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Experiences of Violence, Compassion Fatigue and Compassion Satisfaction on the Professional Quality of Life of Mental Health Professionals at a Tertiary Psychiatric Facility in Nigeria

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Abstract

The well-being of professionals in mental health settings has attracted considerable interest recently. Mental health professionals in the course of their professional duty report being either burdened or exhilarated. This study examined the factors influencing professional quality of life of professionals in a mental health facility in Nigeria. Using a cross-sectional design, 234 participants at the Federal Neuro-Psychiatric Hospital, Benin-City, Edo State, Nigeria responded to a set of questionnaires; professional quality of life and general health questionnaires. The results showed that the experience of violence in the workplace was significantly associated with secondary traumatic stress (t (231) = 2.141; P<0.05). Married participants reported better professional quality of life (t (218) = -2.220; P<0.05). Compassion satisfaction was significantly negatively correlated with psychological distress (r= -0.048; p<0.05). Conversely, burnout (r=0.241, p<0.05) and secondary traumatic stress (r=0.377, p<0.05) correlated positively with higher scores on the GHQ. Staff professional quality of life is influenced by work place characteristics.

Keywords

Professional Quality of Life, Mental Health Professionals, Psychiatric Facility, Nigeria

1. Introduction

Professional quality of life as a subject matter is gaining importance in different work settings due to its connection with the inherent personal characteristics of workers and their exposure to primary and secondary trauma in the workplace (Stamm, 2010). Caring for patients by professional mental health staff in psychiatric settings can be traumatic. Abdel-Hady and colleagues, (2008) reported experiences of trauma by professional mental health staff in a mental health facility in Egypt. The negative aspects of work likely to be experienced by professional mental health staff have been variously described. For example, McCann and Pearlman (1990) put forward the term 'vicarious trauma' which indicates post-traumatic stress experiences resulting from empathic repeated exposure to stories from clients. This is similar to 'compassion fatigue' which has both 'burnout' and 'secondary traumatic stress' as its constituents. While the former may not be conceptually different from the original meaning of burnout, the latter is experienced by staff as a professionally related exposure to extreme trauma of others who they care for in any work setting, and its features are similar to symptoms of post-traumatic stress disorder (Stamm, 2005).

However, professional mental health staff not only suffer negative consequences from their interaction with patients, but sometimes experience satisfaction in the course of caring. So, caring can have a positive and rewarding outlook. According to Pearlman and Caringi (2009), helping others can be vicariously transforming. The positive side of caring according to Stamm (2005) is called 'compassion

satisfaction'. This simply means a sense of happiness or pleasure that comes with one's work or that one receives from one's work. It relates to the positive feelings derived from doing helping work effectively (Stamm, 2005).

Research interest has mostly centered on burnout amongst different professionals since it was considered to be the most important singular factor in occupational health so much so that in some countries, it attained psychopathological status (Schaufeli et.al. 2008). However, more recently, this concept is being considered broadly to include factors that can influence it positively and/or negatively. In an effort to combine the three constructs of burnout, secondary traumatic stress (compassion fatigue) and compassion satisfaction, Stamm in the late 1990s suggested that they be called 'professional quality of life and designed a measuring tool with the same name. According to Stamm (2010), professional quality of life is defined as "the quality one feels in relation to ones work as a helper".

Several studies (Conrad & Kellar-Guenther, 2006; Van Hook, 2008) have attempted to investigate the interrelationships between the three aspects of professional quality of life and have established that there was an inverse relationship between compassion satisfaction and compassion fatigue/burnout. However, other reports (Severn, Searchfield & Huggard, 2011; Stamm, 2009) have indicated that it was possible for both positive and negative aspects of professional quality of life (compassion satisfaction and compassion fatigue) to be high.

Socio-demographic factors such as gender, age, income and years of service, have been shown to have no significant influence on professional quality of life, (Stamm, 2010). Clinical factors like non-psychotic morbidities (general distress) has been found to be positively correlated to compassion fatigue and negatively correlated to compassion satisfaction (Musa & Hamid, 2008).

Professional Quality of life is a relatively new construct, and to our knowledge, there has been no study in this environment, investigating the professional quality of life of mental health professionals in Nigeria. It is important to study the professional quality of life of mental health carers so as ascertain the manner and extent to which the constructs that make up the quality of life affect their enjoyment of their work and service delivery to patients. It will also assist in the development of measures to prevent compassion fatigue and enhance compassion satisfaction among these group of people.

We set out to investigate variables that may be affecting professional quality of life of mental health careers in a psychiatric hospital in Nigeria, as well as to ascertain the interrelationship of the various aspects of the professional quality of life of these careers.

2. Method

2.1. Background of the Study Area

The study was carried out at Federal Neuropsychiatric Hospital, Benin-city, Nigeria. It is a 250-bed hospital. The hospital is situated in Benin, and is one of the oldest cities in the Niger Delta region and is the capital of Edo state, Nigeria. The hospital is one of the two federal psychiatric hospitals in the south-south geopolitical zone of Nigeria. The hospital serves the entire state and the five adjoining states with an estimated population of about 21 million people.

2.2. Design

The study was an ex post facto cross-sectional research design.

2.3. Ethical Considerations

All study participants were provided with informed consent form as approved by the Ethical Review Committee of FNPH, Benin-City. Only those who consented to the research and met the inclusion criteria were allowed to participate in the study.

2.4. Study Population

Mental health professionals of the Federal Neuropsychiatric Hospital, Benin-City who had at least 6 months working experience as at the time of the study were recruited. These included medical doctors (psychiatrists and trainee psychiatrists), clinical psychologists, nurses, occupational therapists, and social workers.

2.5. Sampling

All mental health professionals working in the hospital and who consented were enrolled to participate in the study.

2.6. Inclusion/Exclusion Criteria

All the participants must be working as a mental health professional at the Federal Neuropsychiatric Hospital, Uselu, Benin-City for up to six months. The study excluded only the workers who were on leave or went for a special training during the time of collection of data and any participant who did not consent.

2.7. Instruments

The study made use of a questionnaire divided into three sections:

(1) Section A: is a semi structured socio-demographic/some work experiences questionnaire. It seeks to elicit variable such as the gender of the participants, age, years of experience, occupation, unit in the hospital, etc.

(2) Section B: General Health Questionnaire (12-item version): The GHQ was developed by Goldberg & Williams (1988) as a brief instrument which routinely measures psychological distress. It is a well-used paper and pencil test which has been used in Nigerian studies and can be easily self-administered. There are two scoring systems for GHQ-12; the Scaling system involving the coding to be (0,0,1,1) and the Likert type

with scoring (0,1,2,3,4). The scaling system was utilized for the present study.

(3) Professional Quality of life Scale (ProQol-5). This instrument was developed by Stamm in 2005. It is divided into three scales namely: Compassion Satisfaction (CS), Burnout and Secondary Traumatic Stress. Burnout and Secondary Traumatic Stress are both component of Compassion Fatigue (CF). Compassion satisfaction scale tries to elicit the pleasure derived by professional from being able to do their work well; the Burnout scale seeks to elicit from professional, the difficulties and associated feelings of hopelessness they experience in dealing with their work pressures or in doing their job effectively; while the Secondary Traumatic Stress scale seeks to elicit problems experienced by professionals as a result of being exposed to the traumatic experiences of other people. A score of 43 or less signifies low point on any of the scale, a score around 50 is average while scoring beyond 57 is high. Reliability scores of .87, .72 and .80 have been confirmed for the scale, (Stamm, 2005). Higher scores indicate better quality of life.

2.8. Data Analysis

Data were analyzed using the Statistical Package for Social Science (SPSS 17). Level of significance was set at $p< 0.05$. Analyses were done with two-tailed tests. Frequencies along with percentages were calculated for socio-demographic variables. The hypotheses were analyzed with t-test, and Pearson Correlation.

3. Results

There were two hundred and thirty four participants, of which 159 (67.9%) were female. Most were married; 180 (76.9%) and the mean age (SD) of the sample was 39.23 (7.79) years. The average duration of work experience was 12.33 (8.41) years.

Table 1. *Independent t-test comparison of experienced violence and sub-domains of PQoL*

Variable	Experienced violence	N	Mean	Std. Dev	T	Df	P
Burnout	Yes	176	28.06	5.800	1.331	231	>0.05
	No	57	26.95	4.270			
Compassion satisfaction	Yes	175	38.10	7.756	-1.375	231	>0.05
	No	58	39.69	7.165			
Sec. traumatic Stress	Yes	176	18.59	6.328	2.141	231	<0.05
	No	57	16.63	4.761			

The experience of violence was significantly associated with secondary traumatic stress among participants, $t (231) = 2.141$; $P<0.05$. No significant associations were reported between experiencing violence and the sub-domains of burnout and compassion satisfaction. (See Table 1)

Participants who were married reported significantly better professional quality of life ($t (218) = -2.220$; $P<0.05$). No significant difference was observed when gender was compared to professional quality of life. (See Table 2)

We observed that participants with better compassion satisfaction had better psychological health. Conversely, burnout ($r=0.241$, $p<0.05$) and secondary traumatic health ($r=0.377$, $p<0.05$) correlated positively with higher scores on the GHQ. See Table 3

Table 2. *Independent t-test comparison of gender, marital status and PQoL*

Variable	IV	N	Mean	Std. Dev	T	Df	P
Professional QoL	Male	74	84.76	13.202	0.285	229	>0.05
	Female	157	84.17	15.371			
Professional QoL	Single	42	80.38	13.167	-2.220	218	<0.05
	Married	178	85.80	14.459			

Table 3. *Pearson correlation of Sub-domains of PQol, and General health questionnaire*

	GHQ	P
Compassion satisfaction	-0.048	>0.05
Burnout	0.241**	<0.05
Sec. traumatic stress	0.377**	<0.05

4. Discussion

This study set out to investigate factors influencing professional quality of life of mental health professionals in a mental health setting in Nigeria. The main findings from this study were that the experience of violence was significantly associated with secondary traumatic stress, married participants reported better professional quality of life. Compassion satisfaction had a significant negative correlation with higher scores on the GHQ and that burnout and secondary traumatic health correlated positively with higher scores on the GHQ.

The finding that mental health carers who had experienced violence in the facility were more susceptible to the characteristic features of secondary traumatic stress, is consistent with previous reports. It is practically impossible for mental health professionals having contact with psychiatric patients (some of them who are psychotic), not to experience violence either directly or indirectly. Abdel-Hady and colleagues (2008) confirmed that the experience of violence occurs more commonly in psychiatry facilities compared to other settings, and it is not uncommon for mental health professionals to experience violence. Mental health professionals exposed to violence in Egypt experienced negative psychological consequences such as anger, irritability and anxiety. Lauvrud et.al, (2009) in his study among community mental health workers in Canada reported that, experiencing high levels of violence in a forensic psychiatry setting did not necessarily lead to compassion fatigue.

Considering the effect of socio-demographic factors on professional quality of life in this study, marriage in contrast to gender was found to confer a better professional quality of life. The social support provided in marital relationships may account for this. The importance of strong social support and established relationships with co-workers have been highlighted by Murray et al. (2009) in their study among trauma nurses in the USA. They reported that nurses with poorly established relationships with co-workers and those with poor social support were more likely to experience burnout and compassion fatigue. They concluded that social support has the potential to alleviate stress-related conditions at work and to improve compassion satisfaction for those who interact more. Lazarus and Folkman (1984), assert that a key factor in alleviating stress was the ability of individuals to access and use social support. Killian (2008) also reported that the level of reported social support from family, friends, and community was the most significant predictor of compassion satisfaction. Other studies have also confirmed that gender of the mental health professional does not necessarily correlate with the professional quality of life (Stamm, 2010, Huggard & Dixon, 2011). They assert that professionals are professionals irrespective of their gender, and so share similar experiences in their feelings of altruism and the pain of caring.

Psychological distress correlated with negative aspect of professional quality of life. This is consistent with the study by Musa & Hamid, (2008) on aid workers in Sudan and that of Lousville and colleagues, (1997). Figley (1995), have opined that the development of sudden cumulative or quickly arising symptoms of distress may be beyond the coping capacity of the professionals and so may lead to decompensation. Factors that have been identified to precipitate compassion fatigue in mental health professional includes job stressors for psychiatrists, (Fothergill, Edwards & Burnard, 2004); caring for patients, system problems like high patient assignment (Hall, 2004, Lee and Ashforth's 1996, Killian 2008) and personal issues Yoder (2010). In the present study, factors that could have precipitated compassion fatigue includes job stressors and system issues like a high caseload of patients especially with the dearth of qualified mental health professionals in Nigeria. The consequences of this could be severe on both the mental health professionals and their patients. For example Austin and his co-workers, (2009) reported from their study that nurses who considered themselves as having Compassion Fatigue felt differently in their work performance and felt some distance between them and their patients resulting in them developing pessimistic views toward positive changes in the patient.

5. Conclusion and Implications

The results from this study suggest that the experience of violence and presence of psychological distress in mental health professionals can influence the occurrence of poor professional quality of life. Contrarily social support could play a very significant role in preventing the development of these negative aspects of professional quality of life. This implies that there should be more emphasis on the development of measures to reduce the experience of violence either real or vicarious, by mental health professionals. This could be achieved with the introduction of effective and comprehensive programs aimed at better staff training, better interdisciplinary cooperation, and improvement of work circumstances. There should also be establishments of institutional mechanisms to assist the mental health professionals to enhance their coping mechanisms to create a better outlook in the continuous stressful work-environment of mental-health facility. Promotion of a positive work environment by administrators could also help to improve the compassion satisfaction of these professionals. All these will improve the happiness and productivity of these mental health professionals and eventually impact positively on patient's care.

Limitations

The fact that a single psychiatric facility was used in this study limits the generalizability of the findings in the study to other mental health carers in Nigeria. Also there could be recall bias as well as social desirability bias. However, this effort, representing the first of its kind in this environment could serve as a basis for further research in this important area of study.

References

[1] Abdel-Hady, Ali Ali El-Hawary, Mohamed Shoada (2008).Work place violence against psychiatric health care staff in Mansoura, Egypt.*Paper presented at the Second International Conference onViolence in theHealth Sector; From Awareness to Sustainable Action*

[2] Austin, W., Goble, E., Leier, B., & Byrne, P. (2009). Compassion fatigue: The experience of nurses. Ethics and Social Welfare, 3, 195-214.

[3] Conrad, D., &Kellar-Guenther, Y. (2006).Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers.*Child Abuse & Neglect, 30, 1071-1080.*

[4] Figley, C. R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, Brunner/Mazel.

[5] Fothergill, A., Edwards, D., &Burnard, P. (2004). Stress, burnout, coping and stress management in psychiatrists: Findings from a systematic review. International *Journal of Social Psychiatry,* 50(1), 54-65. http://dx.doi.org/10.1177/0020764004040953.

[6] Goldberg, D.P. and Williams, P. (1988) A user's guide to the General Health Questionnaire.Nelson, Windsor.

[7] Haber, Y., Palgi, Y., Hamama-Raz, Y., Shrira, A., Ben-Ezra, M. (2013). Predictors of Professional Quality of Life among Physicians in a Conflict Setting: The Role of Risk and Protective Factors. *Isreal Journal of Psychiatry RelatSci - Vol. 50 - No 2*.

[8] Hugard, P., & Dixon, R. (2011).“Tired of Caring”: The Impact of Caring on Resident Doctors. *Australasian Journal of Disaster and Trauma Studies,*Vol, 3 URL: http://trauma.massey.ac.nz/issues/2011-3/AJDTS_2011-3_04_Huggard.pdf

[9] Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians wor-king with trauma survivors.Traumatology, 14(2), 32-44.

[10] Lauvrud, C., Nostad, K.,&Palmstierna, T. (2009).Occurrence of post traumatic stress symptoms and their relationship to professional quality of life (ProQoL) in nursing staff at a forensic psychiatric security unit: a cross-sectional study. *Health and Quality of Life Outcomes,* 7:31 doi: 10.1186/1477-7525-7-31. This article is available from: http://www.hqlo.com/content/7/1/31.

[11] Lazarus RS, Folkman S. Stress, appraisal, and coping. New York: Springer Publishing; 1984

[12] Lee, R. T., & Ashforth, B. E. (1996). A meta-analytic examination of the correlates of the three dimensions of job burnout. Journal of Applied Psychology, 81, 123-133Louville, P., Jehel, L., Goujon, E., &Bisserbe, J. C. (1997).*European Psychiatry*, 12, suppl.2, 186s.

[13] Mahoney, M. J. (2003). *Constructive psychotherapy: A practical guide*. New York: Guilford

[14] McCann, I.L., &Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *J Traum Stress 1990; 3: 131-149.*

[15] McFarlane, C. A. (2004). Risks associated with the psychological adjustment of humanitarian aid workers. *The Australian Journal of Disaster*, 1. Retrieved April 20, 2007, from http://www.massey.ac.nz/~trauma/

[16] Murray, M., Logan, T., Simmons, K., Kramer, M. B., Brown, E., Hake, S., & Madsen, M. (2009).

[17] Secondary traumatic stress, burnout, compassion fatigue and compassion satisfaction in trauma nurses. American Journal of Critical Care, 18(3), e1-e17

[18] Musa, S.A. &Abdalla Hamid, A.R.M. (2008).Psychological Problems among aid workers operating in Darfur.*Social Behavior and Personality, 2008, 36 (3), 407-416.*

[19] Pearlman, L.A., &Caringi, J. (2009). Living and working self-reflectively to address vicarious trauma. In C.A. Courtois& J.D. Ford (Eds.).Treating complex traumatic stress disorders: *An evidence-based guide* (pp. 202-224). New York: Guilford Press.

[20] Schaufeli, W.B., Leiter, M.P., &Maslach, C. (2009).Burnout: 35 years of research andpractice. *Career Development International,* Vol. 14 No. 3, pp. 204-220. Emerald Group Publishing Limited1362-0436, DOI 10.1108/13620430910966406

[21] Severn, M., Searchfield, G. &Huggard, P.K. (2011). Manuscript Title: Occupational stress amongst Audiologist’s: Compassion Satisfaction, Compassion Fatigue and Burnout. *International Journal of Audiology*. Accessed on November 30, 2011 from http://informahealthcare.com/eprint/yQTgSru8EahBC6Rem3ut/full (doi: 10.3109/14992027.2011.602366).

[22] Stamm, B. H. (2005). The ProQOL Manual: The Professional Quality of Life Scale: Compassion Satisfaction, Burnout & Compassion Fatigue/Secondary Traumatic Scale. Baltimore: *Sidran Press.*

[23] Stamm, B.H. (2010). The Concise ProQOL Manual. Pocatello, ID: ProQOL.org.

[24] Van Hook, M.P., Rothenberg, M., Fisher, K., Elias, A., Helton, S., Williams, S., Pena, S., Scott, M. & Gregory, A. (2008). Quality Of Life and Compassion Satisfaction/Fatigue and Burnout in Child Welfare Workers: A Study ofthe Child Welfare Workers in Community Based Care Organizations in Central Florida.Presented at North American Association of Christians in Social Work (NACSW).

[25] Yoder, E. A. (2010). Compassion fatigue in nurses. Applied Nurs-ing Research, 23, 191-197.