Before They Crash and Burn (Out): A Compassion Fatigue Resilience Model

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ABSTRACT

Introduction: We propose a working model of compassion fatigue resilience by identifying compassion fatigue (CF) and compassion satisfaction correlates as potential targets for building resilience. Further, we explore focusing on pre-professionals as a method of primary prevention of CF.

Methods: The participants were 143 college students who completed self-report measures to assess current CF, self-care behaviors, self-care beliefs, self-esteem, frequency of helping behaviors, and exposure to others under extreme stress.

Results: Notably, hierarchical regression analyses (controlling for helping frequency and exposure to high stress individuals) suggested that self-care beliefs and self-care behaviors contributed to concurrent experiences of CF, through secondary traumatic stress ($R^2 = 0.3$, $F(5,135) = 11.69$, $p < .001$) and burnout ($R^2 = 0.4$, $F(5,135) = 18.08$, $p < .001$), respectively. Self-care behaviors were associated with compassion satisfaction in our regression model, which explained 36.1% of the variance in compassion satisfaction ($R^2 = 0.36$, $F(5,135) = 15.24$, $p < .001$).

Conclusion: Remarkably, we found self-care beliefs as a significant predictor of concurrent CF. In line with prior research on professionals, we found compassion satisfaction to have an inverse relationship with burnout, and found self-care behaviors to predict concurrent compassion satisfaction. Based on our findings, a working model to build resilience to compassion fatigue is proposed (which centers on the importance of both self-care beliefs and self-care behaviors). Resilience promotion should focus on educating individuals about the risks of secondary traumatic stress and burnout prior to starting a career in the helping professions, before patterns of self-care beliefs and behaviors are firmly established.

INTRODUCTION

In our society, we often admire individuals such as nurses, doctors, social workers, mental health counselors, first responders, and others, who work in the helping professions. Those who seek to enter a helping profession, such as college students may not be fully apprised of potential challenges to this role. When people neglect their self-care to attend to others' needs, it may result in a high cost to the caregiver. Compassion fatigue (CF), a well-researched cost, is the experience of extreme stress from helping or caring for others who are under stress or who have experienced some sort of trauma [1]. Compassion fatigue subsumes burnout (BO), cumulative stress, and secondary traumatization (STS). According to Figley (1995, 2002) compassion fatigue occurs when a helper repeatedly engages empathetically with clients and "takes on" some of their suffering [1, 2]. Compassion fatigue has been predominantly studied in professionals such as nurses, doctors, mental health counselors, veterinarians, and emergency responders, after a problem has already developed. As of this writing, there is a lack of research investigating compassion fatigue in nonprofessionals (those in the general population who engage in helping roles) and

pre-professionals, such as college students, interns, and residents who one day may enter helping professions. Similarly, few studies have examined compassion fatigue's counterpart, compassion satisfaction (CS), which represents the positive feelings and experiences people derive from helping others [3]. Studies of compassion satisfaction also focus on individuals who work in direct care professions. As such, there is a dearth of research that investigated compassion satisfaction in nonprofessional and pre-professional samples, where we have the opportunity to promote well-being and resilience prior to the development of compassion fatigue. The purpose of our study was to examine the relative contributions of self-care behaviors, self-care beliefs, self-esteem, frequency of helping, and exposure to stress, to the concurrent prediction of compassion fatigue and compassion satisfaction in a pre-professional sample.

Compassion Fatigue: Risk and Protective Factors

A significant number of studies have focused on risk factors and negative outcomes related to CF but there appears to be less literature about its counterpart, compassion satisfaction or compassion satisfaction's relationship with positive personality traits

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and subjective well-being. Examining positive qualities associated with helping others is consistent with positive psychology literature that emphasizes measuring positive traits that contribute to well-being and resilience promotion [4]. Further, ways to prevent or build resilience to CF are underrepresented in the literature. Consistently, the two components of CF, secondary traumatic stress and burnout are inversely related to compassion satisfaction. This inverse relationship has been found in a number of different populations such as hospice professionals, nurses, and mental health professionals [5, 6, 7]. There are a number of identified risks factors for developing CF including lack of social support [5, 6], demanding work and workloads [6, 8], lack of cohesion among co-workers [9], lack of a supportive work environment [10], and a person's own trauma history [8]. Interestingly, high levels of emotional empathy have been found to be both negatively related to CF (the negative consequences of helping) and positively related to CS (the positive consequences of helping) [2, 11]. Negative outcomes associated with CF previously identified include physical illness, greater use of sick time, higher turnover rates [1, 2], lowered morale, productivity, and quality of care for clients [5]. In addition, individuals consistently report sleep difficulties, depressed and/or anxious moods, and symptoms of posttraumatic stress disorder (PTSD) (e.g., increased startle response, thoughts and images related to trauma, and avoidance of trauma reminders) [1, 3, 13]. Bride, Radey, and Figley (2007) concluded CF poses a health risk to many helpers and therefore emphasize the importance of prevention efforts [14].

Factors such as increasing positive affect, social support, maintaining ones' physical health, and self-care are associated with higher compassion satisfaction [13]. Promoting self-care and developing self-care strategies are also associated with lower levels of compassion fatigue and burnout [5, 15]. Therefore, resilience building efforts for CF should focus on increasing CS so that the positive rewards of helping outweigh the costs. Since the helping others and self-care balance is tricky to achieve, implementing strategies for self-care and wellbeing awareness is vital early in one's professional career. Finally, providing education and workshops about CF, protective and risk factors for CF, as well as resources for screening and intervention for CF may reduce the deleterious consequence of CF. Self-care, a positive form of coping, can aid helpers and caregivers in dealing with stress, and the symptoms associated with compassion fatigue. Self-care may lead to an increase in compassion satisfaction [5, 13]. According to Chow and Kalischuk (2008), self-care is a primary prevention for illness and promotes personal well-being through resilience [16]. Self-care includes any activity where individuals devote time to focus on their own wellbeing, e.g., taking a bath, meditating, or engaging in recreational sports. Positive coping strategies such as self-care or expressing gratitude help to reduce stress across diverse populations and across a variety of stressors [17, 18, 19,]. Despite the well-established benefits of self-care, individuals may not understand its importance or may feel guilty when they take time for themselves instead of helping others. In other words, individuals' beliefs about self-care may play an important role in engaging in self-care. An authoritative construct in the clinical literature is the importance of thoughts / beliefs in influencing our behaviors

[20]. Resilience building would need to address negative beliefs about self-care in addition to increasing education and access to self-care activities. College students and early career professionals are an ideal audience for addressing self-care beliefs, as young adulthood is a key time to establishing patterns of living. We considered education about self-care, self-care beliefs, and access to self-care opportunities as a primary intervention for compassion fatigue.

Aims

We believe that anyone who engages in helping or caring for others, particularly people or animals under stress or who have experienced trauma is at risk for developing CF. Therefore, the current study focused on compassion fatigue and compassion satisfaction in college students as a result of being involved in "helping roles" at their jobs, through volunteer / internship experiences and / or in their personal relationships with friends, family members, or classmates. We sought to identify potential risk and protective factors for developing compassion fatigue in college students to guide future education and prevention initiatives. We specifically looked at the potential role of self-care beliefs in driving self-care behaviors to ward off the consequences of CF. We proposed self-care behaviors, self-care beliefs, and self-esteem would contribute to the models of burnout, STS, and compassion satisfaction. Specifically, we hypothesized that self-care behaviors, self-care beliefs, and self-esteem would be negatively correlated to both components of compassion fatigue, namely STS and BO. We hypothesized that self-care behaviors, self-care beliefs, and self- esteem would be positively correlated to compassion satisfaction.

METHODS
Participants

The participants were 143 college students enrolled in upper-level psychology courses at a university in the southeastern United States, approximately 39.8% of all upper-level psychology majors enrolled at the time. The majority of participants were women (83.2%) and upper level students (52.4% seniors, 33.6% juniors, and 12.6% sophomores), with a mean age of 21.44 years (SD = 3.07). The participants self-identified their race and ethnicities as: White (64.3%), Black (24.5%), other (7%), Latinx (2.1%), Asian or Pacific Islander (1.4%), and Native American (.7%). Students were recruited through e-mail and direct contact of professors in the psychology department teaching upper-level psychology classes (third- or fourth-year courses). After professor consent, a researcher or research assistant read a recruitment script to the entire class, students provided informed consent, and were given an opportunity to participate immediately after the recruitment script. No students declined to participate. Of the total participants, n = 2 were excluded from the regression analyses due to missing data on a critical number of items for at least one scale included in the regression.

Measures

The Professional Quality of Life Scale [ProQOL, 21], a revision and expansion of Figley's (1995) original Compassion

Fatigue Self-Test [14], is a widely used measure for the assessment of compassion fatigue in both research and practice. In 1993, Stamm introduced the concept of compassion satisfaction, which represents the positive feelings and pleasure that people derive through helping others. The current ProQOL,is a 30 item self-report measure that uses a 5-item Likert-type scale (1 = never to 5 = very often) to measure respondents' positive and negative experiences with helping others. Total scores on the Secondary Traumatic Stress subscale (STS) and Burnout subscale of the ProQOL were used to assess symptoms associated with compassion fatigue. The STS subscale (M = 21.38, SD = 6.31, α = .83 for our sample) reflects secondary exposure to extremely stressful experiences and Burnout subscale (M = 22.49, SD = 5.30, α = .7 for our sample) measures feelings of hopelessness and difficulties in dealing with work. Scores on the STS and Burnout subscales can range from 10 to 50. Total scores on the Compassion Satisfaction subscale were used to assess positive feelings and experiences from helping others and pleasure derived from being able to do one's work well. Scores on the Compassion Satisfaction subscale can range from 10 to 50. Higher scores on this subscale reflect greater satisfaction with one's experience as a helper (M = 37.60, SD = 6.48, α = .85 for our sample). Cut point ranges for all three subscales are as follows: Low = 22 or less, Average = 23-41, and High = 42 or more. The Self-Care Assessment Worksheet [SCAW, 22] is a 70-item self-care indicator that measures the degree to which individuals engage in a variety of self- care activities. It assesses six areas of self-care: physical, psychological, emotional, spiritual, professional workplace, and balance. Respondents are asked to rate each activity on a scale from 1 to 5 in terms of frequency (1 = never occurs to 5 = frequently occurs). An overall total self-care behavior score was calculated by totaling all of the responses on all 70 items (M = 225.15, SD = 29.12). Possible total scores can range from 70 to 350. Higher total scores indicate more engagement in self-care behaviors and activities and lower scores indicate low engagement in self-care behaviors. The Self-Care Beliefs Scale (SCBS) is an instrument developed by the researchers based on the self-care literature to assess individuals' opinions about whether or not they believe that self-care is important, feelings of guilt associated with engaging in self-care, and their general perspective about self-care. The SCBS consists of 12 statements that are responded to on a 5- point Likert scale (1 = strongly disagree to 5 = strongly agree). Possible scores range from 12 to 60 with higher scores indicating greater self-care beliefs and positive views about self-care (M = 40.99, SD = 8.11, α = .85 for our sample).

The Rosenberg Self-Esteem Scale [RSES, 23] is a 10-item indicator of global self-esteem that uses a four-point Likert scale (0 = strongly disagree to 3 = strongly agree) to gauge respondents' current feelings about their self-worth. Scores on the RSES range from 0 to 30 with higher scores indicative of greater self-esteem (M =19.34, SD = 5.46, α = .91 for our sample).

Procedure

Students completed all of the surveys simultaneously in a classroom setting, which took approximately 20-30 minutes to complete. They were asked to answer the questions on the ProQOL related to any experiences in which they had been involved in a "helper role" over the past 30 days including at their jobs, through volunteer or internship experiences, and / or in their personal relationships with friends, family members, or classmates. Students were also asked to complete demographic information (age, gender, and ethnic identification), to rate their frequency of helping others, and to rate their exposure to someone under a lot of stress (using a 5-point Likert scale).

Data Analysis Plan

We planned to complete bivariate associations between all our main study variables including the STS, BO, and CS subscales of the ProQOL, the SCAW, SCBS and the RSES. To test our primary hypotheses, hierarchical regression models will be used, with frequency of helping behaviors and prior exposure to compassion fatigue entered in the first step of the model. We chose to enter these variables first as exposure to helping individuals under duress is necessary to the later development of compassion fatigue. Examination of Mahalanobis distance scores and residual scatterplots did not reveal multivariate outliers in the dataset. In addition, we chose to use three separate hierarchical regression models, one for each component of CF: STS, BO, and one for Compassion Satisfaction.

RESULTS

The correlations between the main variables of interest are displayed in **Table 1**. As expected, the STS and BO subscales of the ProQOL were positively correlated; and the CS subscale was negatively correlated with BO. However, contrary to our hypothesis, CS had no correlation with STS. Self-care behaviors

Table 1: Correlations Between Compassion Fatigue, Compassion Satisfaction, Self-Care, and Self-Esteem

	1	2	3	4	5	6	7	M (SD)
1. Secondary Traumatic Stress (ProQOL)	-							21.38 (6.27)
2. Burn-out (ProQOL)	.61**	-						22.51 (5.28)
3. Compassion Satisfaction (ProQOL)	-.02	-.42**	-					37.56 (6.48)
4. Self-care Behaviors (SCAW)	-.04	-.41**	.5**	-				224.89 (29.18)
5. Self-care Beliefs	-.41**	-.39**	.03	.26**	-			40.9 (8.1)
6. Self-esteem (RSES)	-.38**	-.59**	.29**	.49**	.53**	-		19.37 (5.45)
7. Frequency of helping others	.3**	-.004	.38**	.2*	-.2*	.006	-	4.29 (.76)
8. Exposure to people under stress	.32**	.31**	-.1	-.07	-.23**	-.27**	.26**	3.82 (.94)

ProQOL= Professional Quality of Life Survey; SCAW = The Self-Care Assessment Worksheet; RSES = Rosenberg Self-Esteem Scale; * = $p < .05$, ** = $p < .01$.

were negatively correlated with both the burnout and compassion satisfaction subscales of the ProQOL. Self-esteem scores were negatively correlated with secondary traumatic stress and burnout, and positively correlated with compassion satisfaction and self-care beliefs. Finally, self-care beliefs were negatively correlated with secondary traumatic stress and burnout, and positively correlated with self-care behaviors and self-esteem.

We utilized a two-step hierarchical regression model to test our primary hypotheses, namely, self-care behaviors, self-care beliefs, and self-esteem would be negatively correlated to the components of compassion fatigue. Frequency of helping and prior exposure to individuals under stress were entered in the first step of the model, as they are both considered necessary to develop compassion fatigue. The SCAW, SCBS, RSES, were regressed on STS in the second step of the model. The results of the final regression model indicated the predictors explained 30.2% of the variance in secondary traumatic stress (R2 =.3, F(5,135) = 11.69, p <.001). Overall both self-esteem and self-care beliefs were negatively associated with concurrent secondary traumatic stress, while self-care behaviors (SCAW) did not contribute. See **Table 2** for the full model results.

to individuals under stress were entered in the first step of the model and the SCAW, SCBS, and the RSES were entered in the second step of the model. The results of the final regression indicated the predictors explained 36.1% of the variance in compassion satisfaction (R2 =.36, F(5,135) = 15.24, p <.001). Consistent with our hypotheses, self-care behaviors was positively associated with compassion satisfaction. However, neither self-esteem nor self-care beliefs were associated with concurrent compassion satisfaction in our sample. The complete model results are displayed in Table 2.

DISCUSSION

As previously mentioned, compassion fatigue has historically been associated with professionals in helping roles such as health care personnel, first responders, and social workers. However, this experience is not limited to "professionals". In fact, Kinnick, Krugman, and Cameron (1996) found the existence of CF in members of the public who were exposed to human suffering through mass media outlets [24]. Despite this, there continues to be a lack of research on CF in the general population. Hansen and colleagues (2018) report that "since most adults experience at least one traumatic event during their lifetime, it is important to extend research on compassion fatigue to a more general population" [25, p. 632]. Furthermore, Bride, Radey, and Figley (2007) emphasized that a first step in preventing CF is learning to recognize the signs and symptoms [14]. To our knowledge, few studies have examined CF in non-professional samples with the exceptions of bereavement volunteers [26], graduate social work students [27], and a single study with the general public [24]. The purpose of our study was to examine the relative contributions of self-care behaviors, self-care beliefs,

Table 2: Multiple Linear Regression Analyses of Self-Care and Self-Esteem on the Components of Compassion Fatigue (n = 143)

Outcome Variables	Step	Predictor Variables	B	SE B	β	Δ R^2
STS[a]	1	Helping Frequency	1.94	.55	.23**	.16***
		Exposure to Stress	1.78	.67	.26**	
	2	SCAW	.03	.02	.13	.3***
		SCBS	-.17	.07	-.21*	
		RSES	-.34	.11	-.29**	
Burnout[a]	1	Helping Frequency	-.58	.58	-.08	.1**
		Exposure to Stress			.33***	
	2	SCAW	-.03	.01	-.16*	.3***
		SCBS	-.06	.05	-.09	
		RSES	-.41	.08	-.42***	
Compassion Satisfaction[a]	1	Helping Frequency	3.7	.68	.43***	.18***
		Exposure to Stress	-1.5	.55	-.22**	
	2	SCAW	.09	.02	.39***	.173***
		SCBS	-.09	.07	-.11	
		RSES	-.14	.11	.12	

STS = Secondary traumatic stress, SCAW = Self-care assessment worksheet, SCBS = Self-care belief scale, RSES = Rosenberg self-esteem scale.
a = subscales of the Professional Quality of Life Survey. *p < .05, **p < .01, ***p < .001.

To test if self-care behaviors, self-care beliefs, and self-esteem were negatively associated with burn-out, we again used a two-step hierarchical regression model where frequency of helping and prior exposure to individuals under stress were entered in the first step of the model and the SCAW, SCBS, and the RSES were entered in the second step of the model. The results of the final regression indicated the predictors explained 40.1% of the variance in burnout (R2 =.4, F(5,135) = 18.08, p <.001). Consistent with our hypotheses, self-care behaviors and self-esteem were positively associated with concurrent burnout. Contrary to our hypotheses, self-care beliefs were not associated with burn-out in our sample. See table 2 for the full model results.

To test our final hypothesis, whether self-care behaviors, self-care beliefs, and self- esteem were positively associated with compassion satisfaction, we again used a two-step hierarchical regression model. Frequency of helping and prior exposure

self-esteem, frequency of helping, and exposure to stress to the concurrent prediction of compassion fatigue and compassion satisfaction in a pre-professional sample. Similar to past studies with professional populations such as hospice professional, nurses, and mental health professionals [5, 6, 7] we found burnout to be inversely related to compassion satisfaction in college students.

Recently the importance of trauma-related content in clinical training has received more recognition [26]. We suggest that building resilience related to CF should start even earlier, namely at the undergraduate level. We suspect that young adults who have yet to enter the professional world , or have not yet begun graduate level training are still susceptible to CF and would uniquely benefit from education and prevention efforts. Consistent with previous researchers in professional populations, higher levels of compassion satisfaction were associated

with lower levels of compassion fatigue in our sample. Given this relationship, education and training efforts on increasing compassion satisfaction could be beneficial for resilience building and intervention purposes in pre-professional populations.

Promoting self-care and developing self-care strategies have been associated with higher compassion satisfaction [13] as well as lower levels of compassion fatigue and burnout [5]. The hypothesis that self-care beliefs, self- esteem, helping frequency, and exposure to stress would predict concurrent secondary traumatic stress was supported. While this is not a new idea in professionals, the consistency of this finding in college students suggests resilience-building efforts should start earlier in one's career. Our study uniquely identifies the potential importance of identifying self-care beliefs contributing to the underutilization of self-care strategies. This study suggests the development of unhealthy coping strategies are rehearsed prior to the high-stress work environment. These findings highlight the opportunity to promote prevention strategies in pre-professional samples through psychoeducation, and focused brief interventions.

Advocating for education and regular training initiatives within the helping professions may reduce symptoms of STS and may decrease the high turnover rates in many of these professions. Our hypothesis that self-care behaviors, self-esteem, and exposure to stress would predict concurrent burnout was supported, suggesting self-care behaviors are a likely target for building a CF resilient workforce.

Contrary to our hypothesis, self-care behaviors did not contribute to the prediction of concurrent secondary traumatic stress. Additionally, self-care beliefs and frequency of helping did not contribute to the concurrent prediction of burnout. Further, compassion satisfaction and STS were not related in this sample. These findings could be due to unique characteristics in our current sample, for example perhaps levels of STS were not high enough to be impacted by self-care behaviors or related to CS in our study. Interestingly, self- care behaviors predicted burnout (but not STS), while self-care beliefs predicted STS (but not burnout). Another striking possibility is that self-care beliefs are related to an individual's recent practice of self-care impacting their current feelings of STS, while their established self-care behaviors impact the long-term development of burnout. Therefore, we are advocating for the dual emphasis on both self-care beliefs and self-care behaviors to build resiliency to CF. We plan to specifically measure well-being and resilience in future studies to assess the relationship of self-care beliefs to these constructs directly.

Engagement in self-care behaviors, the frequency of helping others, and exposure to stress emerged as the best set of predictors of CS in our study. Interestingly, and contrary to what we hypothesized, self-care beliefs and self-esteem were not significant predictors of compassion satisfaction when entered simultaneously with other predictors. In this study, self-esteem correlated strongly and positively with self-care beliefs, suggesting those who hold positive beliefs about their worth also believe they deserve to engage in self-care, are worthy of engaging in self-care, or deserve enjoyment in life. Self-care beliefs may be influencing compassion satisfaction indirectly through an increase in self-care behaviors. Although we focused on overall self-care behaviors in our study, these behaviors are commonly broken down into different areas of self-care such as physical, emotional, or spiritual. Alkema and colleagues (2008) found that specific areas of self-care such as emotional, spiritual, and overall balance were better predictors of CS in hospice professionals than other forms of self-care [5].

LIMITATIONS

One limitation of the present study is that our sample consisted of undergraduate college students from upper level psychology courses which limits the generalizability of our findings. Additionally, our sample mean scores for compassion fatigue indicated relatively low levels of STS and burnout for our sample, in other words they were not currently at risk for developing CF. Despite this, our sample means for secondary traumatic stress, burnout, and compassion satisfaction were similar to samples of licensed or certified behavioral health providers [7], bereavement volunteers, and professionals [26]. It makes sense that our sample means would not reflect significant risk for compassion fatigue as our students have not yet entered their future professions or sustained ongoing long-term exposure to clients. We concur with others [7] that compassion fatigue is not limited to professionals who engage in helping roles but rather can occur with anyone who is exposed to the suffering of others. This finding supports the need for education about recognizing and identifying the signs and symptoms of CF early in one's training as well as in the general population in order to build resilience to its negative consequences.

A second limitation is with a cross-sectional design, we are unable to draw any causal conclusions about exposure to stress, frequency of helping, self-esteem, self-care, and compassion fatigue. Despite these limitations, this study provides preliminary data regarding the relationships among these variables in college students. Further, these relationships are consistent with studies of professional samples. To understand the development of compassion fatigue, future research will need to explore these variables with graduate level students, interns, and professionals in helping professions, preferably in a longitudinal design. Finally, the instrument used to measure self-care beliefs in our study is still in the development stages. Since we could not find a published measure of self-care beliefs, we utilized the self-care literature to develop our own instrument, which should be validated in further research of helping professionals. While preliminary psychometric evidence is promising, further evaluation and validation of this scale is warranted.

Compassion Fatigue Resilience Model

The current study informs a working model of compassion fatigue resilience incorporating the impact of self-care on compassion fatigue as displayed in **Figure 1**, and compassion satisfaction as displayed in **Figure 2**. We believe improving self-care beliefs and self-care behaviors will increase an individual's resilience to the deleterious effects of
compassion fatigue. In both models, we assume exposure to the stress of being in a helper role
as preceding the experience of compassion fatigue. We propose that self-care beliefs positively influence self-care behaviors, a
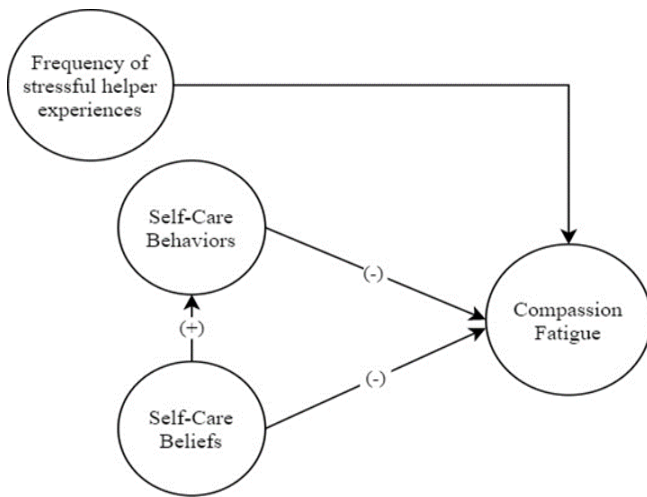
Figure 1: The influence of self-care on compassion fatigue in the compassion fatigue resilience model
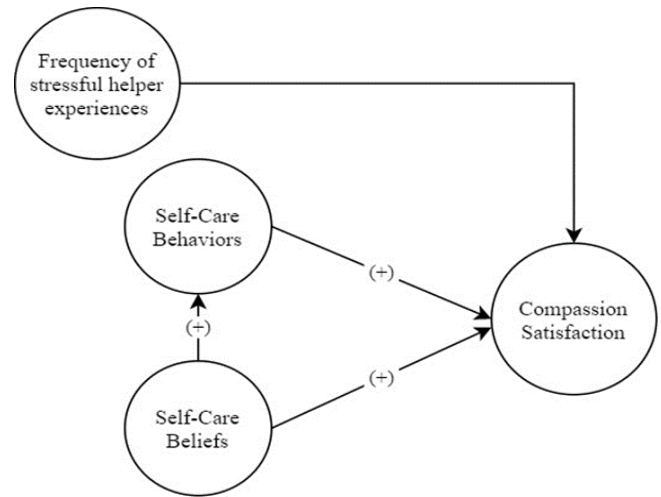

Figure 2: The influence of self-care on compassion satisfaction in the compassion fatigue resilience model

relationship reliably demonstrated in the clinical literature and discussed in detail in cognitive therapy [28]. Consistent with our current findings and previous literature, we propose that self-care behaviors are associated with both compassion fatigue and compassion satisfaction [5]. Specifically, we believe self-care behaviors decrease experiences of secondary traumatic stress and burnout. In addition, self-care behaviors increase feelings of compassion satisfaction. Pointedly, we propose that self-care beliefs are associated with compassion fatigue and compassion satisfaction. Similarly, we propose that self-care beliefs will increase self-care behaviors and feelings of compassion satisfaction, as well as decrease secondary traumatic stress and burnout. While this model is preliminary, future research exploring these relationships with pre-professionals and professionals is required to assist our resilience building and intervention efforts.

CONCLUSION

Aspiring to enter a profession that focuses on helping others is a noble endeavor indeed. However, there is a risk of experiencing compassion fatigue for individuals in these professions. This study sought to identify correlates of compassion fatigue and compassion satisfaction in pre-professionals, namely, college students with an eye towards education and resiliency building. For intervention efforts related to compassion fatigue, it makes most sense to target both self-care beliefs and behaviors since they are more amenable to change than overall self-esteem. Additionally, self-care behaviors and beliefs predicted different aspects of CF. Since higher levels of CS are associated with lower levels of STS and burnout in professionals, it may be important to educate undergraduate students about ways they can increase satisfaction they derive from helping others through personal, work, and volunteer experiences. This strategy encourages them to develop healthy coping skills before they become professionals. The results of this study emphasize the importance of CF education and resiliency efforts, with a focus on addressing self-care beliefs and self-care behaviors prior to entering the workforce.

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