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# A COMPARATIVE STUDY OF THE PROFESSIONAL QUALITY OF LIFE BETWEEN TRAINEES IN THE FIELD OF MEDICINE AND MENTAL HEALTH

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## ABSTRACT

*The purpose of this study was to compare the professional quality of life between trainees of the medical and mental health fields, and measure to what extent compassion fatigue and compassion satisfaction affects these professionals when under training and further to see the difference between the two groups on compassion satisfaction, secondary traumatic stress, and burnout. It was hypothesized that trainees in the field of mental health would be more prone to facing compassion satisfaction, secondary traumatic stress, and burnout in comparison to trainees in medical fields. The sample of the research consisted of 80 participants including both male and female trainees, aged 23-26 years; comprised of two groups. The first group included 40 trainees from the field of clinical psychology. Their education level was at least a master's degree in clinical psychology; and they were currently enrolled in a Post Magistral Diploma in Clinical Psychology (PMDCP) or MS program (1st year) of clinical psychology. The second group included 40 trainees that comprised of the medical field, including BDS and MBBS. They were currently be enrolled in a house-job. Analysis showed significant difference between the two groups on the variable of compassion satisfaction and Secondary traumatic stress.*

***Keywords:*** Mental health, Burnout, compassion fatigue, compassion satisfaction, professional quality of life

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## INTRODUCTION

Professional quality of life for those providing care has been a topic of growing interest over the past twenty years. Research shows that people that have been exposed to traumatic stressors are at risk for developing negative symptoms associated with burnout, depression, and posttraumatic stress disorder. In regards to the helping professions, individuals can face both positive and negative feelings associated with their work.

This research focuses on two main constructs in the field of mental health (i.e. Compassion Satisfaction and Compassion Fatigue). Professional quality of life incorporates two aspects, the positive and the negative. Stamm emphasizes that both the positive and negative aspects of doing one's job influences one's professional quality of life. The positive feelings about people's ability to help are known as Compassion Satisfaction (CS), whereas the negative, secondary outcomes have been identified as Compassion Fatigue (CF) (Stamm, 2010). Compassion fatigue further breaks into two parts: burnout and secondary traumatic stress.

These three domains together – compassion satisfaction, burnout, and secondary traumatic stress – make up the 3 subscales of the Professional Quality of Life Scale (ProQOL), developed by Stamm (2010), and are the most commonly used measure of the positive and negative effects of working with people who have experienced extremely stressful events.

The term Compassion Fatigue is defined as secondary traumatic stress, secondary victimization, and is often referred to as compassion burnout. As mentioned earlier, Compassion Fatigue contains two aspects (burnout and secondary traumatic stress). Both which, although being negative, are very distinct from each other. When both burnout and trauma are present in a person's life, their life can be very difficult (Stamm, 2010).

The first part aspect of Compassion Fatigue referred to Burnout, concerns things such like exhaustion, frustration, anger and depression typical of burnout. The term "burnout" itself has been defined extensively by researchers and psychologists. Fuchs defines it as *"a psychological, emotional and physical stress, exhaustion, indifference, cynicism, a reduced sense of work satisfaction, and social withdrawal, which - apart from internal factors - are contingent upon work overload, a lack of "control" options, i.e., possibilities in self-*

*determination, inadequate financial compensation, breakdown of social networks, absence of fairness, and conflicting basic values*" (Fuchs, Endler, et al., 2009).

When compassion burnout occurs, the integrity of the relationship between the healthcare provider and the patient is compromised. The healthcare professional displays behavior showing he or she is detached from the needs of the patient, which ultimately results in substandard care.

"Burnout" is a psychological term for the experience of long-term exhaustion and diminished interest. Negative feelings of people with a high burnout level are related to loss of a sense of their professional activity, loss of ability to self-realization, and loss of personal perspective (Lavrova & Levin, 2006). Burnout Syndrome is seen to be most prevalent among physicians and health professionals. It is a stress syndrome that manifests itself as emotional exhaustion, along with somatic and interpersonal manifestations. As a result of burnout, individuals feel a lack of accomplishment in their work, and are less satisfied with the results of their treatment regimes. When health care providers start to experience burnout, their clinical work starts to deteriorate: they become less respectful listeners, become easily agitated with patients, decrease contact with patients, and refer patients to others. Due to high levels of burnout, health care professionals experience personal dysfunction, which results in low morale and absenteeism.

Work-related trauma has a distinctive aspect of fear associated with it. The second part, Secondary Traumatic Stress, is a negative feeling driven by fear and work-related trauma (Stamm, 2010). Figley (2002) later defined compassion fatigue as a state of tension and preoccupation with the individual or cumulative traumas of clients. The phenomenon of compassion fatigue emerges suddenly and without warning and includes a sense of helplessness and confusion. It has been described by Figley as *"the cost a caregiver experiences as a result of caring for others.*"

According to Stamm (2010), the overall concept of professional quality of life is associated with 3 main components, which include (a) characteristics of the work environment (organizational and task-wise), (b) the individual's personal characteristics and (c) the individual's exposure to primary and secondary trauma in the work setting. This concept of professional quality of life generally applies to paid workers in the helping profession (e.g. medical

personnel and mental health personnel) and volunteers (e.g. Red Cross disaster responders) (Stamm, 2010).

There are three types of environment which play a role in the development of the feelings of compassion satisfaction and compassion fatigue. These three types of environment include a work environment, client (or the person helped) environment, and the person's environment. The qualities of these environments are determining factors as to which feeling in an individual exacerbates. For example, a poor work environment may contribute to Compassion Fatigue. At the same time, a person could feel compassion satisfaction that they could help others despite that poor work environment.

Research indicates that health professionals have the highest proportion of burnout cases. Burnout is directly recognized in the ICD-10 as "Problems related to life-management difficulty" (ICD -10), and is also recognized in the DSM-IV TR under V62.2 Occupational Problem, where the focus of clinical attention is an occupational problem that is not directly due to a mental problem, but causes enough distress to warrant independent clinical attention (e.g. job dissatisfaction) (DSM-IV-TR). The bottom line when discussing burnout is that when an employee faces a burnout syndrome, his work becomes inefficient.

Another contributor to psychological exhaustion is grief that healthcare professionals experience when their patients die or suffer. It has been found that the topic of healthcare professionals coping with grief and psychological exhaustion is frequently not addressed, which significantly increases the possibility of burnout behaviors.

Frequently, healthcare professionals, especially mental health professionals, follow patients throughout their illness and in some instances provide care for them almost daily. Individuals who have undertaken providing counseling and therapy services to others as a career understand how emotionally demanding the process can be. Therapists are required to be empathic, understanding, active listeners, non-judgmental, and giving, and at the same time are to be in control of their own emotional needs and responsiveness in dealing with their clients. Due to this demand of control of emotions, clinicians are generally at a risk of experiencing emotional, mental, and physical exhaustion when dealing empathically with an adult or child who has been traumatized (Figley, 1995; McCann & Pearlman, 1990; McCann & Saakvitne, 1995; Pearlman & MacIan, 1995).

Empirical studies have shown that counselors who deal with the trauma of others have an increased likelihood of experiencing a change in their own psychological functioning (Chrestman, 1995). A change in psychological functioning could include changes in reactions to environmental circumstances that correlate with the experiences of their patients and the negative effects the clinician witnesses. These negative reactions may include avoidance of the trauma, feelings of horror, guilt, rage, grief, detachment, or dread, and may possibly lead to burnout and counter-transference. When these experiences become a part of the clinician when dealing with clients, they in turn negatively affect the working or therapeutic relationship. If counselors are unaware of this stress response and do not work through it, they may non-deliberately convey a message to their clients that they are unwilling to hear the details of the client's trauma. Since the therapeutic space provides safety and comfort for clients to share their experiences with their therapists and in return expect unconditional positive regard when they do so, the first step of therapy is achieved. When this does not happen because the clinician is experiencing secondary traumatic stress and avoidance of the trauma, the patient may experience re-victimization since they already have limited environments in which telling their story is safe and acceptable to begin with (McCann & Perlman, 1990).

Some researchers suspect that psychiatrists and psychiatry nursing staff are considered to be vulnerable to experiencing burnout. An investigation was conducted regarding the prevalence of burnout syndrome in practitioners, residents and nurses working in the psychiatric hospital of Tunisia. Results showed that high levels of burnout were detected among nurses. Burnout syndrome seems to be highly prevalent among nurses and residents. A strong relationship has been found between personal difficulties and burnout, especially in regards to psychiatric nursing staff (Halayem-Dhouib, Zaghdoudi, Zremdini, Maalej, Béchir, & Labbène, 2010)

Ashtari and colleagues carried out a research in which the objective was to assess the relationship between work performance and job burnout amongst staff at a psychiatric hospital. Results showed that there was a significant correlation between job burnout and inability for job performance (Ashtari, Farhady, & Khodaee, 2009)

When it comes to trainees, there have been studies that have also shown similar correlates, however no significant results were available, as the research regarding trainees is scarce. Therefore, the purpose of this study was to explore

the prevalence of burnout and compassion fatigue among mental health trainees and medical trainees, and compare the results to see which of the two groups faced more burnout and compassion fatigue and how these factors effect their professional quality of work as well as the effect that their work and workload has on the quality of their personal lives. This exploration will lead to a better understanding of how a helper's life is affected by their work, and to what extent this effect in their life, effects their profession.

### *Rationale for this Study*

"Burned out" healthcare professionals are more likely to deliver services which are suboptimal which could potentially result in disaster" (Wood & Killion, 2007). Frequently, healthcare professionals follow patients throughout their illness and in some instances provide care for them daily. The topic of healthcare professionals coping with grief and psychological exhaustion is frequently not addressed, which significantly increases the possibility of burnout behaviors. Therefore, the purpose of this study was to explore the prevalence of burnout and compassion fatigue among mental health professionals and medical doctors, and compare the results to see which of the two groups faced more burnout and compassion fatigue. This exploration will lead to a better understanding of how a helper's life is affected by their work, and to what extent this effect in their life, effects their profession.

## METHOD

### *Research Design*

The following research is a comparative study in which the relationship of job description and satisfaction (in terms of altruism, and satisfaction with career and life) and job description and dissatisfaction (in terms of fatigue, burnout, and stress) is determined. The independent variable would be the individuals' profession, white the dependent variables would be the measures of compassion satisfaction and compassion fatigue (burnout and secondary traumatic stress).

### *Participants*

The sample of the research contains 80 participants which was divided into two groups. The first group included 40 trainees from the field of clinical

psychology. Their education level was of at least a masters degree in clinical psychology (i.e. 12 years of undergraduate study plus 4 years of clinical psychology), and were currently enrolled in a Post-Magistral Diploma in Clinical Psychology (PMDCP) and Masters (MS) program of clinical psychology. In regards to MS, only the students of MS first year were chosen as part of the sample. Both, MS and PMDCP were working towards the completion of the requirement of 100 hours of clinical work during the course of one year as part of their degree requirement. The data was collected from the Institute of Clinical Psychology and the Institute of Professional Psychology, Karachi. The second group included 40 trainees from the fields that comprise of the medical field, including BDS and MBBS. Their education levels were at least a Bachelors degree in their respective fields and were enrolled in a house-job. The data for this group was taken from Hamdard College of Medicine and Dentistry and Baqai Medical University, Karachi. Personal variables of the target sample were also taken into account, which included their age, education, and gender. The sample in both groups included male and female trainees, aged 23-26.

### *Procedure*

For the purpose of the study, the method used to collect data was convenience sampling. The sample of the research was recruited from different educational institutions in Karachi (Hamdard, Baqai, ICP, and IPP), and comprised of mental health trainees and medical house officers, male and female, aged 23-26. Only those subjects were selected to partake in the research that fit the criteria. The participants were briefed about the purpose of the study and were assured that the data they provided would only be used for research purposes and their identities would not be revealed to anyone, either during the course of the study, or after the research has been completed. They were asked to sign a consent form after they had been briefed about the procedures. They were then administered the Demographic Data Form as well as the Professional Quality of Life Scale.

### *Measures*

#### *Demographic Data Form*

Demographic information was obtained through items which will focus on subject's gender, age, profession, and educational level, as well as the number of working hours.

***Professional Quality of Life Scale, 5th Edition (ProQOL 5)***

The ProQOL, developed by Beth Hudnall Stamm, PhD (2010) is the most commonly used measure of the negative and positive effects of helping others who experience suffering and trauma. The scale consists of 30 items, divided into three subscales measuring separate constructs. The first is Compassion Satisfaction (CS) and the other Compassion Fatigue (CF) which is subdivided into Secondary Traumatic Stress (STS) and Burnout (BO). For compassion Fatigue, the inter-scale correlations show 2% shared variance (r=-.23; co-σ = 5%; n=1187) with Secondary Traumatic Stress and 5% shared variance (r=.-.14; co-σ = 2%; n=1187) with Burnout. While there is shared variance between Burnout and Secondary Traumatic Stress the two scales measure different constructs with the shared variance likely reflecting the distress that is common to both conditions. The shared variance between these two scales is 34% (r=.58;; co-σ = 34%;14 n=1187). The scales both measure negative affect but are clearly different; the BO scale does not address fear while the STS scale does (Stamm, 2010).

## RESULTS

In order to interpret the data in statistical terminology, t-test was applied with the help of Statistical Package for Social Sciences (SPSS). The description under each table explains the interpretation of the results.

**Table 1**
***Descriptive Statistics for the Age of the Sample***

| **Groups** | ***N*** | ***M*** | ***SD*** |
|---|---|---|---|
| Male | 25 | 24.8 | 1.137 |
| Female | 55 | 24.07 | 1.088 |
| Total Sample | 80 | 24.14 | 1.088 |

**Table 2**
***Profession-Gender Cross Tabulation***

| **Profession** | **Male** | **Female** | **Total** |
|---|---|---|---|
| BDS | 7 | 13 | 20 |
| MBBS | 12 | 8 | 20 |
| Psychologist Intern | 6 | 34 | 40 |

**Table 3**

***Percentage of Compassion satisfaction amongst Medical House officers and Mental health Professionals***

| Level of Compassion | Medical House Officers | | Mental Health Professionals | |
|---|---|---|---|---|
| | *f* | *%* | *f* | *%* |
| Low | 0 | 0 | 0 | 0 |
| Average | 13 | 32% | 21 | 52% |
| High | 27 | 67% | 19 | 47% |

**Table 4**

***Percentage of Secondary Traumatic Stress amongst Medical House officers and Mental health Professionals***

| Level of Secondary Traumatic Stress | Medical House Officers | | Mental Health Professionals | |
|---|---|---|---|---|
| | *f* | *%* | *f* | *%* |
| Low | 7 | 17% | 23 | 57% |
| Average | 33 | 82% | 17 | 42% |
| High | 0 | 0% | 0 | 0% |

**Table 5**

***Percentage of Burnout amongst Medical House officers and Mental health Professionals***

| Level of Burnout | Medical House Officers | | Mental Health Professionals | |
|---|---|---|---|---|
| | *f* | *%* | *f* | *%* |
| Low | 13 | 32% | 12 | 30% |
| Average | 26 | 65% | 28 | 70% |
| High | **0** | 0% | **0** | 0 |

**Table 6**

***Differences between the Compassion Satisfaction between Medical House Officers and Psychologist Trainees***

| Groups | *N* | *M* | *SD* | *t* | *Sig.* |
|---|---|---|---|---|---|
| Psychologist Trainees | 40 | 39.67 | 4.671 | 3.806 | .000 |
| Medical House Officers | 40 | 35.30 | 5.571 | | |

$p < .05$, $df = 78$

**Table 7**

***Differences between the Variable of Burnout between Medical House Officers and Psychologist Trainees***

| Groups | *N* | *M* | *SD* | *t* | *Sig.* |
|---|---|---|---|---|---|
| Medical House Officers | 40 | 24.75 | 5.592 | .111 | .912 |
| Psychologist Trainees | 40 | 24.63 | 4.407 | | |

$p > .05$, $df = 78$

**Table 8**

***Differences between the Variable of Secondary Traumatic Stress between Medical House Officers and Psychologist Trainees***

| Groups | *N* | *M* | *SD* | *t* | *Sig.* |
|---|---|---|---|---|---|
| Medical House Officers | 40 | 28.98 | 7.671 | 5.180 | .000 |
| Psychologist Trainees | 40 | 21.38 | 5.222 | | |

$p < .05$, $df = 78$

## DISCUSSION

Our first hypothesis was that mental health trainees will be more prone to experiencing compassion satisfaction as opposed to medical house officers. The results are consistent with the hypothesis ($t = 3.806$, $p < .05$, table 3). Mental health trainees as well as professionals are, while treating their clients, developing a rapport with their clients which ultimately leads to a deeper

understanding and empathy for the client. When the treatment proves to be beneficial for the client and the practitioners see a positive result in their clients through the efforts that they have put forth, it results in a feeling of satisfaction and happiness in trainees, that their endeavors to help an individual and bring about a positive change in their life have been successful.

Medical professionals on the other hand do not delve into the personal lives of their patients, rather deal with their patients through a more scientific procedure, by prescribing medication and following scientific protocols. It can be assumed that since they are not on a personal level with their patients, even though medication proves to be helpful for patients, they may not feel that specific sense of interpersonal satisfaction that one experiences when they put their own emotional and empathetic efforts into treating a patient, therefore, resulting in a lower degree of compassion satisfaction.

Secondly it was hypothesized that mental health trainees will also face more burnout as opposed to medical house officers. Results of the second hypothesis suggested that there is no significant difference between Mental Health Trainees and Medical House Officers on the variable of burnout. According to McHolm (2006), Compassion fatigue results from giving high levels of energy and compassion over a prolonged period to those who are suffering, often without experiencing the positive outcomes of seeing patients improve (McHolm, 2006). A research conducted by Vićentić et al. (2010) investigated the doctors' exposition level to professional stress. Stress level in general practitioners was compared with a group of psychiatrists and risk level for the appearance of burnout syndrome. The obtained results showed a high burnout risk level in both, GPs and psychiatrists, groups. In both groups there was no presence of psychic disorders (anxiety, depression, insomnia), while there was a high level of emotional exhaustion and over tension by job, and also a lower total personal accomplishment. Level of exposition to professional stress is higher in GPs than in psychiatrists, but the difference was not statistically significant (Vićentić et al., 2010). From a broader perspective, it can be seen that both groups are in the position of being a helper and both groups face an overwhelming workload when it comes to patients and casework. Although they may have different treatment regimens, their workload seems to be the same, in terms of the time, effort, and dedication they give to their professions.

Thirdly it was hypothesized that mental health trainees would face more secondary traumatic stress as opposed to medical house officers. The results of

the third hypothesis indicate that medical house officers are more prone to facing secondary traumatic stress ($t$ = -5.180, $p$ > .05, table 5). Medical House Officers are more exposed to patients of acute conditions, especially when working in the trauma sector. Due to being more directly exposed to severe conditions, Medical House Officers seem to be more prone to facing secondary traumatic stress. Mental health trainees on the other hand are exposed to clients whose primary condition has either subsided or is being controlled my psychiatric medication, focusing more on the client's emotional state and working in an environment where a warm, comfortable, and genuine environment is formed through the development of rapport.

### *Conclusion*

As can be seen from the results, our first hypothesis was consistent with the findings. Our second hypothesis was inconsistent with the findings, indicating that there is not statistical difference between the burnout faced by both groups. Our third hypothesis was also inconsistent with the findings, indicating that medical house officers are more prone to facing secondary traumatic stress than mental health professionals.

## Recommendations and Implications for Reducing Compassion Fatigue in Healthcare Organizations

Many researchers have suggested that healthcare organizations should devise strategies to reduce healthcare employee burnout while increasing employee work performance. According to Akgun et al., this can be catered to in the following ways:

1. Organizations can provide individual and group therapies for staff found to be at risk of burnout and/or general health complications.
2. Health care institutions should identify the factors influencing burnout (i.e. gender, marital status, profession, length of job tenure, income, and daily working time) and take these into consideration when selecting staff, developing training programs, and improving working conditions.
3. Decreasing long working hours, rotating duties between units, conducting team-building exercises, offering stress management training, and teaching health-care staff how to relax.
4. Many health care professionals, especially high performers, have developed the capacity for tolerating stress and physiological strain,

causing them to work long hours and spend less time with friends and family. Therefore, encouraging informal interactions among colleagues can also play a major role in helping to reduce burnout and stress. Avoiding family and friends promotes exhaustion and cynicism and impedes professional efficacy.

5. Health care professionals should be encouraged to seek emotional support, which also helps to counteract exhaustion and cynicism and promotes professional efficacy. (Akgun, Al-Assaf, & Bakar, 2008)

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