Relationship between Empathetic Reaction and Quality of Life among The Nurses in Psychiatric Unit at Assuit University Hospitals

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ABSTRACT

Empathy is professional states envisioned as learned communication skills are used to convey understanding of the patient's reality. Few studies have evaluated the QOL of health professionals studies are rare among nurses. **Aim** of the study was to determine a relationship between empathetic reaction and quality of life among the nurses in psychiatric unit at Assuit university hospital. **Setting**: psychiatric unit at Assuit University Hospital, Egypt, during the period of 6 months from the first of January till the end of June 2014. **Subjects** The study comprised of 50 psychiatric nurses**.** A descriptive correlation design was used**.** Three tools were used for data collection, 1- Demographic Data, 2- Empathy Scale by Layton 2004; 3- Quality of life assessment Scale by Lehman (1986) .**Result** The main results yielded by the study proved that, 72%, of female were in the age group <30 years. 82% of studied group were married, 56% lived in rural area, 96% were diploma.54% of studied group were 1 to 5 years of experiences. There was no a significant relation between empathy and sub- items of quality of life except empathy part II and family atmosphere at home there was a significant relation. **Conclusion** there was no a significant relation between empathy and level & sub-items of quality of life among Psychiatric nurses. **Recommendation**; applied training program to assess and evaluate knowledge of nurses about meaning empathy and who to applied & improved quality of life among nurses

Keywords: Empathy, Quality of life among nurses.

INTRODUCTION

The notion of "empathy" has a long history marked by ambiguity, discrepancy and controversy among philosophers, behavioral, social, and medical scholars. Empathy has been conceptualized as an "elusive" concept, difficult to define and measure (**Santo et al; 2014)**. There is general agreement in defining empathy as a mode of relating in which one person comes to know the mental content of another, both emotionally and cognitively, at a particular moment in time. Cognition is mental activities involved in acquiring and processing information for better understanding, whereas emotion is sharing of the affect manifested in subjectively experienced feelings. Empathy can be described as a cognitive or an emotional attribute or a combination of both. Recent studies described empathy as the neural matching mechanism constituted of a mirror neuron system in the brain, which enables to place oneself in the "mental shoes" of others **(Decety, & Jackson, 2006 and Santo et al 2014)**

In nursing practice nurses are professionally interacting with human being the relationship that develop between

the nurse and the patient are the foundation of nursing practice. Empathy is the attribute that gives nurses the ability to truly understand their patients, and thereby build up therapeutic professional relationships that promote the health of those patients' (**leiberg &Anders; 2006).**

Empathy has become widely seen as an essential condition of effective nursing care and at the heart of a therapeutic staff \ patient relationship **(Kamel; 2013)**. Empathy is the essence of all nurse patient communication and relationship. A high degree of empathy is one of the most potent factors in bringing about change and learning one of the most delicate and powerful ways of therapeutic use of self**. (Larson Yao; 2005).**

Empathy was described by **Rogers cited in Ancel ;2006** as the state of perceiving the internal frame of reference of another person with accuracy and with the emotional component and meanings that relate to it as one were the other person but without the loss of the self "as if" condition.

Empathy was a professional state envisioned as a learned communication skill composed primarily of moral, cognitive, emotive, and behavioral domains that are used to convey understanding of the patient's reality. Empathy has been found to be affected with important psychological attributes in both the empathizer and the target person such as emotions, sensitivity, conscience, experience, and affiliation tendency. As well other factors were also found to affect empathy among which are the empathizer workload, quality of life and burnout **(Keen; 2007).**

Nurse's well-being is the foundation of professionalism. It is the responsibility of both individuals and institutions to maintain and enhance staff well-being support professionalism and promote optimal patient care. It has been proposed that personal wellbeing may actually affected by aspect of professionalism such as empathy compassion **(leiberg &Anders 2006)**.

Professional quality of life was increasingly viewed as important. Professional quality of life" refers to the positive and negative emotions that an individual **feels (Kim ;,Han ; Kwak , and Kim ; 2015).** Quality of life an individual's perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns **(Barrientos & Suazo; 2007).** Personal wellbeing goes beyond the absence of distress and is characterized by being challenged, successfully responding and attaining satisfaction in a varity of domains of life. These include family, community, spiritual, mental, physical, and emotional health, and experiences that stimulate personal and professional growth. **(Langford etal; 2006).**

It was important to study whether nurses leave enough room and time to "cultivate" their own Quality of Life. To the extent that these professionals feel satisfied with their own Quality of Life, they will be capable of transmitting to their own category and others the needed to use physical, psychological, social, spiritual and environmental resources to live life fully **(Barrientos & Suazo; 2007).** That motivated to get to know nurses' the relationship between empathetic reaction & Quality of Life that can be associated with the nurses.

Aim of the study:

The aim of the study is to determine the relationship between empathetic reaction and quality of life among the nurses in psychiatric unit at assuit university hospital.

Research question:-

Was a relationship between empathy and quality of life among the psychiatric nurses?

Research design:

A descriptive correlation design was used**.**

Subjects and methods:

I. Setting:

The study was conducted at the Psychiatric Unit at Assuit University Hospital2014. It employees 55 nurses (4 Bsc degree nurses, , 46 diploma nurses and 5 first aid nurses) and 36 psychiatrist (3 professors. 2 assistant professors, 5 lecturers, 6 assistant lecturers, 3 resident and 14 assigned physicians).5 social workers, 5 psychologists. There are three sections to patients' women, men and emergency section each section consists of 36 beds.

II. Subjects:

Subjects of the study comprise all nurses at the psychiatric unit, 50 psychiatric nurses in the all shifts.

Tools of the study:

An interviewing questionnaire was used of this study, it inluded the following:-

I. Demographic data sheet:

Demographic sheet were developed by the researchers in the light of information in the related literatures which include age, sex, marital status, level of education, years of experience and residence.

II. Empathy Scale:-

The tool was developed by **Layton 2004** it is based on Roger's concept of empathy and was developed as a test for knowledge of empathy as well as evoking and then measuring nurse's empathy for the purpose of comparing the relationship between nurses' empathy and well-being. There ware two forms of this inventory each has three parts **part I** consisted of 12 true – false statement items about empathy **part II** consisted of six forced two choice items each describing a patient situation followed by two nurse responses one of theme reflects the most empathic response which is expected to be selected by the respondent **part III** consisted of six items with the same format as **part II** except that the respondent is asked to select the least empathic response. There ware no common items on form I and II. Higher scores are indicators of higher empathy level. This scale valid and reliable and used as it was.

III. Quality of life assessment Scale:-

(QOL). Original scale was constructed by **Lehman (1986)** to assessed quality of life. This scale was used to measure the current concept of quality of life. It consisted of 57 items divided into six domains or subscales:-

- First subscale is composed of (10) items covering the physical health function.

- The second subscale was consisted of (12) items reflecting psychological condition of nurses.

- The third subscale included (11) items related to personal and social relationship with others.

- The forth subscale included (7) items representing the level of dependency as regard personal hygiene, clothes, grooming, drinking and eating food.

- The fifth subscale included (4) items related to family atmosphere at home feeling of rest security and privacy in home.

- The six subscales were consisted of (5) items used to collect data about spiritual concern& personal belief, values and habits of religion,

Response were measured on a three points likert scale ranging from 0 to1 .In which the higher scores. The better QOL, the total score was 114 points, who obtained a score less than 57 points were considered to have a low quality of life .While those who scored between 57- < 85 points were considered to have moderate quality of life, and finally, those who scored more than 85 points were considered to have a high quality of life. Those called the three levels of quality of life. This scale was valid and reliable for total domains and subscale (0.70) (Alfa Coeffient) (**Zaki; 2009).**

Methods of data collection:

1) Permission was obtained from the dean of the faculty of nursing –Assiut University directed to the chairman of the Psychiatric department at Assuit University Hospital

2) The aim of the study was explained to nurses before starting data collection. Nurses are informing about what was done for them.

3) Each nurse had been interview at psychiatric unit.

4) Consent (verbal agreement) was taken from the nurses who are reassured about the confidentiality of the obtained information to avoid misunderstanding and providing privacy for them.

5) The data were collected by the researchers during the period of 6 months from the first of January till the end of June 2014.

6) The nurses were interviewed for about one hour at one time.

Ethical consideration:-

Research proposal was approved from ethical committee in the faculty of nursing. There was no risk for study subject during application of the research. The study was following common ethical principles in clinical research. Privacy was provided during data collection. Confidentiality and anonymity was assured. Nurses had the rights to refuse to participate of the study without any rational.

Statistical analysis

The data was computerized and verified using the SPSS (Statistic Package for Social Science) version 16 to perform tabulation and statistical analysis. Descriptive statistics were described in frequency and percentages, statistical significance was considered at p – value <0.05.

Results*:*

Results of the present study showed that:

Table (1) showed that demographic data of the studied group, the studied group was female 72 %, concerning their age, 62.0% were age group <30 years , while 38% of them were 30+ years, 82% of studied group were married, 56% the studied group was leave in rural area. Regarding education 96% of studied group were diploma while 4% of them were universal. According to years of experience 54% of studied group were 1 to 5 years of experiences while 28% of them were years of experience more than 15 years

Table (2) illustrated that description of subscale quality of life and empathy scale among studied group. Regarding subscale of quality of life the mean and SD was nearly for each other among deferent subscale except psychological statues and level of dependency (15.2±3.0, 15.3±3.6) respectively. According to empathy scale part I and part II the mean and SD was nearly equal (26.9± 2.8, 26.8±3.0).

Table (3) showed that description levels of quality of life scale among studied group. 70% of the studied group was moderate level of quality of life. 8% and 22% of them was low and high level of quality of life respectively.

Table (4) showed that there were no a significant relation between sub-items of quality of life and demographic data except, There was statistical significance deference between psychological condition and sex (p= 0.05) and statistical significance deference between level of dependency and marital statues (p= 0.03). There was statistical significance deference between personal and social relationship and age (p= 0.05).

Table (5) showed that a relationship between age and quality of life scale (Sub items) and total score among studied group**.** There were a significant relation between age and physical health function, personal & social relationship, and total score of quality of life (r= 0.37, 0.32, 0.31) respectively. While others sub- items of quality of life no significant relation with age

Table (6) illustrated that relation between empathy and sub- items of quality of life among studied group**.** It was obvious that there was no a significant relation between sub- items of quality of life and empathy (part I and Part II) except family atmosphere at home and empathy part II there was a significant relation (r= 0.41, P= 0.004).

Table (7) Showed that descriptive data between levels of quality of life and demographic data among studied group. There was no a significant relation between levels of quality of life and demographic data except level education was a significant relation (p= 0.008).

Table (8) Illustrated relation between empathy and levels of quality of life among studied group there was no a significant relation between levels of quality of life and empathy (part I and Part II) P value more than 0.05.

Table (9) Showed that there were no a significant relation between empathy (part I or part II) and different items of demographic data among studied group.

Table (10) Showed that there were a significant relation between empathy (part I) & total score of empathy and age (r= 0.31, 0.30). While no a significant relation between empathy (part II) and age.

Table (1) Demographic data of the studied group (no = 50)

Demographic items	**No.**	**%**
1- Age in years		
<30 y	31	62.0
30+ y	19	38.0
2- Sex		
Male	14	28.0
Female	36	72.0
3- Marital status		
Single	9	18.0
Married	41	82.0
4- Residence		
Rural	28	56.0
Urban	22	44.0
5- Education		
University	4	8.0
Diploma	46	94.0
6- years of experience		
<5 y	27	54.0
>5 < 10 y	3	6.0
>10 < 15 y	6	12.0
≥15 y	14	28.0

Table (2) Description of quality of life and empathy among the studied group (no = 50):-

Subscale of Quality of life	**Mean ± SD**
Physical Health Function	14.3±2.8
Psychological condition	15.2±3.0
Personal and Social Relationship	13.4±3.7
Level of dependency	15.3±3.6
Family atmosphere at home	5.7±1.6
Spiritual concern personal belief	9.8±2.5
Total Quality of life	73.7±11.7
Empathy scale	**Mean ± SD**
Empathy Part I	26.9± 2.8
Empathy Part II	26.8±3.0
Total Empathy scale	53.7±4.3

Table (3) Description levels of quality of life among the studied group (no = 50):-

levels of quality of life Scale	No.	%
Low	4	8.0
Moderate	35	70.0
High	11	22.0

Table (4) Relation between quality of life sub items and demographic data among the studied group (no =50):-

Demographic data	Sub items of Quality of life scale					
	Physical health function		Psychological condition		Personal &social relationship	
Marital states: Single	**Mean ± SD**	**P. value**	**Mean ± SD**	**P. value**	**Mean ± SD**	**P. value**
	13.2 ± 1.6	**0.228**	**14.4 ± 1.9**	**0.442**	**13.7 ± 3.1**	**0.815**
Married	**14.5 ± 3**		**15.3 ± 3.2**		**13.3 ± 3.9**	
Residence						
Rural	**13.8 ± 2.7**	**0.219**	**14.8 ± 2.7**	**0.381**	**13 ± 3.3**	**0.440**
Urban	**14.8 ± 3**		**15.6 ± 3.4**		**13.9 ± 4.2**	
Education						
University	**18 ± 1.4**	**0.099**	**18.5 ± 3.5**	**0.240**	**19 ± 1.4**	**0.062**
Diploma	**13.7 ± 2.1**		**14.8 ± 2.3**		**12.7 ± 2.5**	
Years of Experience						
<5 y	**14.5 ± 3.3**	**0.118**	**15.3 ± 3.6**	**0.592**	**13.6 ± 4.5**	**0.111**
>5 < 10 y	**13.5 ± 2.2**		**14.7 ± 2.3**		**12.6 ± 2.4**	
>10< 15 y	**14.7 ± 1.5**		**16 ± 1.7**		**13.3 ± 1.2**	
≥15 y	**14.2 ± 3.5**		**14.8 ± 3.1**		**12.3 ± 3.8**	
Sex						
Male	**15.7 ± 3.5**	**0.610**	**16 ± 4.4**	**0.058***	**15.4 ± 5.4**	**0.907**
Female	**13.9 ± 2.8**		**13.9 ± 2.7**		**13.5 ± 4.7**	
Age <30 **y**	**13.8±2.2**	**0.122**	**14.9±2.3**	**0.397**	**12.6±2.3**	**0.055***
≥30 y	**15.1±3.6**		**15.6±4**		**14.7±5.1**	

Table (4) continued: -

Demographic data	Sub items of Quality of life scale					
	Level of dependency		Family atmosphere at home		Spiritual concern personal belief	
Marital states: Single	**Mean ± SD**	**P. value**	**Mean ± SD**	**P. value**	**Mean ± SD**	**P. value**
	13 ± 3.3	**.032***	**5.2 ± 1.6**	**0.293**	**9.7 ± 3.3**	**0.823**
Married	**15.8 ± 3.5**		**5.8 ± 1.5**		**9.9 ± 2.4**	
Residence						
Rural	**15.3 ± 3.5**	**0.975**	**5.4 ± 1.5**	**0.136**	**9.8 ± 2.7**	**0.954**
Urban	**15.3 ± 3.8**		**6.1 ± 1.6**		**9.9 ± 2.4**	
Education						
University	**18.5 ± 0.7**	**0.280**	**8 ± 0**	**0.102**	**11.5 ± 0.7**	**0.453**
Diploma	**14.7 ± 3.4**		**5.7 ± 1.6**		**9.5 ± 2.7**	
Years of Experience						
<5 y	**14.4 ± 3.3**	**0.301**	**5.6 ± 1.5**	**0.626**	**9.4 ± 2.8**	**0.647**
>5 < 10 y	**16.3 ± 5.5**		**6 ± 2**		**11 ± 1.7**	
>10< 15 y	**16 ± 3**		**5.3 ± 1.5**		**10.3 ± 1.4**	
≥15 y	**16.5 ± 3.9**		**6.1 ± 1.6**		**10.1 ± 2.6**	
Sex						
Male	**14.8 ± 3**	**0.533**	**5.2 ± 1.8**	**0.153**	**8.9 ± 3.1**	**0.114**
Female	**15.5 ± 3.8**		**5.9 ± 1.4**		**10.2 ± 2.2**	
Age <30 **y**	**15±3.3**	**0.456**	**5.5±1.5**	**0.323**	**9.6±2.7**	**0.361**
≥30 y	**15.8±4**		**6±1.6**		**10.3±2.3**	

Table (5) Relationship between Age and Sub items of quality of life and total score among the studied group (no= 50).

Quality of life	Age	
	r	**P. value**
Physical Health Function	**0.37**	**0.009**
Psychological condition	0.14	0.328
Personal and Social Relationship	**0.32**	**0.020**
Level of dependency	0.14	0.317
Family atmosphere at home	0.12	0.410
Spiritual concern personal belief	0.08	0.566
Total	**0.31**	**0.029**

Table (6) Relation between empathy and sub- items of quality of life among the studied group (no =50):-

Quality of life	Empathy Part I		Empathy Part II		Total	
	r	P. value	r	P. value	r	P. value
Physical Health Function	-0.20	0.172	-0.06	0.680	-0.17	0.240
Psychological condition	-0.03	0.856	0.25	0.086	0.15	0.286
Personal and Social Relationship	-0.11	0.453	0.01	0.958	-0.07	0.652
Level of dependency	0.13	0.380	0.13	0.351	0.18	0.220
Family atmosphere at home	-0.03	0.829	0.41	**0.004****	0.26	0.066
Spiritual concern personal belief	0.07	0.621	0.20	0.170	0.18	0.201
Total	-0.04	0.790	0.19	0.186	0.11	0.457

Table (7) Distribution between Levels of Quality of life and demographic data among the studied group (no=50):-

Demographic data	Levels of Quality of life						P. value
	Low (n=4)		Moderate (n=35)		High (n=11)		
	No.	%	No.	%	No.	%	
Marital states:							
Single	0	0.0	8	22.9	1	9.1	0.363
Married	4	100.0	27	77.1	10	90.9	
Residence							
Rural	2	50.0	21	60.0	5	45.5	0.676
Urban	2	50.0	14	40.0	6	54.5	
Education							
University	0	0.0	0	0.0	4	36.5	**0.008 ****
Diploma	4	100.0	35	100.0	7	63.5	
Years of Experience							
<5 y	2	50.0	22	62.9	3	27.3	0.357
>5 < 10 y	0	0.0	2	5.7	1	9.1	
>10< 15 y	1	25.0	4	11.4	1	9.1	
≥15 y	1	25.0	7	20.0	6	54.5	
Sex							
Male	2	50.0	8	22.9	4	36.4	0.406
Female	2	50.0	27	77.1	7	63.6	
Age <30 y	2	50.0	25	71.4	4	36.4	0.099
≥30 y	2	50.0	10	28.6	7	63.6	

Table (8) Relation between Empathy and Levels of Quality of life among the studied group (no =50):-

Empathy Scale	Levels of Quality of life			P. value
	Low (Mean ±Sd)	Moderate(Mean ±Sd)	High(Mean ±Sd)	
Empathy Part I	26.3 ± 1.7	27.2 ± 2.3	26.1 ± 4.3	0.477
Empathy Part II	27.3 ± 2.6	26.6 ± 3.4	27.5 ± 1.8	0.630
Total	53.5 ± 3.1	53.8 ± 4.3	53.6 ± 5.1	0.991

Table (9) Relation between Empathy and demographic data among the studied group (no=50):-

Demographic data	Empathy Part I		Empathy Part II		Total	
	Mean ±SD	P. value	Mean ±SD	P. value	Mean ±SD	P. value
1-Marital status						
Single	28.3±2.2	0.087	25.9±3.3	0.301	54.2±2.8	0.704
Married	26.6±2.8		27±2.9		53.6±4.6	
2-Residence						
Rural	26.8±3.3	0.792	26.8±2.7	0.887	53.6±4.2	0.787
Urban	27±2.2		26.9±3.4		53.9±4.6	
3-Education						
University	27.5±2.1	0.768	28±2.8	0.734	55.5±0.7	0.601
Diploma	26.6±3.2		26.5±3.1		53.1±5	
Years of Experience						
<5 y	27.2±2.3	0.761	27.1±3	0.871	54.4±3.6	0.664
>5 < 10 y	25.7±2.1		26±2.6		51.7±4.6	
>10< 15 y	26.8±2.6		26.3±3.6		53.2±4.6	
≥15 y	26.5±3.9		26.6±3.1		53.1±5.6	
5-Sex						
Male	26.7±4.5	0.798	26.5±2.8	0.624	53.2±4.7	0.611
Female	26.9±1.9		27±3.1		53.9±4.2	
Age <30 y	27.4±2.2	0.128	27±3.1	0.57	54.4±3.5	0.165
≥30 y	26.1±3.6		26.5±3		52.6±5.3	

Table (10) Relation between Age and empathy among studied group (no=50):-

Empathy scale	Age	
	r	P. value
Empathy Part I	-0.31	**0.029***
Empathy Part II	-0.14	0.329
Total	-0.30	**0.035***

Discussion:

The importance of empathy in the nursing context is related to a core of common aims and purposes (Branch, 2001). There is general support that nurses' empathic attitude is important for patient's adherence to treatment, (Sayumporn; 2012, Veloski, &Hojat 2006). The importance of QOL increasingly being recognized as an important outcome measure in diverse health populations, including workers in stressful working conditions (Katching & Krautgartner, 2002). Quality of life can be defined as physical, mental, and social well-being (World Health Organization [WHO; 2000). Also, quality of life can be defined as "an individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives and in relation to his/her goals, expectations, standards and concerns Shaher & Hamaideh(2012)

Table (1) present study found that the majority of studied group was female, more than half of the studied group were age group <30 years, the most of studied group were married, more than half of studied group was leave in rural area related to civilization, the majority of studied group were diploma, more than half of studied group were 1to 5 years of experiences while nearly one third of them were years of experience more than 15 years. This study partially supported by Kamel (2013) which was conducted to investigate the relationship between Alexithemia constructed and emotional empathetic response among psychiatric hospital staff, reported that almost of study staff was female, nearly half of the study staff was in the age group of 20 to less than 30 years, three quarter psychiatric hospital staff were married, nearly one quarter of the nurses had five to less than ten years of experience, while less than quarter of the staff less than five year of experience.

Table (2) the present study found that subscale of quality of life the mean and SD was nearly for each other among deferent sub-items except psychological condition and level of dependency (15.2±3.0, 15.3±3.6) respectively this. According to empathy scale part I and part II the mean and SD was nearly equal (26.9± 2.8, 26.8±3.0). Rios (2010) which was conducted to evaluate the quality of life (QOL) and depression among nurses can be observed that the environment, physical and overall quality of life domains had the lowest mean scores in this group. This result may be revered to social, daily living, and occupational problem and Furthermore consistency in response to questionnaire. In addition the difference in the tools used.

Table (3) showed that description levels of quality of life scale among studied group. The majority of studied group was moderate level of quality of life while the minority of them was low and high level. According to Gholami etal (2013) which was conducted to assess the QOL in nurses working in Neyshabur hospitals and some factors associated with it, with the use of Short Form Health Survey (SF-36) scale, found that the total mean score of SF-36 was 64.7 that indicates a relatively moderate QOL in Neyshabur' nurses. In a study conducted by Assarrodi (2012)

which was conducted to investigate the relation between spiritual well-being and QOL in nurses, they observed that the mean score of QOL was 64.38 .In another study conducted by Allaf Javadi (2010) in order to compare the QOL in nurses of special care and internal surgical wards, they observed that mean scores of QOL were 69.66 and 62.17, respectively. This result may be revered to variance in spiritual culture

Table (4) showed that there were no a significant relation between subscale of quality of life and demographic data while was statistical significance deference between psychological condition and sex, and was statistical significance deference between level of dependency and marital statues. There was statistical significance deference between personal and social relationship and age (p= 0.05) (p= 0.03, p= 0.05) respectively. Gholami etal (2013) showed that, single/divorced participants reported higher QOL in compare to married participants, years in occupation was the most important factor affecting the QOL of study population. In the report of Aghamolaei (2011), This study aimed to investigate the determinants of health related quality of life in general population living in Bandar Abbas they observed that marital status could not significantly decrease the scores of SF-36 in both mental and physical aspects.Psychological state affected by sex because the women sensitive, patient and responsible more than men as well as years of experience gave the individual ability to communicate and merge with others

Table (5). There were a significant relation between age and physical health function, personal & social relationship, and total score of quality of life (r= 0.37, 0.32, 0.31) respectively, while others sub-items of quality of life no significant relation with age Aghamolaei(2011), This study aimed to investigate the determinants of health related quality of life in general population living in Bandar Abbas. Reported that sex, age, education and employment status were significantly related to the physical health and mental health items. This referred to increased the age would be increase experiences and became mature and developed social ability

Table (6) It was obvious that there was no a significant relation between sub-items of quality of life and empathy (part I and Part II) except Family atmosphere at home and empathy part II there was a significant relation (r= 0.41, P= 0.004) may be related to lack of knowledge further more empathy has a long history marked by ambiguity, discrepancy and controversy among social, and medical scholars .

Table (7) Showed that descriptive data between levels of quality of life and demographic data among studied group. There was no a significant relation between levels of quality of life and demographic data except level of education was a significant relation and age (p= 0.008) (p= 0.057). kim etal (2015) In this study, aims to classify types of professional quality of life experienced by Korean nurses, The demographic factors that significantly differed among the three clusters were identified. In particular, the groups differed significantly by age ($\chi^2 = 21.35$, $p < .001$), marital status ($\chi^2 = 11.06$, $p = .004$), educational status ($\chi^2 = 16.08$, $p = .013$). However, the groups did not differ significantly by gender, and number of years of nursing experience Thumboo (2003) observed that educational level and housing type (markers of socio-economic status) were also associated with SF-36 scores and QOL. This result may be related to influence of education and experience by age on the view of quality of life

Table (8) Illustrated relation between empathy and levels of quality of life among studied group there was no a significant

relation between levels of quality of life and empathy (part I and Part II) P value more than 0.05.This may be related to lack of study and negligence of research to this topic. Paro etal (2014) this study aimed to assess medical students' empathy and its associations with gender, stage of medical school, quality of life and burnout reported that. the empathy scores were weakly correlated with quality of life ($r<0.3$) Gleichgerrcht &, Decety (2014) this study investigated the way individual dispositions relate to behavioral measures of pain sensitivity, empathy, and professional quality of life, and found that. Minimum levels of empathy appear necessary to benefit from the positive aspects of professional quality of life in medicine this result may be related to differentiation between tools and socio-cultural factors.

Table (9) &Table (10) Showed that there were no a significant relation between empathy (part I or part II) and different items of demographic data among studied group. While there were a significant relation between empathy (part I) & total score of empathy and age ($r= 0.31, 0.30$). There were no a significant relation between empathy (part II) and age. Che KUO etal (2012) reported that all demographic data except gender were significantly correlated with the empathy score, such as age ($r = 0.19$, $P = 0.001$), marital status ($t = -3.76$, $P = 0.004$), educational level ($t = -2.16$, $P = 0.02$),

Conclusion-

There was no a significant relation between level and sub-items of quality of life and empathy among psychiatric nurses.

Recommendation:

1- Applied training programs to assess and evaluate knowledge of nurses about meaning of empathy and who to apply & improved quality of life among nurses.

2- Increase the sample of the study from different regimen and future research should included other measures of empathy and another associated factors related to quality of life.

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