the addition of the COVID-19 pandemic and its concomitant restrictions, there are further threats to their wellbeing (Kalwani, 2021). Thus, the need for self-care is more important than ever before (Kalwani, 2021).

Work-Related Factors

For mental health practitioners working in organisations, institutions, or private practices, the following working conditions may be more conducive to preventing and mitigating the adverse effects of burnout and compassion fatigue: reasonable working hours and caseloads (Harrison & Westwood, 2009; Iliffe & Steed, 2000; Lonergan et al., 2004), optimal working spaces, the opportunity to take small blocks of leave to tend to medical appointments and the like, and adequate break times throughout the day (Parker et al., 2021). Furthermore, several studies have noted the critical importance of peer support and clinical supervision as viable strategies for preventing and mitigating burnout and compassion fatigue (Clemans, 2004; Iliffe & Steed, 2000; Lonergan et al., 2004; Pistorius et al., 2008; Smith et al., 2007), preventing feelings of isolation, and promoting debriefing opportunities (Hunter & Schofield, 2006). Additional work-related factors that may significantly prevent and mitigate the adverse effects of burnout and compassion fatigue are occasional team-building days, and investment in wellbeing or lifestyle programs by one's employer (Parker et al., 2021).

Challenges of the COVID-19 Pandemic

The immense challenges posed by the COVID-19 pandemic for the self-care and wellbeing of mental health practitioners is an area in need of ongoing research. Indeed, the long-term implications of the COVID-19 pandemic on the mental and emotional wellbeing of mental health practitioners are yet to be revealed (Nardi & Cosci, 2021). However, several studies have noted the ongoing challenges of managing the ever-changing structure and nature of work in relation to employees' mental health (Elraz, 2018; Li et al., 2021), a phenomenon well noted throughout the pandemic (Kalwani, 2021).

In such an unprecedented and unparalleled situation, Kalwani (2021) posited that the antidote to burnout and compassion fatigue could very well be the emphasis and use of compassion itself as a significant organisational and work-related factor. Indeed, Kalwani (2021) advocated establishing and introducing an organisational COVID-19 “compassion care” arrangement, which supports overwrought and emotionally exhausted employees. It has been empirically noted that compassion is a crucial variable conducive to an individual’s general wellbeing and mental health (Cosley et al., 2010; Feldman & Kuyken, 2011; MacBeth & Gumley, 2012). Furthermore, compassion is an apt antidote to those suffering from physical, mental, and emotional pain and vulnerability (Goetz et al., 2010). Unfortunately, the exact nature of Kalwani’s (2021) COVID-19 compassion care arrangement has not been elucidated in great detail. However, this may include granting employees additional leave, should they desire or need it.

Stress Challenges

The aforementioned work-related factors, coupled with the deleterious effects of the COVID-19 pandemic and its concomitant restrictions, may not always be within the means of mental health practitioners to alter. Hence, Sansbury et al. (2015) postulated a four-step process in the self-care journey of all mental health practitioners for addressing their own personal stressors and triggers. The first step is to identify stressors and triggers by exercising a degree of self-knowledge, self-awareness, and self-assessment (Sansbury et al., 2015). According to Rothschild and Rand (2006), a mental health practitioner lacking in self-knowledge and self-awareness is at greater risk of experiencing burnout and compassion fatigue.

As a corollary, the second step of the self-care process for mental health practitioners, as postulated by Sansbury et al. (2015), is to commit to managing their stressors and triggers. According to Sansbury et al. (2015), the best and optimal means for mental health practitioners to manage their stress and physiological arousal levels is to create a pluralistic, customised, and uniquely tailored self-care plan, which is the third step. The final step in the self-care process posited by Sansbury et al. (2015) is for mental health practitioners to act on and be accountable to their self-care plan.

No single self-care strategy will resolve the difficulties of burnout and compassion fatigue for all mental health practitioners, since one size certainly does not fit all (Parker et al., 2021). However, in the second of the three studies conducted by Parker et al. (2021), the researchers asked their 622 participants to list the self-care strategies they had personally trialled, and the degree to which each strategy was deemed efficacious in alleviating the adverse effects of burnout and compassion fatigue. The findings can be seen in Table 1, but they are by no means an exhaustive list of the self-care strategies available or utilised by all mental health practitioners.

Table 1. Efficacious Self-Care Strategies

Strategy	Percentage who attempted each strategy	Percentage who found the strategy helpful
Increasing exercise (other than walking)	44%	82%
Going for walks	60%	81%
Quitting my job	24%	79%
Consulting a mental health professional	54%	78%
Taking some time off work	44%	77%
Talking to a family member or friend	59%	75%
Improving sleep and/or resting more	47%	69%
Consulting a general practitioner	50%	69%
Practising mindfulness	46%	67%
Taking medication other than an antidepressant	15%	62%
Going on an action-packed holiday	8%	55%
Talking to my boss/manager	26%	46%
Using a web-based self-help tool	25%	45%
Talking to human resources at work	9%	30%
Meditating	35%	73%

Taking an antidepressant medication	36%	72%
Going on a relaxing holiday	21%	71%
Talking to a colleague	40%	71%
Taking up new hobbies/activities	28%	69%

Note. From *Burnout: A Guide to Identifying Burnout and Pathways to Recovery* (p. 2775 e-book), by G. Parker, G. Tavella, and K. Eyers, 2021, Allen & Unwin. Copyright 2021 by Gordon Parker, Gabriela Tavella, and Kerrie Eyers.

Of the self-care strategies listed in the table above, the most efficacious strategies appeared to be walking or another form of exercise; consulting others; seeking support from family members, friends, or another mental health practitioner; mindfulness and meditation; improving one's sleep hygiene and quality; and taking some much-needed leave from work for a holiday (Parker et al., 2021). These self-care strategies have also received empirical validation from a plethora of other studies. Particularly, scholars have focused on exercising to alleviate stress (Hunter & Schofield, 2006; Iliffe & Steed, 2000; Naturale, 2007; Pistorius et al., 2008; Splevins et al., 2010; Steed & Downing, 1998); resting and meditating (Naturale, 2007; Pistorius et al., 2008; Splevins et al., 2010; Steed & Downing, 1998); engaging in pleasurable activities, such as taking holidays and socialising (Harrison & Westwood, 2009; Hunter & Schofield, 2006; Iliffe & Steed, 2000; Splevins et al., 2010); and personal psychotherapy with another mental health practitioner (Bell, 2003; Hunter & Schofield, 2006; Lonergan et al., 2004; Pistorius et al., 2008; Splevins et al., 2010).

Conclusion

Herman (1997) once wrote:

There is no such thing as "getting used to combat". Each moment of combat imposes a strain so great that men will break down in direct relation to the intensity and duration of their exposure. Thus, psychiatric casualties are as inevitable as gunshot and shrapnel wounds in warfare. (p. 33)

This article has sought to highlight and delineate the emotional toll taken on mental health practitioners owing to the demanding nature of their work in the helping field (Sansbury et al., 2015). This emotional toll, often denoted as burnout and compassion fatigue, can subsequently cause a plethora of adverse effects on mental health practitioners' intrapersonal and interpersonal functioning, with catastrophic consequences on both their

personal and professional lives (Jankoski, 2012; Sansbury et al., 2015). However, the current body of empiricism concurs that work and organisational factors and personal self-care strategies can considerably prevent and mitigate the adverse effects of burnout and compassion fatigue among mental health practitioners (Cohen & Collens, 2013; Parker et al., 2021).

Regarding the emotional toll on mental health practitioners stemming from the unprecedented severity of the COVID-19 pandemic, Kalwani (2021) posits that the antidote to burnout and compassion fatigue is the introduction and establishment of COVID-19 compassion care arrangements among organisations and private practices. However, as the long-term implications of the COVID-19 pandemic become more apparent with time, particularly its effects on mental health practitioners' caseloads, work demands, and work structures, further research will be required to extend this small body of empirical literature.

A few implications stem from the current work. First, in terms of practical implications, this article reinforces the necessity of work and organisational support mechanisms to prevent and mitigate the adverse impacts of trauma work and empathic engagement among mental health practitioners (Cohen & Collens, 2013; Parker et al., 2021). These work and organisational support mechanisms could include debriefing opportunities throughout the day, investment in wellbeing programs, peer support, and clinical supervision (Cohen & Collens, 2013; Parker et al., 2021). Second, in terms of personal and clinical implications, this article reinforces the necessity for mental health practitioners to engage proactively in constant self-monitoring and subsequently commit to addressing any signs of burnout and compassion fatigue through a uniquely customised self-care plan (Cohen & Collens, 2013; Parker et al., 2021; Sansbury et al., 2015). This article has sought to highlight empirically validated self-care strategies, for example, exercise, the need for interpersonal support networks, and meditation (Cohen & Collens, 2013; Parker et al., 2021; Sansbury et al., 2015).

In terms of implications for future research, this article emphasises the need for a more holistic and proactive meta-perspective in mental health practitioners' formation, training, growth, and development. Indeed, a holistic and proactive meta-perspective should consider aspects such as formational, educational, and clinical programs for building emotional resilience and immunity early in one's training and career. In addition, developing a greater awareness of, and becoming involved in, activities relating to social justice and altruism (Cohen & Collens, 2013) are recommended. Furthermore, becoming aware of and involved in activities relating to social justice and altruism can cause neurobiological changes causally linked to feelings of contentment and belonging, and a reduction in feelings of isolation and loneliness (Post, 2014). Further research is needed to determine whether these initiatives could also be viable options for preventing and mitigating the adverse effects of burnout and compassion fatigue among mental health practitioners.

Declarations

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