



Effect of Training Program about Compassion on Professional Quality of Life of Mental Health Nurses

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ABSTRACT

Background: Improved recognition and awareness of compassion fatigue, burnout, and compassion satisfaction as basic components of professional quality of life among mental health nurses are expected to prevent emotional exhaustion, and aid in the identification of appropriate coping strategies and quality intervention. **Aim:** To determine the effect of training program about compassion on professional quality of life of psychiatric nurses. **Study design:** A quasi-experimental research design. **Tool of the study:** Professional Quality of Life Scale Version 5. **Sample:** All available nurses who provide direct care for psychiatric patients (50) nurses at the time of the study. **Setting:** The study was conducted at The Psychiatry Center of Tanta University. **Results:** The result revealed that there were statistically significant difference in total score of compassion satisfaction, burnout, and secondary traumatic stress through phases training program. **Conclusion:** The study concluded compassion has positive effect on improving professional quality of life of mental health nurses, and also confirmed the effect of educational training program. **Recommendations:** The study recommended by t in services training program for nurses about; how to assess and improve professional quality of life.

Keywords: Professional Quality of Life, Compassion, Mental Health Nurses, Compassion Satisfaction, Burnout & Secondary Traumatic Stress.

Introduction

The nature of mental nursing differs significantly from that of many other professions. Physical and mental strains are common among mental health nurses, and they can have an impact on their job performance, contentment, and professional quality of life (ProQoL). Compassion and empathy are two important qualities that a nurse must possess in order to work as a mental health nurse. Improved recognition and awareness of compassion satisfaction, compassion

fatigue, burnout, as basic components of professional quality of life among mental health nurses are expected to prevent emotional exhaustion, and aid in the identification of appropriate coping strategies and quality nursing intervention.⁽¹⁻⁴⁾

Professionals' quality of life has evolved as a rising topic of attention in the health care literatures particularly nurses as they first frontline contact with patients. Working with patients suffering from mental illness expose nurses to pain and suffering which may

be a great source of emotional and psychological strains. These all results in devastating impacts on psychiatric nurses' professional quality of life by exposing them to the intense suffering of patients and their families.⁽⁴⁾ The journey to become a psychiatric nurse involves demanding work-loads, challenging placements, and witnessing of traumatic events, with subsequent stress sometimes affecting professional quality of life.⁽¹⁻³⁾

Professionals' quality of life is defined as the sense one has when performing his duties as a helper. Because professional quality of life is linked to work environment (organizational and task-based) features and personality attributes, and exposure to primary and secondary trauma in the workplace, the concept of professional quality of life is complicated.⁽³⁻⁵⁾

Professional quality of life is composed mainly of compassion satisfaction (CS), burnout (BO), and compassion fatigue (CF)⁽⁶⁾. Compassion is defined as a compassionate attitude toward another person's suffering, identifying a person's wants and a desire to help or support them. It also is defined by empathy, hardship tolerance, and kindness⁽⁵⁻⁷⁾. In the same line compassion satisfaction is described as the happiness that an individual derives from being able to execute his/her job successfully. It's the pleasant experience that comes from knowing that a health professional has helped others in some way⁽⁸⁻¹⁰⁾. Meanwhile compassion fatigue is defined as physical, mental, social, and emotional depletion seen among health workers as result from the constant and intensive contact of health professionals with patients. With its adverse effects, compassion fatigue may lead to reductions in work performance and professional quality of life and psychological endurance.^(11, 12)

On the other hand burnout is a state of emotional and physical exhaustion caused by excessive and

prolonged stress. Depersonalization, a diminished sense of personal success, and discouragement as an employee are all symptoms of burnout. Burnout manifests itself in more mental than bodily ways. Powerlessness, hopelessness, emotional weariness, alienation, loneliness, anger, irritation, being imprisoned, failure, and despair are some examples.^(8, 9) Compassion fatigue and burnout are important for health-care organizations because they can anticipate the relationship between nurse retention, turnover, and patient safety and satisfaction and strain professional quality of life.^(13, 14)

Professional quality of life is that the stability among compassion satisfaction, burnout, and compassion fatigue. This means, once compassion satisfaction is high, and every burnout and compassion fatigue are low, the professional's quality of life is turning into high^(2, 3). It had been noted that high levels of compassion operate as a protecting issue against burnout and compassion fatigue. Within the same line, a lot of studies counsel that compassion satisfaction is taken into consideration because it's defensive agent that may be used to alleviate or mediate the negative result of each compassion fatigue and burnout. Compassion satisfaction is that the positive aspects and potentially growth that enhancing consequence of compassionate between nurses and patients.⁽¹⁴⁻¹⁶⁾

As psychiatric patients typically display symptoms and behaviors associated with a serious risk of suicide, absconding with a significant threat to safety, or aggression, psychiatric nurses experience a wide variety of physically and emotionally demanding challenges when delivering care⁽¹²⁻¹⁷⁾. As a consequence, the potential impact of this demanding work on nurses' professional quality of life is significant. According to several researches, nurses

who want to continue offering compassionate care should first learn about compassion, professional quality of life, and self-management techniques that enable them handle with the emotional demands of clinical practice. (18-22)

Compassion can be used as a defensive agent to mitigate or mediate the negative effects of both compassion fatigue and burnout. It is the tool and the opportunity of psychiatric nurse for potential professional growth. A mental health nurse with a high compassion is more likely to be able to: effectively use communication skills, particularly empathetic skills, have more self-awareness for attitude toward patients, be able to cope effectively in a work environment with heavy emotional burden, and be able to relax and in turn having professional quality of life. (23-24)

Significance of this study

The significance of this study stems from the fact that both psychiatric nurses and patients value professional quality of life. Compassion fatigue affects nurses in particular, and it can have a detrimental impact on their mental and physical health as well as the quality of their patient care. It is hoped that enhancing psychiatric nurses' understanding and awareness of compassion will reduce compassion fatigue and burn out and aid in the identification of appropriate intervention. As a result, psychiatric nurses will be able to retain empathetic and compassionate personnel and ultimately improved their professional quality of life.

Using an excellent ProQoL program to assess CS, STS, and BO in mental health nurses is a huge help in detecting and treating possible psychological and physical effects in this population. Among reality, with thorough evaluation and creation of suitable intervention programs, the number of cases of BO and CF in mental health nurses might be reduced or

eliminated, resulting in better patient care and health outcomes.

Aim of the study: to determine the effect of training program about compassion on professional quality of life of psychiatric nurses.

Research hypothesis:

H1: Professional quality of life of psychiatric nurses is expected to be improved after nurses' attending implementation of training program about compassion.

Subjects & Method

Research design: A quasi- experimental research design was used in this study.

Sample: All available nurses who provide direct care for psychiatric patients (50) nurses at the time of the study, 30 of them working in the male ward and 20 nurses working in the female ward.

Setting: The study was conducted at The Psychiatry Center of Tanta University. Capacity of center (28) beds divided into (18 beds) for males and (10 beds) for females.

The Study Tools:

Professional Quality of Life Scale (ProQoL) Version 5 (2009) (25): It included two parts

- **First part: Socio-demographic and professional characteristics of nurses :**

This part is developed by the researcher. Socio-demographic characteristics such as (age, sex, & level of education).as well as professional characteristics such as (years of experiences in care of psychiatric patients, academic qualifications or training related to psychiatric field).

- **Second part: Professional Quality of Life Scale (ProQoL) Version 5 :-**

It was developed by Stamm, (2009) (25) that was

designed to measure professional quality of life among health care profession.⁽²⁵⁾ It composed of (30) items. Each items was rated on a 5-point Likert scales (from 1 = Never to: 5= Very Often) except items 1, 4, 15, 17, and 29, its score was reversed. It divided into the following subscales each one composed of (10) items, namely:

1- **Compassion Satisfaction subscale**, this subscale focus on measuring compassion satisfaction. Like statement "I'm getting satisfaction from helping others. To score this subscale add scores on questions (3, 6, 12, 16, 18, 20, 22, 24, 27, 30).

2- **Compassion fatigue subscales**, which in turn classified into burnout subscale and traumatic stress subscale.

a) **Burnout subscale**, like statement; " I am not happy ". To score this subscale add scores on questions (1,4,8,10,15,17,19,21,26,29).

b) **Traumatic Stress subscale**, To score this subscale add scores on questions (2,5,7,9,11,13,14, 23, 25,28).

Each subscale was summed and ranged from 10:50, that indicate level of each one scheduled as following:

The sum of each subscale questions is	Level
≤ 22	Low
23 : 41	Average
≥ 42	High

Method

The study was accomplished according to the following steps:

1-An official letter sent from the dean of the faculty of nursing to the director of study setting to request their permission for data collection.

2- Ethical considerations:-

- Approval from Ethical Committee in the faculty of nursing was obtained.
 - Informed written consent was obtained from the participants after explanation of the study purpose.
 - The participants were reassured about confidentiality of their information and it would be used for the research purpose only.
 - Respecting the right of the participants to withdraw at any time during the data collection period.
 - The nature of the study inflicted no harm on the patients.
- 3- The researcher translated the study tools into Arabic and had them examined for internal validity by a jury of 5 specialists in both psychiatric nursing and psychiatric medicine. The necessary modification was done as needed.
- 4- Tools of the study were tested for reliability using Cronbach's alpha test. Its values were 0.974 for compassion satisfaction, 0.949 for burnout, and 0.937 for traumatic stress.
- 5- A Pilot study was carried out on (10 %) of the studied sample who was selected randomly to ensure the clarity and applicability of the study tool and to estimate the approximate time required for filling the tool as well as to find out any problem or obstacle during data collection. The results of pilot study revealed that the studied sample didn't have any difficulties when responding to the study tool.

6- Actual study was divided into four phases:-

Phase one: Assessment phase (pretest):

Tool of the study was filled by the study subjects in individual basis and the subjects were asked to fill the questionnaire in the

presence of researcher for any clarification as pretest. Filling of the questionnaire ranged from 15 to 20 minutes, this phase aimed to determine the study subject's needs as a base line of training program.

Phase two: Planning phase:

The researcher was formulated educational program based on result from assessment phase, and related literature review.

The priorities, goals and expected outcome criteria, setting objectives, and preparation of the content were covered the objectives behind application of the sessions.

The overall goal of the training program was to improve the professional quality of life of psychiatric nurses following attending of a compassion training program.

The developed program was written into simplified Arabic language by the researcher and revised by the supervisors to ascertain its content and appropriateness and applicability. As a result, the required modifications and corrections were carried out.

Phase three: Implementing phase:

1. The program was carried out in eight subgroups. A total of 5-7 nurses made up each subgroup. Each subgroup had a total of eight sessions.
2. These sessions were conducted using a variety of teaching methods and media, including lecture, group discussion, visual aids, role play, and handouts, which were utilized to enhance discussion when necessary.
3. These sessions were scheduled as two sessions per week for four weeks. The time for each

session were about (45:60 Minutes) according to the session content.

4. The training sessions were conducted as follows: within the first 5 minutes, the researcher clarified the session theme and planned activities. The remaining 35-45 minutes were used for completing the session work, and last 10 minutes for seeking feedback, thanking nurses, and reminding them about the time of the next session. Each training session began with a review of the prior one.
5. Prior to each training session, the researchers informed the nurses about the group's rules, such as confidentiality and honesty, as well as what to expect from them in terms of their own roles, such as listening attentively to one another. There were no right or wrong answers, and everyone had an equal chance to participate. The subgroups were also placed in a circular pattern.
6. The data collection starts from February 2020 to August 2020.

The sessions of training program were scheduled as following:

1. **The First session:** (Introductory session), establishing relationship, obtaining verbal consent, explaining aim of the program and its schedule.

At the end of the session the studied nurses was able to:

- Be acquainting with each other's.
- Recognize the purpose of the program.
- Describe schedule of the program.
- Outline content of the program.

2. **The Second session:** Main definitions of terms related to concepts of compassion, myth about self-compassion, and professional quality of life.

At the end of the session, nurses was able to:

- Define compassion.
 - Define professional quality of life.
 - Discuss dimension of professional quality of life.
 - Compare and contrast myth and facts about self-compassion.
3. **The Third session:** Elicit compassionate response for various situations.

At the end of this session researcher was able to:
Discuss nurses' response for various situation.

4. **The Fourth session:** Demonstrate compassionate response for certain situation.

At the end of this session nurses was able to:

- Train nurses on compassionate response for certain situation.
 - Demonstrate problem solving and critical thinking processes on certain situation.
5. **The Fifth session:** Self-management technique, empathetic skills.

At the end of this session nurses was able to:

- Examine meaning of self-management.
 - Discuss and train on self-management techniques.
 - Examine meaning of empathy and apply empathetic skills.
 - Compare and contrast between empathy and sympathy.
6. **The Sixth session:** Strategies to improve professional quality of life as psychiatric nurses.

At the end of this session nurses was able to:

- Formulate strategies to prevent compassion fatigue.
 - Train on application of strategies to improve professional quality of life.
7. **The Seventh session:** Strategies to improve self-awareness and stress management techniques.

At the end of this session nurses was able to:

- Conduct strategies to improve self-awareness.
 - Train on application of strategies to stress management techniques.
8. **The Eighth session:** Summary session, it contains making summary about any things that the nurse need clarification and conduct posttest (1).

At the end of this session nurses was able to:

- Summarize main points of training program.
- Apply immediately posttest.

Phase four: - Evaluation phase:

Evaluation of educational program was done by reapplying tool of the study twice this was done as follows:

- Immediately after implementation of the program (Post intervention1).
- Three months later after implementation of the program (Post intervention 2).

Concerning implementation the program content:

Generally, the researcher was the initiator, provider and encourage of exchange knowledge between studied nurses and researcher, fostering exploration of their replies, issues, thoughts, and attitudes. The researcher also served as a facilitator, instructor, and trainer for the participants

- During the sessions, nurses' clinical experiences were considered. Symbolic rewards (paper notes, pens, and tea breaks) and emotional rewards (positive remarks and appreciations) were used to encourage nurses to participate in the discussions throughout the sessions.

- At the end of the program, a printed booklet of the training program was distributed for all of the nurses who were participated in the study.

Specifically,

The theoretical Sessions was implemented by using lecture interwoven with discussion and sometimes demonstration method.

- A group discussion was used to stimulate nurses' attention and encourage their active participation. The subjects offered examples from their work experiences in addition to the examples and illustrations provided by the researcher to ensure understanding.

- The lecture was delivered in an effective and easy manner, with attractive power point slides made by the researcher in a simplified and intelligible Arabic language for the study subjects and appropriate for the time allotted.

- Lectures and group discussions were employed as teaching methods, while handouts, PowerPoint presentations, and posters were used as teaching media.

In the practical sessions,

The researcher employed a variety of teaching methods in the practical sessions, including role play, demonstration, and re-demonstration, as well as lecture and group discussion, visual aids, and video, as noted in the session index. Nurses and the researcher both participated in role-playing exercises.

At the start of each session, all of the nurses in the study were given handout papers having information about the simulated situations and scenarios. In each practical session, simulated nurse, situations presented by the researcher through data show and then discussed with the studied subjects.

▪ **Firstly**, the researcher gave nurses the opportunity to think critically and provide a

wide range of their own responses to various situations, which were then analyzed. After that, the researcher presented the most therapeutic responses at the end of each situation's discussion, as well as providing rationale and analysis for each choice.

- Nurses brought clinical situations in most of the sessions, which they discussed. Role playing for simulated scenarios was also employed as a teaching approach for demonstrating therapeutic responses to clinical situations, and this strategy assisted nurses in understanding how to communicate the appropriate response. Nurses were also given homework after each session in which they were to write down more incidents and their therapeutic responses, which would be reviewed in the next session.
- For example, in implementation of compassion skills, empathetic skills. After the researcher provide all knowledge about the skills by using attractive power points and after listening video or scenario to qualified nurses when deal effectively with themselves and patients, the researcher played role of nurse and studied nurse played another role to make role play of effective and therapeutic response between nurses and patients while providing care as mentioned in the program.

E. Statistical analysis

The SPSS software version 20 was used to computerize and verify the study data. The mean, range, and standard deviation were determined for quantitative data. The t-test was employed to make comparisons between means. The f-value of analysis of variance (ANOVA) was determined for comparisons between more than two means. Burnout and traumatic

stress both had independent and interaction impacts on compassion satisfaction, according to a two-way analysis of variance. The Pearson's correlation coefficient was used to assess the correlation between variables.

Results

Table (1): Presents distribution of the studied nurses according to their socio-demographic characteristics. It presents that more than two third (74%) of the studied nurses were females with mean age of (28.66 ± 5.161) . Regarding their educational level, majority of the studied nurses (82%) have technical institution. Regarding marital status, (70%) were married. In relation to residence more than two third (70%) lived in rural area.

Table (2): It showed that (42%) of the studied nurses had from five to ten years experiences in psychiatric field, while (26%) of the studied nurses had more than ten years experiences with a mean score (1.94 ± 0.767) . Regarding previous training in nursing field majority of the studied nurses (96%) did not have previous training. While all the studied nurses did not had any previous training in psychiatric nursing field.

Table (3): It presents that there is highly statistically significant improvement among nurses compassion satisfaction pre the program implementation, immediately post, and three months after implementation of the program in which (P-value =0.000). Where the studied nurses had mean score (19.78 ± 8.59) pre the program implementation, while this level became high immediately and three months post the program implementation $(32.88 \pm 8.45 \& 30.22 \pm 9.98)$ respectively.

Table (4): Illustrates mean score of burnout among the studied nurses throughout phases of implementation of the training program. . It can be

noticed that there is highly statistically significant improvement among nurses burnout mean score pre the program implementation, immediately post, and three months after implementation of the training program in which (P-value =0.000). Where the studied nurses had mean score (40.6 ± 7.83) pre the program implementation, while this level became low immediately and three months post the program implementation $(28.48 \pm 10.45 \& 31.26 \pm 11.18)$ respectively.

Table (5): Present mean score of traumatic stress among studied nurses throughout phases of implementation of the training program. It presents that there is highly statistically significant improvement among nurses traumatic stress mean score pre the program implementation, immediately post, and three months after implementation of the training program in which (P-value =0.000). While the studied nurses had mean score (42.36 ± 6.10) pre the program implementation, while this level became low immediately and three months post the program implementation $(32.22 \pm 7.59 \& 34.1 \pm 8.32)$ respectively.

Figure (1): Shows distribution of the studied nurses according to their levels of compassion satisfaction pre, immediately post, and three months after implementation of the training program. It presented that there is a statistically improvement without significant relation between levels of compassion satisfaction pre the program implementation, immediately post, and three months after implementation of the training program. The result showed that only (8%) of the studied nurses had average level of compassion satisfaction pre the program implementation, while the levels increased to (64%) immediately post implementation of the training

program and then it became (46%) three months after implementation of the training program.

Figure (2): Represents that there is a statistically significant relation between levels of burnout pre the program implementation, immediately post, and three months after implementation of the training program as (P-value = 0.004). The result showed that more than half of the studied nurses (70%) had high level of burnout pre the program implementation, while it decreased to (20%) immediately post implementation of the training program and then it became (26%) three months after implementation of the training program.

Figure (3): It shows that there is a statistically significant relation between levels of traumatic stress pre the program implementation, immediately post, and three months after implementation of the training program as (P- value = 0.02). The result showed that more than of the studied nurses (72%) had high level of traumatic stress pre the program implementation, while it decreased to (20%) immediately post implementation of the training program and then it became (28%) three months after implementation of the training program.

Table (6): Presents correlation matrix between compassion satisfaction, burnout, and traumatic stress among the studied nurses. It illustrate that there is negative statistically significant correlation between compassion satisfaction and burnout as pre the program implementation p-value = (0.000), $r = (-0.755^{**})$ then $r = (-0.933^{**})$ immediately post, then became $r = (-0.823^{**})$ three months after implementation of the program. Regarding correlation between compassion satisfaction and traumatic stress there is negative statistically significant correlation as pre the program implementation p-value = (0.000), $r = (-0.646^{**})$ then $r = (-0.925^{**})$ immediately post, then became $r = (-0.845^{**})$ three months after implementation of the program. This mean high level of compassion

satisfaction linked to lower level of burnout, traumatic stress, and vice versa. Regarding correlation between burnout and traumatic stress there is positive statistically significant correlation as pre the program implementation p-value = (0.000), $r = (0.768^{**})$ then $r = (0.945^{**})$ immediately post, then became $r = (0.929^{**})$ three months after implementation of the program. This mean high level of burnout linked to high level of traumatic stress and vice versa.

Table (7) Summarizes results of two way analysis of variance test the effect of independent variable (burnout) on dependent one (compassion satisfaction), the result revealed that burnout is statistically influenced level of compassion satisfaction (F = 8.288, P = 0.001). Then test the effect of independent variable (traumatic stress) on dependent one (compassion satisfaction) the result showed that traumatic stress also statistically influenced level of compassion satisfaction (F = 11.13, P =0.000). Moreover, two way analysis of variance test the interacting effect of two independent variables (burnout and traumatic stress) on dependent one(compassion satisfaction) the result revealed that burnout interact with traumatic stress to affect compassion satisfaction among studied nurses (F = 6.10, P = 0.005) .

Tables and figures

Table (1): Distribution of the Studied Nurses According to Their Socio-Demographic Characteristics.

Socio-Demographic characteristics	Number (50)	%
Sex		
Male	13	26
Female	37	74
Age		
<25	17	34
25-30	19	38
>30	14	28
Mean \pm SD	28.66 \pm 5.161	
Range	(21-40)	
Marital status		
Single	11	22
Married	35	70

Socio-Demographic characteristics	Number (50)	%
Divorced	2	4
Widow	2	4
Educational Level		
Diplome	4	8
Technical Institution	41	82
Bachelor's Degree	5	10
Residence		
Urban	15	30
Rural	35	70

Table (2): Distribution of The Studied Nurses According to Their Professional Characteristics.

Professional characteristics	Number (50)	%
Years of experience in psychiatric field		
<5	16	32
5-10	21	42
>10	13	26
Mean ± SD	1.94 ± 0.767	
Range	(1-18)	
Previous training in nursing field		
No	48	96
Yes	2	4
Previous training in Psychiatric nursing field		
No	50	100

Table (3): Mean Score of Compassion Satisfaction Among The Studied Nurses Throughout Phases of Implementation of The Training Program.

Items	Compassion Satisfaction Mean ± SD	Comp.	Difference		Paired T- test	
			Mean	SD	T	P- value
Compassion Satisfaction	Pre the program implementation	Pre- Post	-13.1	12.94	-7.15	0.000
	Immediately post the program implementation	Pre- Follow up	-10.44	13.23	-5.57	0.000
	Three months post the program implementation	Post - Follow up	2.66	7.00	2.68	0.010

Table (4): Mean score of burnout among the studied nurses throughout phases of implementation of the training program.

Items	Burnout Mean ± SD	Comp.	Difference		Paired T- test	
			Mean	SD	T	P- value
Burnout	Pre the program implementation	Pre- Post	12.12	13.71	6.25	0.000
	Immediately post the program implementation	Pre- Follow up	9.34	14.17	4.66	0.000
	Three months post the program implementation	Post - Follow up	-2.78	6.33	-3.10	0.003

Table (5): Mean score of traumatic stress among studied nurses throughout phases of implementation of the training program

Items	Traumatic Stress Mean ± SD	Comp.	Difference		Paired T- test	
			Mean	SD	t	P- value
Traumatic Stress	Pre the program implementation	Pre- Post	10.14	9.55	7.50	0.000
	Immediately post the program implementation	Pre- Follow up	8.26	9.99	5.84	0.000
	Three months post the program implementation	Post - Follow up	-1.88	4.79	-2.77	0.000

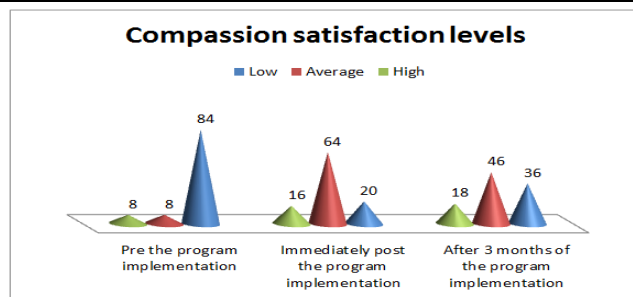


Figure (1): Distribution of the studied nurses according to their levels of compassion satisfaction pre, immediately post, and three months after implementation of the training program. (No=50).

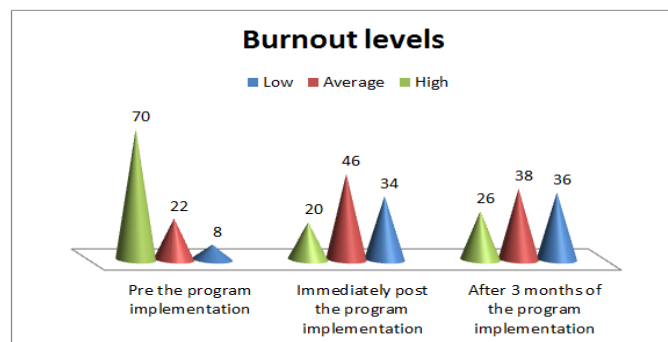


Figure (2): Distribution of the studied nurses according to their levels of burnout pre, immediately post, and three months after implementation of the training program. (No=50).

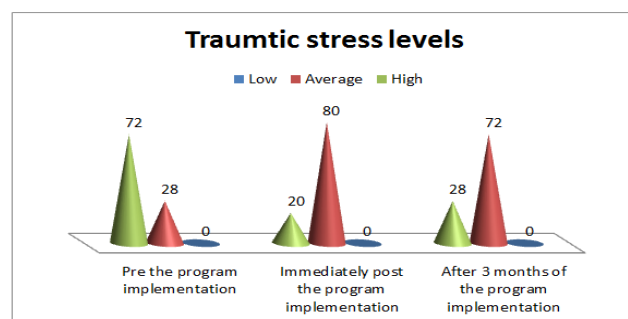


Figure (3): Distribution of the studied nurses according to their levels of traumatic stress burnout pre, immediately post, and three months after implementation of the training program. (No=50).

Table (6): Correlation matrix between compassion satisfaction, burnout, and traumatic stress among the studied nurses (No =50).

Items		Burnout	Traumatic Stress	Correlation coefficient
Pre program implementation	Compassion Satisfaction	-0.755** 0.000	-0.646** 0.000	r p
	Burnout	---	0.768** 0.000	r p
Immediately after	Compassion Satisfaction	-0.933** 0.000	-0.925** 0.000	r p
	Burnout	---	0.945** 0.000	r p
After 3 months	Compassion Satisfaction	-0.823** 0.000	-0.845** 0.000	r p
	Burnout	---	0.929** 0.000	r p

** . Correlation is highly significant at the 0.01 level. * . Correlation is significant at the 0.05 level.
r : Pearson correlation coefficient P < 0.05

Table (7): Two-way analysis of variance to test independent and interaction effects of burnout and traumatic stress on compassion satisfaction

Compassion satisfaction		Variables
P-value	F	
0.001	8.288	Burnout
0.000	11.13	Traumatic stress
0.005	6.10	Burnout* Traumatic stress (Compassion Fatigue)

Significant (P ≤ 0.005)
satisfaction)

Dependent variable (Compassion satisfaction)

Discussion

In the Egyptian health system, nurses are the frontline care providers, notably in the mental health system. Psychiatric nurse faces significant hurdles in caring for psychiatric patients, as well as the nature of mental health disorders, which involves extensive interpersonal interaction with patients and careers. Mental health nurses face abnormally and extremely high levels of work-related stress. Workplace stress can result in emotional tiredness, inefficient coping with difficult situations, and a reduction in their professional quality of life. (15,26)

Positive outcome from working with challenging mental ill patients has been known as compassion satisfaction. It reflects the rewards of caring for others, that has been identified as a possible element that counterbalances the risks of CF. It gives nurses the

strength and flexibility to take charge to improve their ProQoL and grow from their mistakes without any fear of rejection thus, it is required for nurses to have the necessary knowledge and skills to manage mentally ill patients without having CF in the process. In order to do this, mental health nurses need to be educated and trained to increase their compassion when confronted with work related stressor and to be able to manage its effect successfully. (14, 15)

Results of this present study illustrated that majority of the studied nurses had technical institution. This result is harmony with finding of Zaki (2016) Egyptian study about job stress and self- efficacy among mental health nurses working in mental health hospitals at Cairo, clarified that the majority of studied nurses had diplomat in nursing and more than half of them are working as a staff nurse.(26) Meanwhile, these results disagree with Yada (2015) who studied the factors influencing job-related stress in Japanese mental health nurses and noticed that Forty-one participants were managers (head or chief nurse).(27)

The current study results clarified that more than two third of the studied nurses were females. This may be due to students in the nursing program are predominantly females. This result is consistent with Verhaeghe (2014) who studied the mental health nurses’ attitude and self-efficacy to adult inpatient aggression, found that more than two -third of mental health nurses under his study were female and were married.(28) Moreover Zaki (2016) results who clarified that females were relatively more common as main workforce constituting more than two- third of mental health nurses under the study and more than three-quarter of them are married. (26)

Emerging result of the present study revealed that the training program about compassion has the positive effect on nurses' ProQoL immediately and after three

months of implementation of the program. This results may be attributed to before developing and designing the program the researcher assessed studied nurses needs about compassion such as (problem solving skills, empathetic skills,...etc.) and according to these needs researcher developed the program in addition to its clarity, simplicity, and motivating staff to participate on practical and theoretical sessions of the training program. Also this positive effect may be related to the way of implementation of training program in which researcher used role play and different teaching methods such as demonstration and re-demonstration. This method gives the researcher opportunity to demonstrate positive attitude that mainly helped in replacing negative attitude by positive one, and additionally help nurses to be more self-awareness for their attitude toward themselves, patients, and work environment.

The current study illustrated that studied nurses who attended the psycho-education program acquire knowledge about ProQoL than before implementation of the program. They know main terms related to concepts of compassion and ProQoL and its dimension. Also acquire skills of problem solving, critical thinking, self-management, stress management techniques and empathetic skills. Conduct training on strategies to prevent compassion fatigue, improve self-awareness and improve ProQoL. But their knowledge decreased after three months of program implementation this may explain that knowledge may be liable to forget, by time, while the skills that continuous practice and applicability in daily life events are fixed.

Compassion is a central concept to psychiatric nursing and nurses are vital in caring of psychiatric patients so that nurses must be understand that psychiatric patients are unique and their needs are urgent and therefore their intervention should cater for

their patients' needs, and this require from the nurse to be more self-confident, self-aware and more self-autonomy. Those points were the topical importance of the training program which enables nurses to provide effective care for those patients.

On the other hand, the present study reveals that studied nurses acquired more confidence and self-awareness to resist trigger situations after attending the psycho-education training program. Nurses, reported during the training program, that they had the power to deal with different situations such as unpleasant emotions, or conflict with others. From the researcher's view improve of the studied nurses abilities and skills will improve their quality of life.

Additionally, as a post-simulation activity, the researcher assigned the nurses homework, which improved their attitude since it allowed them to analyses their attitudes toward compassion and become more self-aware, resulting in personal and professional improvement. The researcher supplied homework in theoretical sessions by combining lecture with group discussion. A group discussion was used to stimulate nurses' attention and encourage active participation. Furthermore, the researcher was keen to conduct the program in a pleasant and welcoming atmosphere that allows nurses to freely communicate and express their negative attitudes.

The result of present study are supported by Stamm (2010) who found that ideal work environment in terms of managing stress and trauma is one that combines high CS with low BO and STS. Then interpret finding as this is the most positive result. This result represents mental health nurse who receives positive reinforcement from work; carry no significant concerns about being "bogged down" or inability to be efficacious in work-either as an individual or within organization. This mental health nurse may benefit

from engagement, opportunities for continuing education, and other opportunities to grow in position.⁽⁵⁾

In the same line Slocum-Gori et al (2011) in a study about understanding compassion satisfaction, compassion fatigue and burnout. Results indicated that health care systems could increase the prevalence of CS then ProQoL through educational training programs to support health care professionals in work environment.⁽²⁹⁾ Moreover Hevezi (2016) in a study about using compassion intervention to reduce the effects of stressors associated with compassion fatigue among nurses. A result indicated that the intervention performed on nurses decreased the scores presented in BO, STS, and increases the scores in CS.⁽³⁰⁾

Also Al-Majid et al(2018) in a study about assessing the degree of compassion satisfaction and compassion fatigue among nurses found that improving of ProQoL of the studied nurses can be explained by training received in the hospital in the identification and recognition of CF by nurses.⁽³¹⁾ Furthermore Zhang et al(2018) in studies evaluating aspects of ProQoL among nurses showed that stress and negative affect (behaviors and attitudes toward work) may promote CF whereas the positive affect and sociality may promote CS.⁽³²⁾

In the same line Yilmaz et al. (2018) in a study about evaluating effect of a nurse-led intervention program on professional quality of life and post-traumatic growth among nurses found that a nurses-led intervention program with two sessions about CF, coping methods, breathing exercises, baksi dance, mandala painting, relaxation, and questions about empathy and two counseling follow-ups with motivational messages via a smartphone was effective in reducing CF and BO and increasing CS.⁽³³⁾ Moreover Siyavuya Maila et al(2020) in a study about

professional quality of life among nurses in psychiatric observation units found that professional quality of life for mental health nurses is an important aspect of career satisfaction and retention, and the ongoing investigation of professional quality of life of all nurses working in mental health settings is essential to ensure job satisfaction and to retain an experienced nurses for mental healthcare.⁽³⁴⁾

The present study is disagree with Wlodarczyk et al., (2013) found that no statistically significant differences were found between pre and post implementation of nurses group music intervention for grief resolution program in CS and CF.⁽³⁵⁾ Also Zajac et al (2017) study about the effect of program about confronting compassion fatigue who found that there were no statistically significant differences were found between pre and post implementation of the program.⁽³⁶⁾

The assessment of compassion satisfaction and compassion fatigue has become an important issue in the mental health nurses. On one hand, compassion fatigue can negatively affect professionals' health; and it can also produce negative outcomes in patients' health. On the other, when it comes to compassion satisfaction, it can produce an increased sense of responsibility and control over patients' health and feeling, and increase patients' trust toward nurses. With the agreement of these statements, present study assessed compassion satisfaction, burnout, and secondary traumatic stress pre implementation of the program and finding proved that most of subjects had high secondary traumatic stress and high burnout with low compassion satisfaction.

This combination is seemingly the most distressing. Not only does the mental health nurse feel overwhelmed and useless in the work setting, but also mental health nurse was literally frightened by it.

Mental health nurse with this combination of scores are probably helped most by being removed from their current work setting. Assessment for PTSD and depression is important. Treatment for either or both may have positive outcomes, but a return to an unmodified work situation is unlikely to be fruitful. However, if the mental health nurse is willing, it may be that nurse can change the efficacy by addressing skills and systems (such as additional training) or by working with the organization to identify a reorganized work assignment.

Present study illustrated that there was negative statistically significant correlation between compassion satisfaction and burnout. This mean high level of CS linked to lower level of BO, and vice versa. This study supported by Slocum-Gori et al (2011) results indicated a significant negative correlation between CS and BO.⁽²⁹⁾ In the same line Zhang et al (2018) whereas CS had moderate inverse correlation with BO.⁽³²⁾ Moreover Wells-English et al (2019) who study compassion fatigue and satisfaction influence on turnover among nurses results indicate a significant negative correlation between CS and BO and suggest that implementation of strategies to reduce CF both individually and organizationally, which would improve the well-being of the patient and nurses.⁽³⁷⁾

Regarding correlation between compassion satisfaction and traumatic stress, there was negative statistically significant correlation. This mean high level of CS linked to lower level of STS, and vice versa. Accordingly to Slocum-Gori et al (2011) results indicated a significant negative correlation between CS and STS.⁽²⁹⁾ Moreover El-Shafei et al (2018). Who performed Egyptian study on professional quality of life, wellness education, and coping strategies among health care provider found the same results and

reported that ProQoL is affected by and affects professional well-being and performance.⁽³⁸⁾

Presents study illustrated that there was positive statistically significant correlation between burnout and traumatic stress. This mean high level of BO linked to high level of STS and vice versa. This study supported by Hamed et al (2020) who study prevalence and predictors of burnout syndrome, post-traumatic stress disorder, depression, and anxiety in nursing staff in various departments suggested development of health educational program for nurses about different coping strategies can increase personal strength and resilience which is helpful in reducing CF and improve job engagement then furthermore ProQoL.⁽³⁹⁾

Moreover Chemali et al (2019) who performed a systematic review of burnout among healthcare providers in the complex environment of the Middle East reported that BO was highly prevalent among healthcare providers and proved that previous studies examining BO in this region have limitations in their methodology.⁽⁴⁰⁾ Furthermore Zhang et al (2018) study reported that, negative affect and stress were found to be associated with STS and BO. Indeed, both are inter-related phenomenon as stress and neuroticism increases negative affect.⁽³²⁾ Accordingly to Nolte et al (2017) who perform a meta-synthesis of compassion fatigue in nurses and Slatten et al (2011) studies about what managers should know about compassion fatigue and burnout proposed that CF was a temporal condition characterized by the inability to nurture others symptomized by intrusive thoughts, sleeping problems, and depression.^(41,42)

Accordingly to Duarte et al (2017) who study the role of psychological factors in nurses' burnout and compassion fatigue symptoms found that nurses who are more prone to CF are usually more self-judgmental and have less psychological flexibility, which can

affect nursing care.⁽⁴³⁾ While Van Mol et al (2015) study the prevalence of compassion fatigue and burnout among healthcare professionals reported that the ProQoL focuses on elements that detect the quality of life of the individual and how it is projected in different aspects of their life. One of the main factors that may affect mental health nurses in terms of CF is the excessive emotional workload. A clear example is the constant contact with situations of pain, suffering, and death among patients and family members.⁽⁴⁴⁾

Moreover Slatten et al (2011) reported that investments in programs capable of reducing CF and BO can potentially reduce the higher nurse turnover rates and then can improve quality of patients care and professional quality of life. Interventions targeting the reduction of negative affect and social inhibition among nurses and other ways to decrease CF and BO are thus required for understanding and managing these conditions. For the time being, focus on strategies such as patient reassignments, formal mentoring programs, training, and flourishing a compassionate organizational culture are among the possible suggestions.⁽⁴²⁾

Conclusion:

Compassion has positive effect on improving professional quality of life of mental health nurses, and also confirmed the effect of educational training program.

Recommendations:

Based on the results of the study recommended

- 1- The effect of compassion on professional quality of life should be included in nurses' curriculum.
- 2- In services training program for nurses about; how to assess and improve their professional quality of life.

- 3- Establishing of workshop for nurses about effective coping strategies about trigger situation to burnout or traumatic stress.
- 4- Further research to detect different new issue and trends related to professional quality of life.

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