

Module Code: SJSS5002

Assessment number: 1

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Adopting a specific sociological theoretical ‘lens’ of your choice critically explore one of the following contemporary issues in society:

- ‘Disablism’
- ‘Poverty Porn and/or Charity Porn’
- ‘Compassion Fatigue’.

The aim of this essay is to understand what compassion fatigue means and the issues faced by individuals in today’s society. There will be a discussion of the three main paradigms used within the social order. Current legislation will be critically applied throughout that protects those at risk within a health and social care context, and an analysis of how the affects of the issues raised impact on individual’s mental health and well-being (Cocker & Joss, 2016). This assignment will focus its attention on caregivers and how compassion fatigue affects them on a daily basis (Siedine & Laschinger, 2017), looked through the theoretical lens of symbolic interactionism since theory reflects the social meanings through interactions (Clarke & Watson, 1991). Although this assignment’s main attention is regarding caregivers and experiencing compassion fatigue there will be link to poverty and conflict theory (Bartos & Wehr, 2002). There will be a discussion on what is meant to experience burnout, vicarious traumatization and secondary traumatic stress and how these links in with compassion fatigue (Freudenberger, 1974, Figley, 2002 and Nancy, 2009).

The three main paradigms in society are; structural functionalism, conflict theory and symbolic interactionism. Structural functionalism was developed by Emile Durkheim, he looked at society as a system working together to keep it in good health, keeping order and stability of the social systems (Potts *et al*, 2016). Conflict was developed further in the twentieth century when knowledge and understanding of social conflict and technology in society increased (Bathos & Wehr, 2002). Karl Marx is one sociologist who developed conflict theory through classes, composed of different groups within society, it is how we see inequality and conflict

in today's world (Barthos & Wehr, 2002). There have been many criticisms on Marxists, one being that 'Marxists should pay more attention to subjective aspects of human existence, societies must be studied in their totality, and the interrelationship of their parts must be understood', (Barthos & Wehr, 2002, p. 9). Symbolic interactionism looks at society through the way individuals interact and communicate with each other (Tomlinson, 2010). Individuals learn how to behave in society through interactions like how we speak to each other, what gestures we use, our body language, ultimately it is how we learn to interpret and give meaning to society (Zeegers & Barron, 2015). Symbolic interactionism has been widely criticised for failing to look at the history and politics of society through its macro levels and ignoring questions of control and authority (Meltzer, Petras & Reynolds, 1975, Giddens & Turner, 1988, Turner, 1990 and Redmond, 2015).

In 1992, Carla Joinson was one of the first to introduce compassionate fatigue (McNutt & Watson, 2015). One definition of compassion fatigue is, if a caregiver experiences distressing events over a period of time it can cause the individual to be in a state of mental and physical exhaustion, they will then be unable to cope with their everyday settings (Cocker & Joss, 2016, Delaney, 2018 and Sabo, 2006). There have been many definitions on what compassion fatigue is meant in today's society however if you look into the history of the term compassionate fatigue within a healthcare setting, their definition has not been consistent (Day & Anderson, 2011). If you look at Figley's work there can be great confusion with defining compassionate fatigue because it can link with secondary traumatic stress, traumatisation and burnout (Day & Anderson, 2011). However, there is evidence to show that since this term emerged in the 1990s there has been a considerable amount of research done on what compassion fatigue means which in turn has caused a lot of uncertainty (Siedine & Laschinger, 2017). Clark (1997) and Davis (1983) *cited in* (Lilius *et al*, 2008, pp. 193-194), describes compassionate fatigue to be a 'Multi-dimensional process in which three elements of compassion form a tri-partite concept'. These are, being able to notice another person's misery, being able to feel their pain empathically and finally being able to help ease that individual's suffering.

Burnout happens when professionals find the demands of their work load increasing even when they experience cut backs they are still expected to give the appropriate standard of care to individuals (Nancy, 2009). Compassion fatigue is seen to have a faster onset than burnout (Abendroth, 2011). Unlike compassion fatigue burnout has been well researched over the past thirty years, it is described as feeling like a failure, tired and worn out from the ever increasing and demanding work load, having no energy (Nancy, 2009 and Freudemberger, 1974).

Compassion fatigue is a term closely linked with vicarious traumatization and is used interchangeably, nurses who tend to experience vicarious traumatization lose purpose and question life as they know it, they start to lose determination (Figley, 2002 and Nancy, 2009). Secondary traumatic stress otherwise known as PTSD combines the notions of compassion fatigue and vicarious traumatization triggered by empathic engagement (Nancy, 2009). They experience secondary traumatic stress when they have been traumatized by events that have scared or threatened their well-being and have not received the appropriate support to cope, this in turn makes them lose trust, their feelings of fear and loss are amplified (Nancy, 2009).

In general, when the older generation need care and support, it is provided at home by family members, who become their primary caregiver (Schumacher, Beck and Marren, 2006). It is estimated within the Alzheimer's disease international *cited in*, (Broady, Saich & Hinton, 2018) that in the UK there are eight hundred thousand people living with dementia and out of that figure six hundred and seventy thousand are unpaid carers who support them. 'Six in ten carers have been pushed to breaking point and a quarter of them required medical treatment' (Carers UK, 2014, p.2). However, these statistics are out dated and there has been little research completed on family carer givers (Davies *et al*, 2017). Care of the elderly has been under review in the Francis report due to failings in vital care in a hospital in England, this included reports on families who have criticised the care their loved ones received (Davies *et al*, 2017). The majority of care for the elderly with dementia is carried out by unpaid family caregivers and the Alzheimer's society has claimed that without family care givers the care system would breakdown (Davies *et al*, 2017). All caregivers are at danger for developing emotional collapse from their work, if they are able to show compassion and empathy towards the individual they are then at greatest risk for developing compassion fatigue through experiencing grief and loss at work (Badger, 2000 and Nancy, 2009). If caregivers are experiencing compassionate fatigue then it can lead to poor patient care, relationships with colleagues can be affected and they can develop mental health problems like anxiety and depression (Cocker & Joss, 2016), it can also lead to an individual being unable to react sympathetically to a crisis (McNutt & Watson, 2015). Caregivers tend to re-experience their loved one's traumas and/ or health problems, they then in turn experience a reduced interest and empathy towards the suffering of the people in their care (Abendroth, 2011). Carers mental health and well-being often worsens from going without vital support they need to be able to care for their loved ones properly (Carers UK, 2014). Without the support a carer needs and deserves they then find it unable to rest, attend their own appointments and access treatment themselves, it is reported that many have to fight

just to receive some support (Carers UK, 2014). Negative behaviours; like drug and/or alcohol abuse, anger and exhaustion are all traits of compassion fatigue (Cocker & Joss, 2016). Hirschfeld's survey of thirty caregivers, *cited in* (Day & Anderson, 2011) found that they would feel 'resentful, helpless, and hopeless and that they had little free time'. This can impact on their relationships with their friends and family, which in turn affects how isolated they can become and the feeling of being worthless and not being able to relate to others increases. Figley *cited in* (Day & Anderson, 2011 and Siedine & Laschinger, 2017) explains that for a caregiver to develop compassionate fatigue they must firstly experience compassionate stress over a prolonged period of time.

Figley's model *cited in* (Siedine & Laschinger, 2017) links empathy with the carers ability to interact and help the individual in need, he also says that the carer is required to invest in their time and energy for this to be successful. One restriction of the model was that empathy was considered the main grounding for helping individuals and the main development of care givers experiencing compassion fatigue, however recent research has shown that patient and professional outcomes are improved by empathy (Siedine & Laschinger, 2017). Sabo *cited in* (Siedine & Laschinger, 2017), also suggests that Figley's model also failed to illustrate the positive outcomes from helping individuals who need support from carers. To be compassionate towards another person takes more than just empathy, you need to be able to feel or identify with that particular person and to gain an understanding of someone's experiences through life (Lloyd & Carson, 2011). Hence compassion includes seeing things through the person in need of care, their point of view and reflecting on their experience, rather than concentrating on just empathy (Lloyd & Carson, 2011).

Another factor for carers experiencing compassion fatigue and breakdown of their mental health is financial implications (Carers UK, 2014). Carers often feel that they are unsure of what the future may hold with rising costs of living and losses of income from paid work (Carers UK, 2014). It is believed that an estimated 'one in five were forced to give up their jobs' to help care for their loved ones (Carers UK, 2014, p.2). This can then lead to poverty, where the carer now has a lack of resources and basic security to be able to pay for their bills and food, they will not be able to enjoy activities they once did and their health and well-being can be affected (Lister, 2009). Being at risk of living in poverty can have serious effects on a person's mental health (Elliot, 2016).

For an individual to reduce the chances of developing compassion fatigue, evidence suggests that using positive emotions like, gratitude, kindness and interest can have positive outcomes that can reduce burnout and compassion fatigue (Epstein & Marshall, 2017). The six C's aims are for professionals to deliver high quality patient care, to help deliver compassion towards patients which in turn improves the quality of care a patient receives (Bostock-Cox, 2013 and Chadwick, 2017). The six Cs are care, compassion, courage, communication, competence and commitment (Bostock-Cox, 2013 and Chadwick, 2017). It is said to understand the true meaning of compassion fatigue can help professional promote self-care and to improve the care the patients receive, which in turn improves patient outcomes and improves relationships (Abendroth, 2011). Stebnicki *cited in* (Nancy, 2009) states that, overtime the more you give of yourself to help care for someone else takes that little bit away from you each time, until eventually you will need healing yourself. Carers and professionals must be able to prepare their minds and bodies to be able to over come the stresses that are caused from caring for people over a long period of time (Nancy, 2009). If the carer and nursing professionals can learn to find their own coping devices then they will be able to counterbalance the negativities that come with their caring role, which will help balance their mental and physical well-being (Nancy, 2009).

The Care Act 2014 was implemented to help improve individuals' independence and welfare, the act also introduced new functions for local authorities to abide to, this was to ensure individuals who live in their surrounding areas receive the correct care so it will prevent them from becoming more unwell, the act also ensures that information and advice is available for people who need it (Department of Health & Social Care, 2016 and Marczak, 2017). This Act was introduced as previously there were many entitlements for care and support across a number of acts, and these were seen to be quite complex and out of date, it also created rights for carers to apply for support (Department of Health & Social Care, 2016). The Act has been criticised for being too unclear and comprehensive, although it places individuals who need the support in a solid position in the process of needs assessment, the advice from the act does not give clear instruction on how local authorities and individual views help entitlement (Marczak, 2017).

The Mental Health Act 2007 previously the 1983 Mental Health Acts main aims are, to empower the treatment of individuals who suffer with mental health conditions, when they are unable or not willing to give permission and agree to treatment, this comes of use when they are at risk of harm or injury to themselves or others (Watts & McKenzie, 2014). If an individual

lacks the capacity to make informed decisions for themselves then this is when the Mental Capacity Act 2005 comes into action, this shows that the mental capacity acts focus is different to the mental health act (Watts & McKenzie, 2014). The mental capacity act unlike the mental health act does not always use treatment as the main focus but helps individuals to carry out daily tasks, help make decisions, whether this will be about what clothes to buy or what holiday home to purchase (Watts & McKenzie, 2014). The negative points about the mental health act is that this is mainly used by professionals in some cases the nearest relative can make a request, however, this is rare, unlike the mental capacity act which can be used by both professionals and the public who have concern about an individuals' well-being and health (Watts & McKenzie, 2014).

The deprivation of liberty safeguards aim is to offer legal protection and give rights to individuals who are seen to be vulnerable within society and who are being deprived of their liberty, it is to ensure individuals who lack in capacity are not denied their rights and that their liberty is not breached (Dow, 2008). It ensures hospitals and care homes have the correct training and direction to ensure they are working within the new safeguards (Dow, 2008).

There has been a brief discussion on the theoretical lens' in society which then looks further into compassion fatigue through symbolic interactionism with links to poverty. There has been a discussion critically on what compassion fatigue is defined as in today's society and how it affects carers on a day to day basis (Cocker & Joss, 2016, Delaney, 2018 and Sabo, 2006). The limitations these individuals can feel every day is overwhelming and the lack of support that they are in receipt of is astonishing there are statistics that show just how many people care for their loved ones who do not receive any money, or lose their job, from caring for their loved ones (Carers UK, 2014), which can then result in poverty. Even though there are policies and legislations in place to help carers in todays society it is still limited and too complex (Marczak, 2017). Individuals find that they need to fight to receive the vital support that is needed to care for their family members (Carers UK, 2014). Having no time for themselves (Carers UK, 2014) often makes their compassion towards the people they care for diminish and then this is where problems in their care develop. Their mental health can be affected which in turn exaggerates the problems that are arising from suffering with compassion fatigue. There has been a brief discussion on what can be done to help prevent compassion fatigue and to promote an individual's well-being (Epstein & Marshall, 2017). It has been interesting to learn about compassion fatigue, burnout, vicarious traumatization and secondary traumatic stress and how compassion fatigue links together (Nancy, 2009). Ideally there should have been more link to

carers suffering with compassion fatigue with the current policies and legislations in place to aid them, when they are at a disadvantage, however, overall there has been a lengthy discussion on carers who are experiencing compassion fatigue and burnout.

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