

DOI: 10.5455/msm.2019.31.172-176

Received: Jul 11 2019; Accepted: Sep 10, 2019

© 2019 Kalliopi Katsantoni, Afroditi Zartaloudi, Dimitrios Papageorgiou, Marianna Drakopoulou, Evdokia Misouridou

This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/4.0/>) which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited..

ORIGINAL PAPER

Mater Sociomed. 2019 Sep; 31(3): 172-176

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

General Maternity District Hospital "Helena Venizelou", Athens, Greece¹

Nursing Department, University of West Attica, Athens, Greece²

Corresponding author: Evdokia Misouridou, Ass. Prof., PhD, MSc, RN, University of West Attica. Email: emis@uniwa.gr. ORCID ID: <http://www.orcid.org/0000-0002-0401-1749>.

Kalliopi Katsantoni¹, Afroditi Zartaloudi², Dimitrios Papageorgiou², Marianna Drakopoulou², Evdokia Misouridou²

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.

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 fulfil 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

1. INTRODUCTION

Compassion fatigue (CS), secondary traumatic stress (STS) and vicarious traumatization are

report feelings of intense moral distress and horror when they witness disrespectful and abusive care which violates norms of professional conduct (8-9, 13).

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 Caesarean 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 resources 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 registered and assistant nurses and midwives who worked full time, in three rotating shifts of 3 public hospitals in the greater metropolitan area of Athens's Greece.

Procedure and ethical considerations

The Ethical Committee of University of West Attica approved of the study protocol. Additionally, the study was conducted after review and written approval by the Administrative and Scientific Society of each hospital. The researcher informed the head nurse of each obstetrics/gynecology unit about the purpose of the study and then the head nurse informed the nursing staff. Furthermore,

all participants were informed of their rights to refuse or to discontinue their participation, according to the ethical standards of the Helsinki Declaration of 1983. Participation in the study was contingent on individual verbal consent. An anonymous self-administered questionnaire was then distributed to maternity and gynecology care providers (registered and assistant). The primary researcher personally collected the questionnaires. Data were collected between May 2017 and October 2017.

Measures

The questionnaire booklet contained a set of 21 items on demographic (personal and work-related) characteristics as well as the Professional Quality of Life Scale (ProQOL R-IV) developed by Stamm (27). The demographic questionnaire was constructed in the Faculty of Nursing, University of West Attica for the purpose of this study. The Professional Quality of Life Scale (ProQOL R-IV) is a 30 item self-report measure on a 6-point scale (from never to very often) and consists of three discrete scales: compassion satisfaction (CS), burnout (BO) and compassion fatigue/secondary trauma (CF/STS) that do not yield a composite score (27). The Greek translated ProQOL version was employed for the purpose of the study (28). The Cronbach's α value was found to be 0.80 for compassion satisfaction, 0.73 for burnout, and 0.83 for compassion fatigue.

Analysis

A descriptive analysis was used to identify samples' characteristics. One-way ANOVA, and t-tests were calculated to determine significant differences in means, and Pearson and Spearman coefficients of correlations were calculated to determine the strength of linear relations between variables. Linear regression analysis was performed as well, to examine the relationship between the various personal and occupational variables and each of the three dependent variables: compassion satisfaction, burnout and compassion fatigue/secondary traumatic stress. Variables with $p \leq .05$ were considered significant. All statistical analyses were performed using the Statistical Package for Social Sciences, Version 22.0 for Windows.

3. RESULTS

Demographic and Work-Related Characteristics

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 (33.9%) 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

Characteristics	Mean ± SD/n (%)
Age	37.3 ± 8.03
Sex	
Male	4 (3.3)
Female	117 (96.7)
Position	
Registered nurse or midwives	80 (66.1)
Nurse or midwives' assistant	41 (33.9)
Marital status	
Single	51 (42.1)
Married	64 (52.9)
Widowed	1 (0.8)
Divorced/Separated	5 (4.1)

Table 1. Demographic Characteristics (N = 121).

Characteristics	n (%)			
	Always	Most of the times	Sometimes	Rarely
Good relationship with patients	22 (18%)	72 (59.5%)	25 (21%)	2 (1.5%)
Staff works as a team	24 (20%)	83 (68.5%)	14 (11.5%)	0 (0.0%)
Desire to leave the obstetrics-gynecology unit	Soon	In a year	In few years	Never or indifference
	3 (2.5%)	4 (3.3%)	25 (20.7%)	89 (73.6%)
Workplace environment	Excellent	Very Good	Good	Poor
	9 (7.4%)	67 (55.4%)	36 (29.2%)	9 (7.4%)
Physical health	27 (22%)	73 (60.3%)	17 (14.0%)	4 (3.4%)
		Yes	No	
Traumatic birth experience	45 (37.2%)	76 (62.8%)		
Personal choice of work in obstetrics-gynecology unit	20 (16.5%)	101 (83.5%)		
Desire of the same career for their children	42 (34.7%)	79 (65.3%)		
Choice of the same career again for their selves	69 (57.0%)	52 (43.0%)		
Experience the death of a loved one in the last years	31 (25.6%)	80 (74.4%)		

Table 2. Work related characteristics (N = 121).

good to excellent. Sixty-nine nurses (57.0%) would choose the same profession again. Most of them (65.3%) would not recommend nursing/midwifery as a career to their children. Eighty-nine (73.6%) of the participants do not intend or they are indifferent to leave the obstetrics-gynecology unit. Forty-five participants (37.2%) had provided care to a woman who had experienced a traumatic birth event. Nineteen participants had cared for a woman after stillbirth, 21 participants had cared for a woman with intense depression or stress and 5 participants had cared for a woman with a painful labor experience. Thirty one participants (25.6%) had experienced a recent death of a loved one. One hundred (82.6%) nurses describe their physical health as very good or excellent.

Professional Quality of Life

Based on the norms provided by Stamm (2005), the average scores for the sample were “low” for compassion satisfaction (mean = 30.38, bottom 25% cut point = 33), “moderate” for burnout (mean = 19.58, bottom 25% cut

	Compassion Satisfaction	Burnout	Compassion Fatigue
M ± SD	30.38 ± 7.47 (vs 37 ± 7.3) ^a	19.58 ± 4.49 (vs 22 ± 6.8) ^a	19.61 ± 7.45 (vs 13 ± 6.3) ^a
High	24 (19.8%)	6 (5.0%)	89 (73.9%)
Moderate	17 (14.1%)	66 (54.5%)	24 (19.8%)
Low	80 (65.8%)	49 (40.5%)	8 (6.3%)

Table 3. Professional Quality of Life Scores and Frequencies (N = 121). a The findings by the original author

Independent variable	B	p-value
Constant	0.617	0.982
Compassion satisfaction	0.174	0.211
Burnout	0.726	0.001**

**p<0.01

Table 4. Linear Regression Analysis Results for Compassion Fatigue.

	Compassion Satisfaction	Burnout
Burnout	r = -0.73**	
Compassion Fatigue	r = -0.13	r = 0.36**

**p<0.01

Table 5. Bivariate Correlations for Compassion Fatigue.

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 using the compassion satisfaction and the burnout as independent variables the 13.3% of the compassion fatigue variability is explained (F = 7.61, p < .001). 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 = -.73, p < .001, CF: r = -.13, p = .177). There is a positive correlation between BO and CF (r = .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. 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, BO and CS. Findings suggest that the majority of participants reported a high risk for compassion fatigue (73.9%),

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.

- **Declaration of patient consent:** The authors certify that they have obtained all appropriate patient consent forms.
- **Author's contribution:** K.K. and E.M. gave substantial contributions to the conception or design of the work in acquisition, analysis, or interpretation of data for the work. K.K., A.Z., D.P., M.D. and E.M. had a part in article preparing for drafting or revising it critically for important intellectual content. K.K., A.Z., D.P., M.D. and E.M. gave final approval of the version to be published and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.
- **Financial support and sponsorship:** None.
- **Conflicts of interest:** There are no conflicts of interest.

REFERENCES

1. Misouridou E. Secondary Posttraumatic Stress and Nurses' Emotional Responses to Patient's Trauma. *Journal of Trauma Nursing*. 2017; 24: 110–115.
2. Stein DJ, Seedat S, Iversen A, Wessely S. Post-traumatic stress disorder: medicine and politics. *Lancet*. 2007; 369: 139–44.
3. Summerfield D. The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ*. 2001; 322: 95–98.
4. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (5th edn)*. US: Washington, DC, 2013.
5. Sheen K, Spiby H, Slade P. Exposure to traumatic perinatal experiences and posttraumatic stress symptoms in midwives: prevalence and association with burnout. *International Journal of Nursing Studies*. 2015; 52: 578–587.
6. Beck CT, LoGiudice J, Gable RK. A mixed -methods study of secondary traumatic stress in certified nurse-midwives: shaken belief in the birth process. *Journal of Midwifery & Women's Health*. 2015; 60: 16–23

7. Leinweber J, Creedy DK, Rowe H, & Gamble J. Responses to birth trauma and prevalence of posttraumatic stress among Australian midwives. *Women and Birth*. 2017; 30(1): 40–45.
8. Leinweber J, Creedy DK, Rowe H, Gamble J. A socioecological model of posttraumatic stress among Australian midwives. *Midwifery*. 2017; 45:7-13.
9. Sheen K, Spiby H, & Slade P. The experience and impact of traumatic perinatal event experiences in midwives: A qualitative investigation. *International Nursing of Nursing Studies*. 2016; 53: 61–72.
10. Goldbort J, Knepp A, Mueller C, Pyron M. Intrapartum nurses' lived experience in a traumatic birthing process. *Am J Matern Child Nurs*. 2011; 36(6): 373–80.
11. Rice H, Warland J. Bearing witness: midwives experiences of witnessing traumatic birth. *Midwifery*. 2013;29(9):1056–63.
12. Elmir R, Pangas J, Dahlen H, Schmied V. A meta-ethnographic synthesis of midwives' and nurses' experiences of adverse labour and birth events. *J Clin Nurs*. 2017; 26(23-24):4184–4200.
13. Elmir R, Schmied V, Wilkes L, & Jackson D. Women's perceptions and experiences of a traumatic birth: A meta-ethnography. *Journal of Advanced Nursing*. 2010; 66(10): 2142–2153.
14. Sheen K, Slade P, Spiby H. An integrative review of the impact of indirect trauma exposure in health professionals and potential issues of salience for midwives. *Journal of Advanced Nursing*. 2014; 70: 729–743.
15. Moloney S, Gair S. Empathy and spiritual care in midwifery practice: contributing to women's enhanced birth experiences. *Women and Birth*. 2015; 28: 323–328.
16. Hildingsson I, Westlund K, Wiklund I. Burnout in Swedish midwives. *Sex Reprod Healthcare*. 2013; 4: 87–91.
17. Henriksen L, Lukasse M. Burnout among Norwegian midwives and the contribution of personal and work-related factors: a cross-sectional study. *Sex Reprod Healthcare*. 2016; 9:42–47.
18. Yoshida Y, Sandall J. Occupational burnout and work factors in community and hospital midwives: a survey analysis. *Midwifery*. 2013; 29:921–926.
19. Mollart L, Skinner VM, Newing C, Foureur M. Factors that may influence midwives work-related stress and burnout. *Women Birth*. 2013; 26: 26–32.
20. Jordan K, Fenwick J, Slavin V, Sidebotham M, Gamble J. Level of burnout in a small population of Australian midwives. *Women Birth*. 2013; 26:125–132.
21. Newton MS, McLachlan HL, Willis KF, Forster DA. Comparing satisfaction and burnout between caseload and standard care midwives: findings from two cross-sectional surveys conducted in Victoria, Australia. *BMC*. 2014; *Preg Child-birth*; 14:426.
22. WHO. Greece commits to addressing excessive reliance on caesarean sections. Nov 29, 2016. <http://www.euro.who.int/en/countries/greece/news/news/2016/11/greece-commits-to-addressing-excessivereliance-on-caesarean-sections> (accessed May 11, 2019).
23. Timmins F, Parissopoulos S, Plakas S, Fouka G. Economic recession in Greece and effects on quality nursing care. *J Nurs Manag*. 2017; 25(3):163-166. doi:10.1111/jonm.12477.
24. Pratilas GC, Sotiriadis A, Dinas K. Is high use of caesarean section sometimes justified? *Lancet*. 2019; 6, 394(10192):25–26. doi:10.1016/S0140-6736(19)30221-1
25. Kontoyannis M, Katsetos C. What influences women in Athens to choose home birth? *Br J Midwifery*. 2008; 16(1): 44–8
26. Papoutsis D, Labiris G, & Niakias D. Midwives' job satisfaction and its main determinants: A survey of midwifery practice in Greece. *British Journal of Midwifery*. 2014; 22(7), 480-486.
27. Stamm BH. *The ProQOL Manual. The professional quality of life scale: Compassion satisfaction, burnout & compassion fatigue/secondary trauma scales*. US: Idaho State University-Sidran Press, 2005.
28. Mangoulia P, Koukia E, Alevizopoulos G, Fildissis G, Kastostas T. Prevalence of Secondary Traumatic Stress Among Psychiatric Nurses in Greece. *Arch Psychiatr Nurs*. 2015 Oct;29(5):333-8.
29. Kearney MK, Weininger RB, Vachon MS, Harrison RL, Mount BM. Self-care of physicians caring for patients at the end of life: 'being connected, a key to my survival'. *JAMA*. 2009; 301(11): 1155–1164.
30. Raja S, Hasnain M, Hoersch M, Gove-Yin S, Rajagopalan C. Trauma informed care in medicine: current knowledge and future research directions. *Fam Community Health*. 2015 Jul-Sep;38(3):216-26.
31. Hunter B. Mapping the emotional terrain of midwifery: What can we see and what lies ahead? *Int. J. Work Organisation and Emotion*. 2010; 3(3): 253-269.
32. Catling CJ, Reid F, Hunter B. Australian midwives' experiences of their workplace culture. *Women Birth*. 2017;30(2):137-145.
33. Betran AP, Ye J, Moller AB, Zhang J, Gülmezoglu AM, Torloni MR. The increasing trend in caesarean section rates: global, regional and National Estimates: 1990-2014. *PLoS One*. 2016;11(2): e0148343.