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The Hidden Cost Of Caring: Exploring Compassion Fatigue Among Mental Health Professionals Amid Covid-19 Crisis.

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ABSTRACT

Covid-19 had a universal effect on everyone, touching upon each and every person's life, whether infected by it or not. Its effect is so much so that even healthcare workers were not spared from its residual effect in various forms. With the rise in COVID-19, the demand for mental health care needs also increased, leading to increased fatigue and burnout, which ultimately led to compassion fatigue among mental health professionals. Compassion fatigue is an empathetic response resulting from recurrently observing the emotional or physical suffering of others or repeatedly listening to a person's trauma from mental or physical dysfunction, affecting the professional's overall health, leading to high turnover and absenteeism, impacting the quality of patient care and decrease in patient's trust and confidence. Therefore, the present study aimed to explore the causes of compassion fatigue among mental health professionals amid the Covid-19 crisis. The data was collected and interpreted following a Thematic approach. Twelve participants were purposively selected, practicing in the field of mental health for the past five years or more. Semi-structured interviews were used to collect data. Data was analyzed and interpreted into themes discovered during the analysis. Links between the themes and processes underpinning the results were explored with existing literature. Four themes were generated: 1. Similarity, 2. Workload, 3. Declined self-care and 4. Therapist's self-efficacy. The causes for compassion fatigue as perceived by mental health professionals were discussed further. Understanding the causes of Compassion fatigue among mental health professionals will help in planning appropriate interventions, to further help professionals to work at their maximum potential and provide services to the community at large, while maintaining their own mental well-being, along with contributing towards illustrating and escalating upon prior research concerning variables allied with compassion fatigue.

Keywords: Compassion Fatigue, Mental Health Professionals, Covid-19, Thematic analysis Qualitative study.

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INTRODUCTION

Covid-19 had a universal effect on every one (Zhao et al. 2020), however, healthcare field has been most severely affected (Franza, Robert, Pellegrino, Solomita & Fasano, 2020). It has significantly affected mental health professionals. Worldwide, people had experienced extensive mental health issues, even if they were not diagnosed with COVID-19 (Tandon, 2020). Researchers have pointed out to the increased perceived need for mental health care during pandemic among all citizens (Roy et al., 2020). Healthcare sector was universally affected adversely, including mental health care (Tandon, 2020). The consequences of pandemic are so strong that the mental health of healthcare workers was affected negatively (Galbraith et al., 2020). With rapidly mounting number of mental health issues related to COVID-19, the pressure on mental health professionals is also building exponentially (Kar & Singh, 2020). As per the general notion in our society, the mental health of mental health professional is expected to be at par to deal with challenges, so they can't express their stress, fear, anxiety or depression. This presumption is also expected among healthcare professionals of nonpsychiatric department. But the fact is mental health professionals are also human beings and they are not immune to psychiatric issues.

One of the multiple problems to be contemplated about it could be the likelihood of compassion fatigue in mental health professionals. Compassion fatigue is a type of secondary traumatic stress and refers to a "state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing toward reminders, persistent arousal (e.g., anxiety) associated with the patient" (Figley, 2002). Extreme compassion fatigue can hinder with an expert's clinical acumen and efficiency (Bride, Radey, & Figley, 2007). This dereliction of judgment may lead to immoral and inferior levels of care. For instance, psychotherapists can encounter depersonalization which can led to pessimistic emotional state regarding the client (Ackerly et al., 1988). These pessimistic emotions can create a difficult situation for the professional to function toward objectives that are in the greatest concern of the client (Negash & Sahin, 2011). In one research study on compassion fatigue, it was found that the feeling of ineptness and triviality, can make a therapist to choose maladaptive ways to treat their clients (McCarthy and Frieze, 1999). A professional suffering from compassion fatigue can likewise record partly or imprecisely, documenting data about a patient that is prejudiced or misreported (Negash & Sahin, 2011). Similarly, compassion fatigue might damage the therapeutic alliance, ensuing in the therapist displaying a diminished capability to empathize and have regard for the patient (Skorupa & Agresti, 1993).

Alternative studies have proposed a deficiency of emphasis on aiding student trainees or junior workers acquire problem solving skills and self-care programs, to help them in balancing their professional and personal life (Bride and Figley, 2007; Bell, 2003). Therefore, numerous mental health professionals' whitethorn begins their vocations unready to handle the mental and physical outcomes of compassion fatigue (Harr, 2013). Although, psychologists might have a difficulty in identifying and communicating symptoms of compassion fatigue, it is vital that they are conscious of the cautionary signs (Kramen-Kahn & Hansen, 1998) and that additional research is being carried out to reveal the factors that might impact the peril of evolving compassion fatigue (Craig & Sprang, 2010).

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Data about the extent of compassion fatigue in mental health professionals is rare and varying; though most of it, allies with outcomes from researches performed with professionals from non-mental health background (Craig & Sprang, 2010). Professional helpers who have to face numerous stressors are vulnerable to CF (Gleichgerrcht and Decety, 2014; Yu et al., 2016).

During the COVID-19 outbreak, State-specific intervention strategies, telepsychiatry consultations, toll free number specific for psychological and behavioural issues have been issued by the Government of India. Along with that India has also witnessed various universities and institution taking the initiative to reach out to masses providing mental health services to address the psychological impact of COVID-19. Mental health services become online and with the arrival of mental health chatterbots, mental wellbeing devices are being furthermore achievable in the middle of the lockdown (Garg, Bisht and Singh, 2020). These online mental health professionals may experience CF when facing help-seekers from time to time. Investigating the factors that can affect CF is necessary, regarding the negative impact of CF on mental health professionals providing both tele-consultation and online, that may help researchers design efficacious and empirical intervention programs to reduce CF.

We could find very few quantitative studies on compassion fatigue among mental health professionals but no qualitative study in this area, additionally, no study was found focusing on compassion fatigue among mental health professionals specifically during lockdown, to the best of our knowledge. A study done by Brandi Roelk, 2016, pointed out by the authors is that the questionnaire didn't capture the subjective aspects of compassion fatigue. Numerous professionals would specify an objective answer, yet they wrote remarks on the side. Analysing these remarks for similarities by the investigators could have revealed additional data about compassion.

Research questions:

Central question-

1. What are the causes of compassion fatigue identified by mental health professionals?

Sub questions-

2. How does therapist's self-efficacy relate to compassion fatigue?
3. How does case load relate to compassion fatigue?

Method

Participants

12 Mental health professionals, practising for 5years or more in the field of mental health, who had experienced compassion fatigue were recruited using an opportunistic and purposive sampling strategy. They were explained the purpose of the research and all of their queries were promptly addressed. After seeking their consent of each participant, they were interviewed through zoom video call meeting by the first author and the interviews were conducted. The interviews lasted between 30 to 55minutes and manual transcription produced twelve individual verbatim transcripts. A sample of 12 was considered practical for the study.

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Data collection process

Recruitment

The prospective participants fulfilling the inclusion criteria were identified from the first author's professional group and hence recruited through personal connection. Preliminary discussion on the background of the study were then conducted with the prospective participants by contacting them through emails and phone. They were briefed about the study through Participant Information Sheet and an opportunity to raise any query regarding the study was offered. Snow ball sampling technique was used to achieve our desired sample of n=12.

Interview schedule

Funnelling approach was used to design the interview questions. Some of the questions asked were as follows:

1. How does helping others affect you emotionally?
2. How confident are you in your abilities to use helping skills effectively, in counselling/treating most clients?
3. How many clients do you see in a week and how does that affect you?

Data Analysis (Thematic)

For data analysis Braun and Clarke's (2006) phases of thematic analysis were followed. All stages of the analysis were peer reviewed by the second author and quotations used to represent themes were subject to 'member checking' with the relevant participant. The original interview transcripts were then re-read to ensure the final themes were supported by the original data.

Reflexivity

With the rapid onset of pandemic, the first author's personal experience of encountering compassion fatigue herself while delivering counselling services in a university counselling centre during pandemic, incited this research. Along with that the need to explore various common themes among mental health professionals in the context of compassion fatigue encouraged our decision to espouse Thematic analysis. To warrant the reliability and eminence of our research, it was evaluated against Yardley's (2000) criteria. Data analysis procedure was also given significant consideration. For example, each interview proceeded by the reflexive writing task by the first author, followed by discussion of the same with research supervisor. This step was done to avoid any kind of pre-existing expectations or assumptions held by the first author from influencing the analysis. To validate additional transparency, verbatim excerpts are propounded as proof.

Results

Table 1. Main themes and sub-themes.

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THEMES	SUB THEMES		
1) Similarity	a) Similar nature of the problem	b) Living conditions	c) Financial issues
2) Workload	a) No work life boundaries	b) Increased Inflow of clients	
3) Declined Selfcare	a) Psychological self care	b) Decreased social connectedness	c) Lack of physical exercise
4) Therapist's Self-efficacy	a) Lack of guidelines	b) Virtual barriers	

Table 1 describes the key themes and sub-themes that appeared from the transcripts. The results of this study generated four themes (see Figure 1). The four themes were "Similarity", "Workload", "Declined selfcare" and "Therapist's self-efficacy". These were all adjudged to be recurrent themes within the dataset and highly striking for the most of the subjects. The themes are further described below:

Causes of compassion fatigue

Similarity

With the 'similarity', all participants believed that it led to an increase in empathy which led to an increase in compassion. But with further increase in compassion for them, it led to fatigue and frustration, because they were also facing the same issues as their patient's, which were difficult to deal with.

1. Similar nature of the problem

According to the participants, the nature of problems that they were dealing with during lockdown and the problems that the patients were facing were similar. This had led to increase in empathy and compassion with the client and their respective problems. Here is P1 discussing her issues:

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"Empathy I believe kind of increased for me it worked negatively…….. because I'm also struggling with mostly the same things and they are also coming up with similar things……. so empathy as in I could relate with them, empathy is there but increased empathy I think led to frustration and fatigue……. " (P1)

P3's account also reflected the similarity of therapist's issues with clients issues

"the kind of issues that I was seeing, most of them came with…….., the grief the apprehension about the future and their work and career etc,…… so interestingly we were also in that particular phase so its not that the client are facing something different and we are facing different"

For P10, separating her feelings from patients sufferings was a difficult task, while going through the same kind of trauma.

"so its like certain part of you had to shut off……. you have to provide this phase wherein you're also going through same kind of a grief that the other person is also undergoing…… so we had to kind of distance ourselves from the grief and the uncertainty, the apprehension that we are also facing, from them……. that was a tasking thing, very novel thing I would say and we also didn't had any practice to you know do that" (P10)

2. Living conditions

Due to lockdown most of the patients were living alone or restricted to home, which is again an issue similar to what the therapists were dealing with personally. For P1 living alone and not having anyone to unroll was a similar situation faced by her patients.

"first important part was that I did not have a roommate or my boyfriend or my family member with me……..so when you have family members around you, after the session I could just go and you know unwind……That was the same issue my patient was facing….." (P1)

Similarly, P4 and P12 emphasized the importance of human touch along with not being able to go out as two major factors for stress.

"no human touch, no one to talk to, you can't go out, …… similar situation my patients were facing, so it became very easy to relate to them" (P4)

"I was living alone because my husband was posted to some other location, and when my patients used to say that I feel lonely there's no one to interact with, have lunch with etc, I could relate her on so many levels" (P12)

3. Financial issues

Continuing to next level of profundity, they reported feelings of helplessness when patients used to discuss about their job loss or wage cut and ultimately asking for discounts in sessions. According to the participants, Psychologist were also facing the same issues and at one level they could relate to the patient and on another level it was difficult for them to proffer a discount to their clients. This lead to a feeling of helplessness and later to frustration and lack of motivation. Here is P1 asserting her issues:

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"that time was really difficult…….. patients used to ask for discount as they had a jobloss or may be getting half salary, I could totally empathise with them, since I was also facing similar situation but I couldn't give them a discount on every session and that too to every client…… that would be unfair to myself and my hard work" (P1)

P2 also talked about the same factor,

"patients used to ask for discounts, because of various financial issues during lockdown, initially I gave them discounts, for few patients I took really low charges or no charge at all, but it affected my earnings ultimately and I have a house to run, and then it created a lot of frustration and anxiety" (P2)

P3's account reflected the frustration of empathising with patients and providing them free sessions and then facing negative consequences for that.

"I worked with a helpline (during COVID-19), so there the charges were very low or no charge at all, I had to give my number for emergency, but then my number started to be misused and I think it was free or low cost service, hence people didn't value it, it affected me negatively" (P3)

Workload

Another element that is mentioned very frequently is the increased workload due to the sudden boost in the number of clients. Based on their responses it appears that, initially before pandemic, all professionals were seeing a limited number of clients, but during pandemic the awareness for mental health care increased. This led to a sudden inflow of clients in large numbers leading to a huge amount of fatigue and burnout among professionals.

1. Increased inflow of clients

The first subtheme recognised from the transcripts is that participants believed that with increased number of clients they had to invest increased efforts and time, to match the requirement of each client. Increased effort directly led to increased exertion and hence increased fatigue.

P1's account reflected the direct link between increased number of clients and increased exhaustion:

"Seeing a certain amount of clients would make you feel exhausted there would be less time available for other things that piled up……., so when that happens this exhaustion also leads to a little amount of wishful thinking, in which you wish that you have less amount of clients to see" (P1)

P6 expressed her feeling of relaxation on having no appointments on some days, as she felt already overwhelmed by seeing increased number of patients.

"yes it increased during corona, it was like 25 in 5 days but like if I am seeing 5 patients in mid-week I would start feeling the fatigue even though you're not consciously willing to do it but the exhaustion was there around those things...……". (P6)

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2. No work life boundaries

According to the participants, boundaries between work and family life were disrupted by the pandemic. The daily life during the pandemic and lockdown blurred the boundaries between work and family responsibilities, as they were seeing a huge number of clients throughout the day and were not getting any time to spare for themselves or their family.

Like P1's account reflected her negligence towards personal life and putting entire focus on her patients:

"during those days I used to work beyond my capacity…… I didn't get time to think about my self…… I was not getting enough time to focus on other things in life…… and that was sometimes frustrating and led to fatigue" (P1)

P3 asserted how she was not able to devote her attention to her academic work because of her unstructured working hours.

"I could not follow any routine……. As I'm currently pursuing my Ph.D. along with my practice, so I didn't used to get enough time for my research work and my working hours were not structured. I couldn't focus on my research work because after work I used to get completely drained out and that used to make me irritable and fatigued" (P3)

Declined self care

One of the aspects recognised by participants was a declined self-care. They also believed that having good self-care including venting out sessions, social connectedness and physical exercises were important for avoiding the negative effects of fatigue or their practice in general.

1. Psychological self-care

Participants pointed out that they could not vent out or didn't get an opportunity for catharsis, they were not able to do personal counselling, spending time with oneself and care for oneself, which together could be called a psychological self -care (Coster & Schwebel, 1997; O'Connor, 2001).

Not being able to introspect about oneself and the session itself, along with inability to vent out to someone, led P1 to a state of fatigue. P1's and P3's account reflected the same:

"Usually after wrapping up for the day I spend some time with myself introspecting what was done in the session, try to do personal counselling if something bothers me, and vent out with my husband about anything that is bothering me, but during pandemic this was not possible because of lack of time and getting fatigued and overwhelmed after seeing so many patients back to back" (P1)

"The biggest factor that I feel that seeing clients consecutively also impacted my mental health because I couldn't really vent out or I couldn't really wind up my day properly. If a person would have been there, it would have helped. So that was the main thing I believe. I was not able to spend time with myself and reflect back what ever happened in the session." (P3)

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P6 emphasized on the importance of discussing the patient's issues with your colleagues and referred to it as a source of catharsis.

"In normal days we used to discuss about sessions with our colleagues, which worked out as a catharsis session (smiles) and also we used to go out to spas, gym or do yoga meditation etc, because we had time…… during covid we didn't get time for self-care" (P6)

2. Decreased social connectedness

Mental health professionals reported that not being able to socialise or go out to meet their friends and family was also a contributor to an increase in their fatigue and burnout.

Professionals asserted that the pandemic dissuaded social connections among professionals due to lockdown and lack of time to connect with each other, which ultimately led mental fatigue. For P1 expresses the same concern here:

"I believe it was like COVID had to do with compassion fatigue, why because like when you go to an offline center ……..there are three other people eg psychiatrist, clinical psychologist….., so you're also having this wind up time during your stay in your office that you talk about other things, joke around, you share your critical cases, so that bond was kind of missing during COVID, because you're all on your own…… I would say in that sense that offline you would have, you know the space to just express but when you're doing it on your own, and that too online I believe that it was a limiting experience for me".

Similar concern was expressed by P12:

"Before pandemic I used to meet my colleagues and discuss some of my difficult cases and take their perspectives on it…. During the pandemic this was no more an option, again you can't do that on a call. Also not able to meet my loved even once at that time also created a kind of negative emotion I feel" (P12)

Participants pointed out the importance of spending time with family and socialising with friends as one of the major stress buster, but unfortunately, due to pandemic this was not an available option. P3's account reflected the same need:

"Earlier I used to go out and spend time with my family and friends and that was a stress buster and therapeutic for me I feel like, but during pandemic that was not there and it affected me negatively" (P3)

3. Lack of physical exercise

In addition, there are numerous discourses that highlighted lack of physical exercises as one of the major issues leading to burnout and consequently to fatigue. Self care has been indicated by all the professionals as a very important ingredient for relieving stress and fatigue, which they were not able to practise unfortunately, during pandemic. P8's discourse indicated the same:

"Since I was seeing so many patients, I was not able to spare time for my normal daily routine of yoga and meditation, which made me feel tired, lethargic and fatigued most of the day" (P8)

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Lack of exercise and not getting enough sunlight, were the two key factors highlighted in P1's account, responsible for compassion fatigue according to her.

"I was not mindful of getting enough exercise or enough sunlight, I was not doing that or having enough of physical exercise, which I used to do otherwise …….So that physical exercise was not there and I was not getting enough sunlight because I was just hooked up in my room the whole day ……..that might have brought in compassion fatigue" (P1)

Therapist's Self-efficacy

For most of the participants the lack of self confidence or low self efficacy was related to them, dealing with the pandemic situation for the first time and not having any past experience or training for the same. This led them to doubt the effectiveness of the therapy they were providing, further leading to low therapist's self efficacy.

1. Lack of guidelines or procedures for therapy

   Mental health professionals, especially, clinical psychologists voiced a need for vigorous ethical guidelines. They revealed that due to lack of structured format of therapy to be used during pandemic or no guidelines from any government body, led to a state of uncertainty and low self confidence in the therapy they are providing to the client. They felt they were not prepared for dealing with issues that people have during pandemic as there were no workshops or training programmes from any government or professional body for dealing with issues that people face during such pandemic situation. P6 voiced his concern:

   "I had a lot of patients having issues pertaining specifically to pandemic……. But I was not confident enough at first to deal with such issues at first hand…… it led to a state of confusion and decreased self efficacy for me……. Since we were not trained for dealing with such pandemic situations before" (P6)

   P1 affirmed the same:

   "I felt low on confidence, since this was the first time I was dealing with pandemic related issues…….. I was following guidelines from NIMHANS but that was not enough or I would say even sufficient to tackle those issues……. So that lead to lot of mental work and mental fatigue" (P1)

2. Virtual barriers

   Many participants stated that they used to feel reluctant to use humour or certain specific words in the online sessions, as it was difficult to really predict the environment of the session in the online mode of therapy. There was uneasiness in using certain words or humour during the session because of lack of control and novel nature of the online mode of therapy sessions.

   The hesitation and uncertainty in the session itself acted as a deterrent in P1's focus and attention on patient's concerns.

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"it was like since I'm meeting the client online only and don't know about her/his background really, only having limited information that they gave, so it didn't feel easy or comfortable……., I was always cautious what im saying, what I should say, should I use personal reference or not, or should I bring some hilarity in the session, etc, so my attention was diverting there also, which was exhausting after sometime, since I was taking back to back session, and also because it was pandemic, which was not the case in offline mode"

Participants also highlighted that initial reluctance to use certain words because of lack of comfort with the patient in initial few sessions in an online mode. P6's account reflected the same concern:

"I think in online mode, you cannot be really certain about many things, although after having many sessions with the client that comfort can be reached, but not just after few sessions, unlike offline mode, so when such situation is there, you're reluctant to use certain words or may be whether I should use humour at this time, that was stressful actually" (P6)

DISCUSSION

The current study was based on a gap in the literature as pointed out by the study done by Brandi Roelk in 2016. Acoording to the author, in their quantitative study, they tried to find a significant relationship between compassion fatigue and counselling self efficacy and they did not found any significant relationship between the two variables. Nevertheless, self-efficacy been related to compassion fatigue in many previous researches (Saleem & Hawamdeh, 2022, Zhang, Ren, Jiang, Hazer-Rau, Zhao, Shi, Lai & Yan, 2021, Zhang, Wang, Xu, Li, Li, Wu, Li, Chen & Zhang, 2022).

First theme that emerged in our study which was previously not acknowledged by the researches, mostly because this study was done focusing on the crisis situation during pandemic, is "Similarity". Three sub themes, viz, similar nature of the problem, Living conditions and Financial issues, were identified under this theme. Mental health professionals alluded that majority of the patients were going through issues which were similar to what they have been experiencing at that time. This could possibly be one of the biggest reasons of increase in empathy with the patients which consequently led to increase in burnout and further compassion fatigue.

It was found that professionals believed that the issues patients were bringing in the session at that time and the troubles therapists were facing due to pandemic were similar in nature. Which included grief (loss of a loved one), apprehension/uncertainty about future and work & career related issues. Additionally, the living conditions of almost all of the clients were very much similar to that of the mental health professionals. Due to pandemic everyone was locked up in their homes, hence the basic human touch was missing, since most of the people were living alone or only with their partners. Further, it led to no venting out or discussions about their problems or how their day went, with some other person, which led to more bottled-up emotions. Furthermore, the pandemic led to job loss for many people, which led to financial issues, as a result of which patients asked for discounts in the sessions or even free sessions, which was not possible for therapists as they also have to run their household. But

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again, they were providing discounts for some patients who really needed them but it ultimately led to a loop of financial difficulties as it again led to financial loss for the therapist. All the problems that patients or clients were facing were very similar to the complications mental health professionals were facing which led to an increase in the empathy they developed for their clients and hence it ultimately led to an increase in compassion fatigue.

Avenues for further research as indicated in the study done by Brandi Roelk (2016), included exploring the match between patient characteristics and experiences and therapist characteristics and experiences. For example, therapists who feel that they are similar to their clients may empathize more and feel that they are in the patient's place more than those who don't. This suggestion indicated by the researcher also is in line with our findings.

Another theme generated in our study is Workload. Almost all mental health professionals communicated about this theme in their interview. They all identified the rapid upsurge in the number of clients as one key factor for fatigue. According to the professionals, they usually take 3-5 consultation sessions with their clients on daily basis, with exceptions for few of them, but at the time of pandemic, this figure surpassed to startling levels. So much so that they didn't get time for themselves, their household chores or their family members. Reason for this expansion in the number of clients seeking mental health care could be the intensification of the awareness about mental health in India and in general during pandemic, along with that the rise in prevalence of anxiety and depression (Santomauro, Herrera, Shadid, Zheng, Ashbaugh, Pigott, ... & Ferrari, 2021). This sudden growth in the patient caseloads led to decreased time for self, family or other tasks, which further led to feeling of helplessness, frustration and fatigue, as reported by the professionals. This finding is supported by the research findings of Udipi, McCarthy Veach, Kao and LeRoy (2008).

It was further found that disruption in work life balance led to a sense of frustration and fatigue. Some of the professionals reported that they were not able to give time to themselves, their families or other work at hand hence it caused a feeling of helplessness. They felt frustrated at times, because in sessions they were being exposed to mostly negative emotions and traumatic life events of the clients and at the same time at home they were having such negative emotions because of not being able to do certain important tasks which left them with feeling irritated and exhausted. Additionally, many therapists believed that since the number of clients augmented abruptly, they didn't really have all the time, resources, etc available for the session. This led to putting more and more efforts in the session itself. When the traditional therapies didn't work on these clients, therapists had to equip themselves with innovative and fresh techniques to cater to the demand of each client. Hence this required additional efforts for each client's unique issues, which eventually led to amplified fatigue.

Another very common theme identified in most of the transcripts is "Declined self-care" as a cause of compassion fatigue, which is in line with previous researches (Adimando, 2018, Edmonds, Lockwood, Bezjak, & Nyhof-Young, 2012; Marine, Ruotsalainen, Serra, & Verbeek, 2006; Figley, 2007 & Figley, 2002). Many professionals indicated in the interview, that they were not able to indulge in self-care, which usually they do, due to pandemic and increase work pressure. This decline in self-care led to an increase in stress and over all fatigue that they were experiencing. Not indulging in self-care means no care of physical,

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social or emotional needs, that their body required. Hereafter, it led to an intensification in compassion fatigue eventually.

It was identified by the participants that venting out/catharsis, personal counselling and care for oneself, which is a part of psychological selfcare, is important for them also, as they are being exposed to secondary traumatic experiences (Macran, Stiles, & Smith, 1999, Mackey & Mackey, 1994, Coster & Schwebel, 1997; Norcross, 2005). In addition, they pointed out that not being able to socialize with colleagues, friends and family, which could have provided them personal support, ultimately led to decreased self-care (Coster & Schwebel, 1997; O'Connor, 2001; Stevanovic & Rupert, 2004). Many professionals highlighted that they used to go out and discuss work related stuff, their new cases or anything new related to therapy with their colleagues and friends before pandemic which provided a way of catharsis too. They used to make plans with their friends and family and hang out with them which gave a sense of happiness and they could unwind from their work-related fatigue but during pandemic this was not an option which led to decreased social connectedness. Another very important factor raised by many participants is lack of physical exercise. There are numerous benefits of physical exercise identified in literature (Dishman, 2003, Callaghan, 2004 and Lustyk, Widman, Paschane, Olson, 2004 and Anderson, King, Stewart, Camacho, & Rejeski, 2005) but during pandemic professionals were not able to indulge in such self-care activities, which ultimately kept on building up their fatigue levels.

Based on the results obtained in our study, one of the causes perceived as generating CF among mental health professionals is therapist's self-efficacy. Although past studies have found self-efficacy to be positively related with compassion satisfaction (Haktanir, 2018; Watson, 1992), but in our study it was found to be positively related to compassion fatigue. The inconsistency of our results with previous study could be due to the fact that our study focus was towards finding causes of compassion fatigue specifically during pandemic times. As most of the professionals reported that since all the sessions during that time were through online mode and it was mostly the first time for them to take sessions online, hence there were a lot of barriers due to online mode which ultimately led to decreased self-efficacy. Some of the sub themes recognised were "Lack of guidelines" and "Virtual barriers".

Consequently, as it can be seen very clearly that decreased level of therapist's self-efficacy was not due to therapist's doubt in their own skills but rather their doubt on using their skills in a novel situation for which they were not ready. Most of the psychologists pointed out to the fact that they were not provided any training in the past on how to deliver therapy in pandemic situation currently or to be tackled in future. They were basically tacking a leap of faith and relying on trial and error while treating their clients, emphasizing on the fact that there were no formal guidelines or procedures to be followed. In addition, they also pointed out that they felt lack of control in an online therapy setup, because of the virtual barriers, which is anxiety provoking. This finding is consistent with the results of a study done by (Smith & Gillon, 2021, Tsalavouta, 2013, Fletcher-Tomenius & Vossler, 2009).

CONCLUSION

This study has culled out numerous significant aspects linked to compassion fatigue among mental health professionals amid COVID-19 crisis in India. It exhibited that compassion fatigue is a multifaceted phenomenon.

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The study also highlights the significance of identifying mental health professionals at-risk of developing compassion fatigue and dispensing them with appropriate and prompt assistance, by designing appropriate therapy and training for them, with the backdrop of the causes of compassion fatigue acknowledged in the current research, for equipping mental health professionals to deal in a healthier way with such pandemic situations in future.

Future Implications

Mental health professionals are surrounded by secondary traumatic experiences. These issues, that often go forsaken, cannot be covered in just one thematic quantitative investigation. To condense the actual fundamental of these problems, inscribing the lived experiences of mental health professionals, grips plenty of implications.

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