Prevalence of Compassion Fatigue, Burn-Out and Compassion Satisfaction Among Maternity and Gynecology Care Providers in Greece

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ABSTRACT

Introduction: Maternity and gynecology professionals are exposed to distressing events, trauma and suffering that may trigger compassion fatigue. Aim: The aim of this study was to investigate the prevalence of compassion fatigue/secondary traumatic stress (CF/STS), burnout (BO) and compassion satisfaction (CS) in maternity and gynecology care providers. Material and Methods: The Professional Quality of Life Scale (ProQOL R-IV) and a demographic and work-related characteristics questionnaire were distributed to 121 certified nurses, midwives and nurse/midwife assistants in 3 public hospitals in Greece. Results: The majority of participants were at the high-risk category for CF/STS (73.9%) while only 19.8% and 5% of nurses expressed high potential for CS and BO, respectively. Awareness of the factors associated with CF may help nurses to prevent or offset the development of this condition. Conclusion: A compassionate organizational culture, clinical supervision and on-going education may protect care providers from absorbing or internalizing unmanageable emotions which may lead to compassion fatigue and also help them to gain a deeper understanding of their communication and interactions during the emotionally laden moments of maternity and gynecology care.

Keywords: Gynecology Nursing, Midwifery, Compassion fatigue, Compassion Satisfaction, Emotional work.

1. INTRODUCTION

Compassion fatigue (CS), secondary traumatic stress (STS) and vicarious traumatization are the terms which are used almost interchangeably to describe the “cost of caring” for the traumatized individuals in nursing and other disciplines (1). Indeed, nursing researchers report alarmingly high percentages of STS in critical care nursing, emergency department, oncology, pediatric nursing, mental health nursing and midwifery (1). Despite criticism relating to the social and political power issues implicated in the medicalisation of human suffering (2, 3), the risk of emotional distress implicated in working with traumatized clients has certainly been recognized.

Maternity professionals may also experience through their work distressing events that fulfill criteria for trauma (4). Sheen et al. investigated posttraumatic stress in UK midwives (n=421) and concluded that 33% experienced traumatic stress symptoms (5). In the US, Beck et al. found that 36% of a sample of 473 maternity professionals reported clinically significant trauma symptoms (6). In a recent survey of Australian midwives, more than two-thirds of Australian midwives (67%) reported having witnessed a traumatic birth, with 74% experiencing feelings of horror and 65% guilt (7, 8).

Nurses and midwives have reported a variety of sudden, unpredictable and uncontrollable events during labour and birth that can trigger traumatic stress (9-12). These events include obstetric emergencies but also “rough approaches” towards women by health professionals, and disrespectful interactions between caregivers and women. Furthermore, midwives...
Factors that increase the risk of CF are empathy and organizational anxiety (14). The main feature of nursing/midwifery nurses and obstetricians is the high level of empathy and the identification they develop with the woman-patient after a painful labour (15). Qualitative research with maternity professionals having witnessed traumatic events shows that having an engaging, empathetic relationship can expose health professionals to a myriad of emotional responses including feelings of shock, despair, powerlessness, guilt and isolation (9, 11-12). As regards organisational anxiety, the prevalence of moderate and high occupational stress to labour and postnatal care nurses and midwives ranges from 20% to 59% in countries such as Sweden (16), Norway (17), United Kingdom (5, 18) and Australia (19-21).

This study is timely because there appears to be an emerging international interest in the phenomenon of STS and its impact on labour and post-natal nurses and midwives; Moreover, this is the first study conducted in Greece in relation to this topic. The aims of the study were threefold: (1) to investigate the level of risk for compassion fatigue/secondary traumatic stress (CF/STS) and burnout (BO) for maternity and gynecology care providers; (2) to examine levels of compassion satisfaction (CS) for maternity and gynecology care providers; and (3) to explore the possible effects of personal and work-related characteristics on levels of CF/STS, BO and compassion satisfaction (CS).

Cultural considerations
Greece is a country with a high prevalence of Cesarean Section deliveries (22) and with shrinking health care funding due to a prolonged period of austerity (23). Public Maternal Hospitals are sub-optimally staffed, low in recourses while proper and close monitoring of women in labour in one to one ratio is impossible and therefore many doctors resort to CSs (24). Nonetheless, the birth culture in Greece was highly medicalised even before the crisis since almost all births were performed in hospital settings in both the Greek National Health Service and the private health care system (25). Furthermore, there are no primary obstetric care settings or birth clinics in community. Interestingly in an investigation of job satisfaction levels of hospital practising midwives, 45.5% of midwives reported being satisfied from their work (26).

2. PATIENTS AND METHODS

Participants

Questionnaires were distributed to 121 maternity and gynecology care providers (registered nurses, midwives and assistant nurses). The sample was predominantly female (96.7%) and married (52.9%). The mean age was 37.3 ± 8.03 years. Forty-one nurses and midwives (35.9%) had completed a 2-year education in the Technical School of Nursing or Midwifery. Eleven participants (9.1%) had a master of science in nursing or obstetrics, 64 (52.9%) had a degree from a Technological College and 5 (4.1%) had a bachelor’s degree in nursing or obstetrics. The demographic characteristics of the sample are presented in Table 1.

Table 2 presents the work-related characteristics. One hundred and seven participants (88%) think that most of the time staff works as a team, and 94 participants (78%) have a good relationship with the patients they care to. Only 20 participants (16.5%) have chosen to work in an obstetrics-gynecology unit, but 62.8% believe that the working environment (relationship with colleagues) is very
The aim of the present study was to investigate the level of risk for compassion fatigue/secondary traumatic stress and burnout for maternity and gynecology care providers. Additionally, our study examined the levels of compassion satisfaction as well as the possible effects of the personal and work-related characteristics of care providers on CF, burnout, and work-related characteristics of care providers on F, burnout, and CS. Findings suggest that the majority of participants (65.8%) reported low potential for CS, moderate risk for BO (54.5%) and high risk for CF (73.9%). The ProQOL scores point (18) and "high" for compassion fatigue (mean = 19.61, top 25% cut point = 17). The majority of the participants (65.8%) reported low potential for CS, moderate risk for BO (54.5%) and high risk for CF (73.9%). The ProQOL scores and frequencies are presented in Table 3. A comparison with the findings noted by Stamm is included.

Correlations Between Professional Quality of Life and Demographic and Work-Related Characteristics

Nurses and midwives who had cared for a woman who experienced a traumatic birth experience reported statistically significant higher levels of CF/STS (t = 4.77, p < 0.001). According to linear regression analysis results by us, the regression analysis results are shown in Table 4. It should be noted that only burnout was found to have a positive and statistically significant relation with compassion fatigue (t = 3.426, p = 0.001).

Burnout and compassion fatigue were found to correlate with compassion satisfaction, and the correlation was negative (BO: r = −0.73, p < .001; CF: r = −0.15, p = 0.177). There is a positive correlation between BO and CF (r = −0.36, p < .001). Bivariate correlations are presented in Table 5.

4. DISCUSSION

The aim of the present study was to investigate the level of risk for compassion fatigue/secondary traumatic stress and burnout for maternity and gynecology care providers.
a moderate risk for burnout (54.5%) while they experienced low levels of compassion satisfaction (65.8%). Additionally, care providers who had cared for a woman with a traumatic labour experience reported higher levels of compassion fatigue compared to those who did not.

Overall, the results of the present study are similar to those of previous research in the UK, US and Australia which indicate that witnessing traumatic labour and birth events impacts on midwives’ and nurses’ psychological well being to the extent of experiencing compassion fatigue (5,9). The possible adverse affects of STS threaten the provision of compassionate maternity care, since health professionals distance themselves from patients as a means of self-protection (7,9,12) and may therefore experience low satisfaction from the care they provide (1). Leinweber discusses the link between defensive care provision and STS in an ecological model of STS in maternity care (8). Besides, there is evidence that other health professionals who report symptoms of secondary post-traumatic anxiety disorder exhibit empathic dysfunction and emotionally remote or defensive care (29,30).

Misouridou discusses the dynamics of trauma which may limit health professionals’ ability to interact in a meaningful and safe way with patients, while internalizing and absorbing of unmanageable emotions that lead to secondary traumatization (1). Health care professionals may over identify with patients or assume inappropriate roles such as that of the rescuer or the uninvolved mother. On the other hand, intimacy in the face of trauma may provoke the fear of being lost in the patient’s pain and anguish and being overwhelmed by it. Nonetheless, instead of repressing or defending against the intense emotions, anxiety and challenging thoughts stemming from traumatic events, professionals may allow themselves to recognize, accept and experience their feelings as an opportunity for personal and professional growth.

Another important result of the present study is that care providers who had cared for a woman with a previous traumatic labour experience reported higher levels of secondary post traumatic anxiety compared to those who did not. Although Sheen et al. found no association between STS and previous traumatic experiences (5), Leinweber et al. reported that midwives who recalled experiencing trauma when giving birth were twice as likely to develop probable PTSD after witnessing a traumatic birth (8). It appears that professionals’ emotional reactions can be partly a result of their own personal history or past reactions at the early stages of their professional life when exposed to the stress and the tensions present in their interactions to traumatized individuals (1). Misouridou stresses that self-awareness, acknowledgement of personal loss history and unresolved issues as well as acceptance of personal limitations constitute necessary equipment of a ‘wounded healer’ in a genuine encounter with those in need (1).

Nonetheless, certain limitations of the study should be taken into account while generalizing the results. The main limitation of the study was the selection of the sample. Midwives, nurses and nurse/midwife assistants were selected from a specific area (3 public hospitals) while there is no weighting on key important factors such as age, gender and years of service.

5. DISCUSSION

Overall, the findings of this study indicate the need for the development of educational and supportive interventions to prepare maternity professionals to cope with the emotional content of their work in the face of trauma. Sheen et al. stress that maternity professionals do not always feel prepared to experience trauma, or to be supported in their workplace after a traumatic perinatal event (9). Organizational support and a supportive workplace culture are crucial to enable midwives and nurses to talk about their feelings of shock, despair and isolation (31,32). Clinical supervision provided regularly on a long term basis constitutes a holding environment for personal disclosures which helps professionals to step back and reflect on their communication and interactions (1). Care during the emotionally laden moments of childbirth may be a source of suffering, anguish and stress for maternity professionals but also an arena of personal maturity and self-actualization. In times of an international rising trend in caesarean sections and declining rates in normal birth (33), maternity professionals should be adequately prepared to face the dynamics of trauma in order to support a care system where birth is viewed as a natural process and thus contribute to a culture of belief in normal birth.

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