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MEDICAL SURGICAL NURSE'S STRESSORS AND THE THREE-COMPONENT PROFESSIONAL QUALITY OF LIFE

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Abstract:
The three components of Professional Quality of Life (ProQOL) include Compassion Satisfaction (CS), Compassion Fatigue (CF) and Burnout (BO). These affect the way nurses perceive their jobs and how they perform during their work, which, in turn, may affect the quality of care rendered to patients. In spite of the implications of ProQOL, little research has been performed in the Philippines. This descriptive correlational study aimed to determine the relationship between the frequency of exposure to stressors and the potential for developing CS, CF and BO among medical-surgical nurses in selected government hospitals in Metro Manila. The researchers utilized a three-part questionnaire: (1) Demographic profile; (2) Personal and Work-Related Stress Tool, which measured the exposure to personal and work-related stressors; and (3) Professional Quality of Life version V, which measured the potential for development of CS, CF, and BO among the nurses. The data was analyzed using Descriptive Statistics and Pearson Product Moment Correlation. The findings revealed that CS had moderately strong negative correlations with a low sense of mastery and purpose in life, inadequate knowledge and experience, and stressful nurse-patient relationships. CF, however, had moderately strong positive correlations with stress from traumatic experiences and inadequate knowledge and experience. Lastly, BO had a moderately strong positive correlation with stress from inadequate knowledge and experience.

Keywords: compassion satisfaction, compassion fatigue, burnout, stressors

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1. Introduction and Literature Review

Nurses are heroes, but even heroes get tired. Nurses are frequently exposed to high levels of stress in their working environment, having to compress a large amount of physical and paperwork all into the timeframe of a single shift. Nurses not only experience stress from the work environment but also from their personal lives, and this stress may also carry over into the workplace. Over time, the stressors may have an effect on how nurses feel about their jobs and, more specifically, their professional quality of life.

Professional quality of life (ProQOL) refers to the quality of life a person feels in relation to their work as a helper. Helpers include those who work in the health care profession, social services, and other forms of professions that serve. Both the positive and negative aspects of doing one's job influence ProQOL, which consists of three aspects: (1) Compassion Satisfaction, (2) Compassion Fatigue and (3) Burnout (Stamm, 2010).

Compassion Satisfaction (CS) is termed as the ability of the nurse to receive gratification from providing care, and this positive aspect of caring helps to balance out the negative aspects of working with acutely ill or traumatized persons (Hooper, Craig, Janvrin, Wetzel, & Reimels, 2010). Nurses are often described as persons who, through their relationship with their patients, develop trust and confidence and promote not only physical healing but spiritual and emotional healing as well (Kret, 2011). These are the characteristics that make nurses exceptionally qualified for patient care and satisfied with their job.

On the other hand, Compassion Fatigue (CF) is the phenomenon of emotional exhaustion in nurses caused by their exposure to the traumatic stress and suffering of the patients that they care for. Their work often requires extensive and direct face-to-face interaction with other people in emotionally charged situations. Intense caring and identification with the patient's suffering ultimately lead to the nurse absorbing the traumatic stress and suffering of the patients, leading to emotional exhaustion in the nurses (Papadatou, 2000 & Joinson, 1992).

Burnout (BO), however, describes the broader consequences of working in a stressful environment, including emotional exhaustion, depersonalization, and reduced personal accomplishment or achievement. It is a gradual process related to chronic tedium in the workplace and is not necessarily related to trauma exposure (Maslach& Jackson, 1981). Nurses suffering from BO withdraw emotionally and physically from patient interactions, jeopardizing the positive intentions of caregiving and reducing the quality of care rendered by the nurse (Akhtar & Lee, 2007). In BO, the demands of the job lead care providers towards having feelings of emotional exhaustion, poor attitudes, and negative feelings toward the people they were working with and toward their own professional role (Gil-Monte, 2002; Pando, Bermudez, Aranda, and Perez, 2000).

Feelings of satisfaction and emotional exhaustion experienced by nurses are affected by different kinds of Personal and Work-Related Stressors. Personal Stressors are

defined as life events or other subjective experiences that cause distress to the nurse, while Work-Related Stressors are factors in the workplace that contribute to the nurse's perception of how stressful their job is.

In spite of the effects of CS, CF and BO on the quality of care provided by nurses, as well as their effects towards the quality of life of the nurses themselves, few researches have been conducted in the Philippines regarding its level of incidence as well as the factors or stressors which contribute to its development. Thus, the study was done to

1) determine the frequency of exposure to personal and work-related stressors;
2) determine the potential for developing (a) CS, (b) CF and (c) BO; and
3) determine the relationship between the frequency of exposure to personal and work-related stressors and the potential for developing (a) CS, (b) CF and (c) BO.

2. Theoretical Review

2.1 Cognitive Appraisal Theory

The Cognitive Appraisal Theory views stress as a relationship between the person and the environment appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being. This personal evaluation of the event is based on cognitive appraisal (Lazarus and Folkman, 1984).

Primary appraisal refers to the judgment an individual makes of an event. Lazarus sees the perceived threat as the central characteristic of stressful situations. Stress occurs when the caregiver discovers that an event threatens an important value or motive.

Lazarus believes that various factors influence stress appraisal, namely:

1) factors related to the event or stimulus itself (e.g. stimulus potency and duration)
2) factors within the psychological structure of the individual (e.g. developmental motives and patterns, general beliefs, values and commitments, intellectual resources, knowledge, past experiences, conflicts, constitutional vulnerabilities; and
3) the comparative power of the harm-producing condition and the individual's counter-harm resources (e.g. social and agency support, economic and physical conditions). (Lazarus and Folkman, 1984).

` Due to these factors, some individuals perceive an event as more stressful, while other individuals perceive it as not as stressful. After the individual has perceived a threat, the secondary appraisal is performed to see what can be done. A person's ability to cope effectively depends upon the stressor itself, its complexity, intensity and duration and the type of coping strategy used. Coping resources include commitment and beliefs, health and energy, problem-solving skills, social skills, social support and material resources. If your work is quantitative, please provide the previous studies that concur or reject your proposed hypothesis.

2.2 Stamm's Theoretical Path Analysis of Professional Quality of Life

Three factors (Work Environment, Client Environment and Person Environment) have an effect and may contribute to a change in the potential for developing CS, CF and BO (Stamm, 2010b). As according to Lazarus and Folkman's (1984) Cognitive Appraisal Theory, stressors are a part of the environment that a person is exposed to. These stressors can contribute to the potential for the development of CS, CF and BO. Nurses handling medical surgical patients are exposed to various types of personal and work-related stressors. The nurses then assess the stressors, using primary and secondary appraisal in order to determine whether or not the stressors affect them and how often they feel they perceive the stressors. The perception of stress may then effect a change in the nurse's potential for the development of CS, CF, or BO.

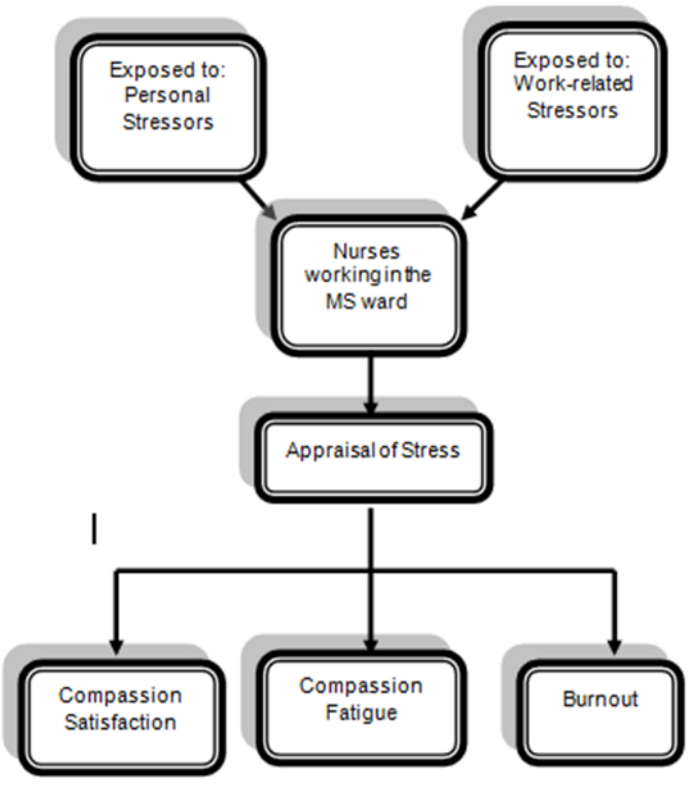

Figure 1: Conceptual Framework

3. Methodology

3.1 Design

The study utilized a descriptive correlational design. Correlational research seeks to determine if certain kinds of relationships exist between the research variables. These research results give insight into how one variable may affect or bring about another. Descriptive correlational research aims to describe relationships among variables rather

than infer cause and effect (Polit& Beck, 2008). This design determined the relationship of personal and work-related stressors and the potential for developing CS, CF, and BO.

3.2 Subjects

Sixty-nine staff nurses from four government hospitals in Metro Manila who met the eligibility criteria, who are (a) regular employees of a tertiary government hospital in Metro Manila and (b) have been working as a medical-surgical (MS) staff nurse for at least one year, were chosen via purposive sampling. Based on a study conducted by Tyson & Pongruengphant (2004) among nurses in public and private hospitals in Thailand, nurses working in public hospitals generally reported more stress than in private hospitals. According to Duchscher (2008), the first stage of entry into professional practice was marked by a tremendous intensity, range, and fluctuation of emotions as graduates worked through the processes of discovering, learning, performing, concealing, adjusting, and accommodating. However, by the ninth and twelfth months of practice, nurses have become less stressed. The factors contributing to their level of stress had changed from their individual capacity to cope with their roles and responsibilities to frustrations in dealing with the system. By the 12-month or 1-year marker, all graduates had reached a relatively stable level of comfort and confidence with their roles, responsibilities, and routines. Based on a power analysis that utilized the study of E., A. Yoder (2010), the minimum sample requirement was reached (n= 68).

Table 1: Demographic Profile of Medical-surgical Nurses
Working in Tertiary Government Hospitals in Metro Manila

	N	%
Gender		
Female	43	62.32
Male	26	37.68
Civil Status		
Single	43	62.32
Married	26	37.68
Years of Practice		
1- 5 years	38	55.07
6- 10 years	11	15.94
11- 15 years	8	11.59
16- 20 years	8	11.59
> 20 years	4	5.80
Usual Shift		
AM	25	36.23
PM	35	50.73
Night	9	13.04

Table 1 showed that the majority of the respondents were female (62.32%) and single (62.32%), who had been practising nursing for 1 – 5 years (55.07%), and most of the respondents (50.73%) primarily worked on the afternoon shift (N=68).

3.3 Research Instrumentation and Data Collection

This study utilized a 3-part questionnaire, namely: Demographic Profile, Personal and Work-Related Stress Tool, and the Professional Quality of Life Scale (ProQOL). The demographic profile was comprised of gender, civil status, years of practice, usual hours of duty per shift (8 or 12 hours) and the usual shift of duty (morning, afternoon or night). Part two was the researcher-made tool called Personal and Work-Related Stress Tool, which is a 30-item questionnaire using a five-point Likert scale from 1 as "Never" to 5 as "Always".

To ensure the validity of the tool, four experts were consulted in the fields of Statistics, Psychology, Psychiatric Nursing, and Medical-Surgical Nursing. Pilot testing was done and revealed $\alpha = 0.867$ reliability.

Part three was the Professional Quality of Life Tool (ProQOL) Version 5, adapted from Stamm, Higson-Smith, and Hudnall and has been used in various studies since 1995. It is composed of 30 questions that operationalized CS (10-items), BO (10-items), and CF (10-items) (Stamm, 2010). It uses a 5-point Likert scale and staff nurses are asked to rate the frequency of experiences described from 1 as "Never" to 5 as "Very often".

This study used it to determine the level of CS perceived by nurses in medical-surgical units and their potential for developing CF. The researchers obtained permission from the developers of the tool by contacting them through electronic mail. The components of the tool revealed CS to yield $\alpha = 0.88$ (n=1130), BO$\alpha = 0.75$ (n=976), CF$\alpha =$ 0.81 (n=1135) reliability.

After securing the informed consent from the target respondents, the researchers handed out copies of the questionnaire and collected the questionnaires right after the respondents had answered them.

3.4 Data Analysis

Data analysis was performed with Stata 10.1 using descriptive statistics and Pearson Moment Correlation. Descriptive statistics was used to obtain the baseline statistics, such as the mean and standard deviation of the demographic profiles, frequency of exposure to personal and work-related stressors, and the potential for developing CS, CF, and BO. On the other hand, Pearson Product Moment Correlation (Pearson's Correlation) determined the correlation between personal and work-related stressors and the levels of CS, CF, and BO. It measures the degree of correlation between two variables, which is signified by the Pearson moment correlation coefficient. The coefficient ranges from -1 to +1, with 0 indicating no relationship, -1 indicating a negative or inverse relationship, and +1 indicating a positive or direct relationship. The statistical formula determined the degree of correlation between the variables: perceived level of affectation by the various intrapersonal and interpersonal stressors, CS, CF, and BO.

4. Results

The following findings were obtained in the study:

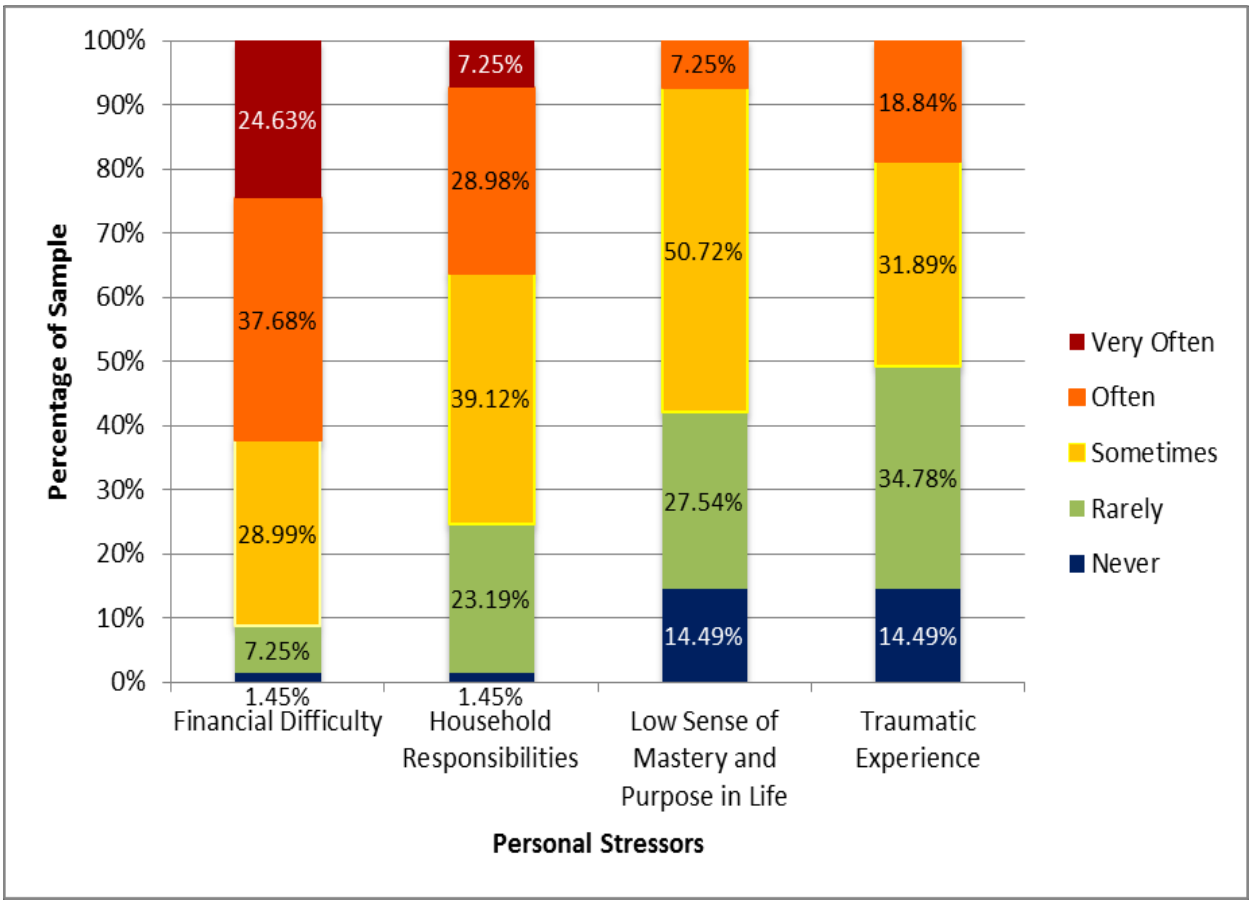

Figure 2: Percentage Distribution among Personal Stressors

Figure 2 shows the reported frequency of personal-related stressors, namely financial difficulty, household responsibilities, traumatic experiences and a low sense of mastery and purpose in life. Generally, most respondents reported that they sometimes experienced stress from all the stressors mentioned. However, it is remarkable that the only personal stressors that were reported to be experienced *very often* were financial difficulties (24.63%) and household responsibilities (7.25%).

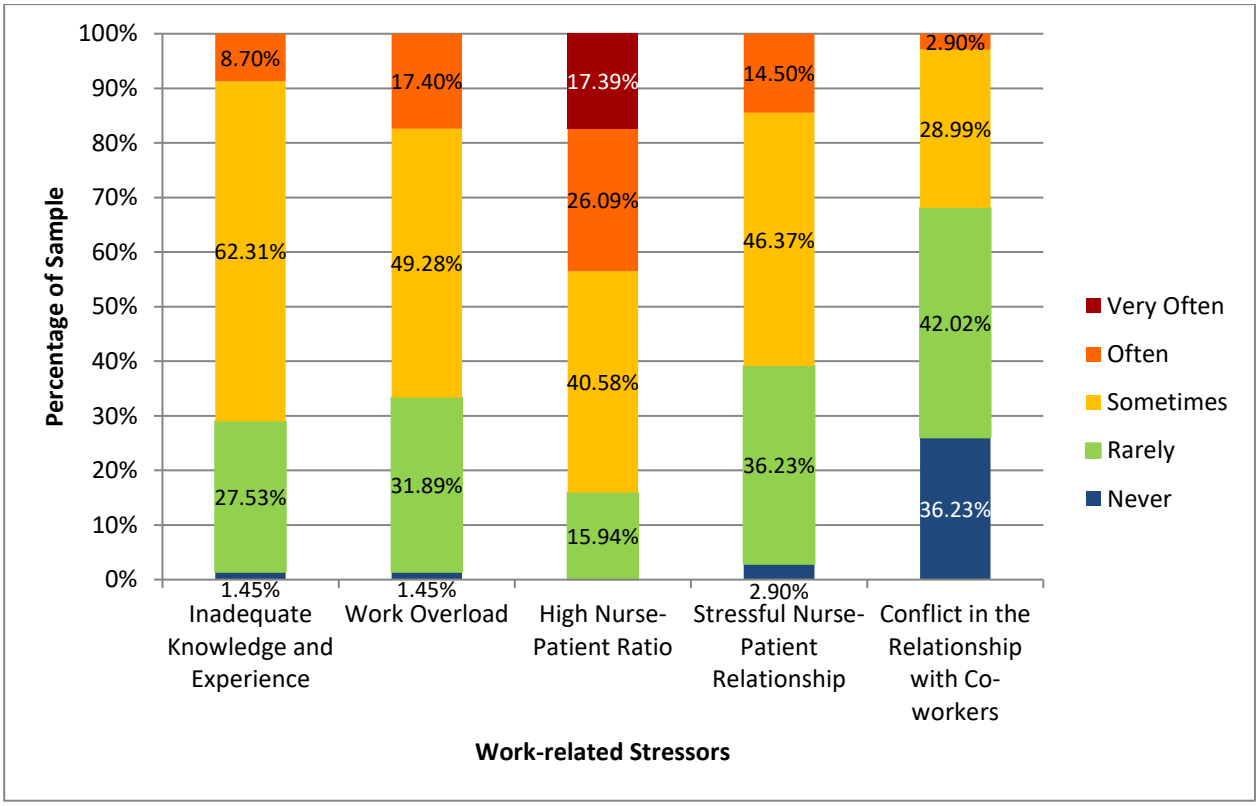

Figure 3: Percentage Distribution among Work-related Stressors

Figure 3 shows the frequency of work-related stressors, namely inadequate knowledge and experience, work overload, high nurse-patient ratio, stressful nurse-patient relationship and conflict in the relationship of co-workers. It is notable that the only stressor experienced very often by a percentage of nurses was the high nurse-patient ratio.

When the results of all respondents were aggregated, it was indicated in Figure 4 that the majority had moderate potential for CS (n=59.42%), as well as a moderate potential for developing CF (n=60.87%), and a low potential for developing BO (n=52.17%). The other respondents were identified to have either low or high potential for developing CS and low potential to develop CF and BO. None of them were identified to have high potential for CF and BO.

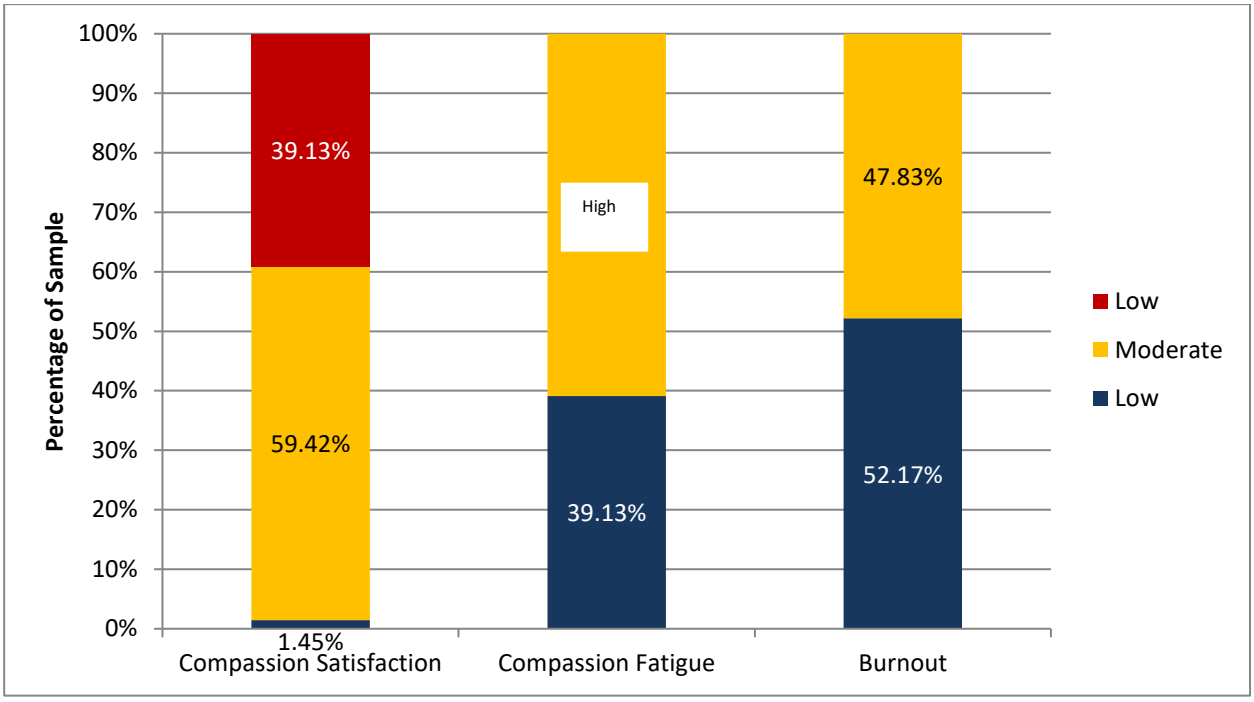

Figure 4: Levels of Compassion Satisfaction, Compassion Fatigue and Burnout

Table 2: ProQOL and Personal and Work-related Stressors

	Compassion Satisfaction		Compassion Fatigue		Burnout	
	Relationship	**Pearson's R**	**Relationship**	**Pearson's R**	**Relationship**	**Pearson's R**
Personal Stress						
Financial difficulty	Weak negative	-0.12	Weak positive	0.10	Weak negative	-0.19
Household responsibilities	Weak negative	-0.14	Weak positive	0.07	Weak positive	0.10
Traumatic experience	Weak negative	- 0.29	**Moderate positive**	**0.38**	Weak negative	-0.04
Low sense of mastery and purpose in life	**Moderate negative**	**- 0.38**	Weak positive	0.07	Weak positive	0.14
Work-related Stress						
Inadequate knowledge and experience	**Moderate negative**	**- 0.36**	**Moderate positive**	**0.34**	**Moderate positive**	**0.30**
Work overload	Weak negative	-0.23	Weak positive	0.21	Weak positive	0.03
High nurse-patient ratio	No relationship	0.00	Weak positive	0.13	Weak negative	-0.15
Stressful nurse-patient relationship	**Moderate negative**	**- 0.30**	Weak positive	0.22	Weak positive	0.10
Conflict in the relationship with co-workers	Weak negative	-0.29	Weak positive	0.26	Weak positive	0.06

Pearson's R interpretation (Ratner, 2012):
0.00 = no relationship
± 0.01 to 0.29 = weak positive/negative
± 0.30 to 0.69 = moderate positive/ negative
± 0.70 to 0.99 = strong positive/ negative
± 1.00 = perfect positive/ negative

CS was found to have moderately strong negative correlations with a low sense of mastery and purpose in life (r= -0.38), inadequate knowledge and experience (r= -0.36) and stressful nurse-patient relationships (r=-0.3), which means that as the frequency of experiencing stress with regards to a low sense of mastery and purpose in life, inadequate knowledge and experience, and stressful nurse-patient relationships increase, the nurse's sense of CS decreases.

CF has a moderate positive correlation with stress from traumatic experiences (r=-0.38) and inadequate knowledge and experience(r=0.34). This means that CF increases when the nurse is exposed to traumatic experiences or stress.

BO has a moderate positive correlation with stress from inadequate knowledge and experience (r= 0.30), which means that BO increases when the nurse feels that he or she lacks adequate knowledge and experience in the nursing profession.

5. Discussion

As mentioned in the results, the respondents reported that they sometimes experienced stress from personal and work-related stressors. Among the personal stressors, experiencing financial difficulty and household responsibilities were the most frequently experienced stressors reported by the MS staff nurses. Both the financial difficulty and household responsibilities were associated with stress, CF and BO, as supported by Lu (2008); Frank and Karioth, (2006); Demir, Ulusoy M., and Ulusoy M.F. (2003) and Al Ashqer (1995). This implies that the average government nurse may have difficulty meeting the needs of the family, especially if they are the sole workers in that family. Lack of time with the family and additional household responsibilities can create a negative impact on the performance of nurses working in government hospitals.

The high nurse-patient ratio was the most frequently experienced work-related stressor of MS nurses. This is supported in the study made by Aiken, Clarke, Sloane, Sochalski & Silber (2002) and Alderman (2001), wherein they all stated that if nurses were given an inappropriate amount of patients to watch over, nurses would be more prone to become highly stressed due to the difficulty of handling a lot of patients and to the feeling of not having enough time to finish tasks. This implies that in order to avoid giving nurses unnecessary stress, it is important for the nurse-patient ratio to be appropriate; thus, a standard ratio of patients to nurses should be set and applied.

The majority of the respondents have a moderate potential for developing CS. This is supported by several researches conducted among other healthcare workers in a military treatment facility (Berry-Cabán, Beder, & Weagraff, 2011), and among child protection caseworkers and supervisors (Conrad & Kellar-Guenther, 2006). Higher CS scores are associated with being an effective caregiver, as well as being energized by the work they do (Stamm, 2010). In contrast to the abovementioned results, nursing staff working in forensic mental health hospitals are in a low potential for developing CS due to frequent exposure to violent behavior (Lauvrud, Nonstad, & Palmstierna, 2009). The

pleasure derived from work will mitigate the stress experienced in the work setting and help prevent CF and BO. This supports the premise that compassion satisfaction may have a positive effect on CF and BO (Figley, 1995).

The majority were identified to be at moderate risk of developing CF. The prevalence was slightly lower than what other studies conducted in special areas have affirmed. In a study conducted by Hooper et al. (2010), emergency, intensive care, nephrology, and oncology nurses had a moderate to high risk of developing CF. On the contrary, Burtson & Stichler (2010) found that MS nurses were at higher risk for CF compared to hospice nurses. This may be due to the variation between types of stressful situations encountered in MS ward and with those wards where nurses were exposed to vulnerable populations such as the traumatically injured and the dying (Beaton & Murphy, 1995); therefore, the nurses' area of assignment may actually contribute to the development of CF. On the other hand, results showed that the majority of the respondents seemed to be able to cope, in one way or another, with their personal and work-related stress and, therefore, registered low levels of BO.

The results of the study showed that the majority of MS nurses have moderate to high potential for CS and moderate to low potential for CF and BO. This result is closest to what Stamm (2010) has identified as the most favourable result of the Pro-QOL, which is high CS and moderate to low CF and BO. This states that as nurses' potential to develop CS increases, their risk of developing CF and BO may decrease. This was supported by a study by Yoder (2010), which demonstrated that CS is strongly negatively correlated to many items on CF and BO subscales. This may be supported by the premise that CS could be a protective factor that can act as a buffer to protect healthcare workers like nurses (Collins & Long, 2003; Saakvitne & Pearlman, 1996). Nurses who obtain this result are likely to have a positive influence on their co-workers, be efficient in their tasks, and accept opportunities positively (Stamm, 2010).

Both personal and work-related stressors can predispose the ProQOL of nurses to be affected, and this can affect the delivery of care to their patients. Hence, the researchers were able to determine the presence of significant correlations between the frequency of experiencing specific personal and work-related stressors and the potential for CS and CF.

Moderately strong negative correlations were determined between CS and the following stressors:

1) low sense of mastery and purpose in life,
2) inadequate knowledge and experience, and
3) stressful nurse-patient relationships.

These findings are in congruence with a study by Lu (2008), wherein she found and stated that a number of personal factors have been linked with decreased satisfaction and fatigue, including a decreased sense of knowledge in the profession. Abdulfattah (2001) showed that they experienced high levels of stress that were significantly related to inadequate knowledge, which led to difficulty in being happy at their work.

Through this, it can be inferred that when nurses are working in the ward, they feel that the care that they are administering to their patients is not enough, or they feel that they do not know what more they can do in order to alleviate the patient's condition or status, it becomes harder for them to be satisfied with their job and with their ability to render care.

A decreased sense of mastery or purpose in life was also found to be a factor in decreased satisfaction in the job and increased potential for the development of BO. According to Sherman (2004), a decreased sense of mastery and purpose in life is a personal factor considered as not being in control of one's own life, which significantly affects the nurse and causes them stress. Failure or inability to achieve one's personal goals was also found to be a source of great stress among nurses, which may lead to a loss of satisfaction in the job and increased feelings of exhaustion (Valent, 2002)

Through this, it can be inferred that being unable to feel in control of their personal life or failing to meet the goals that they have set for themselves in their personal will also carry over into their work life and lead to them having a decreased sense of satisfaction with the job. Relationships that were considered to be stressful included hostile clients, clients suffering from chronic and complex diseases or problems, clients who have a decreased ability to adapt and uncooperative clients and families (Walcott-McQuigg and Ervin, 1992; Raquepaw and Miller, 1989; Jayaratne and Chess, 1984, and Cherniss, 1980). Patient demands are related to the feeling of stress (Bakker, Schaufeli, Sixma, Bosveld, and Van Dierendonck, 2000). In addition, Maslach and Jackson (1984) stated that the feeling of stressfulness of a nurse is aggravated if the patient is aggressive, passively dependent and difficult or defensive. According to Akhtar and Lee (2007), tension in the professional work relationship and nurse-patient relations were among the significant sources of stress. They contributed to a nurse's exhaustion and inability to be satisfied at work. Ackerley, Burnell, Holder and Kurdek (1988) found that negative client behavior positively correlates with emotional exhaustion and lack of personal accomplishments.

CF had been found to have a moderately strong positive correlation with having previous or being exposed to traumatic experiences or events and having feelings of inadequate knowledge and experience in the workplace. According to Papadatou (2000) and Joinson (1992), CF occurs when nurses are exposed to and absorb the traumatic stress and suffering of the clients that they care for. In a study by Frank and Karioth (2006), having a history of traumatic experiences or having unresolved trauma predisposes nurses to develop CF. Findings revealed that experiencing trauma and having excessive empathy were key determinants of CF risk (Abendroth and Flannery, 2006; De Carvalho, Muller and Bachion, 2005). CF can be described as a state of tension which may involve a preoccupation with the traumatic experience of the client, re-experiencing the traumatic events, and avoidance of reminders of the traumatic event with the added effect of BO (Sabo, 2006).

These findings indicate that when professionals, including nurses, are exposed to patients who have undergone traumatic experiences, they absorb the traumatic stress of their patients, and this builds up and can lead to the nurses having emotional exhaustion.

The study done by Lu (2008), which was able to find a relationship between decreased satisfaction and fatigue and a decreased sense of mastery or knowledge in the profession, also suggests that inadequate knowledge and experience increase the risk for CF. Abdulfattah (2001) also adds to this since his findings of inadequate knowledge at work being related to post-traumatic stress suggest that CF risk increases when there is inadequate knowledge

BO was determined to have moderately strong positive correlations with stress experienced from inadequate knowledge and experience. According to Demir et al. (2003), in a study done in Turkey, nurses who have higher levels of education and work experience were found to have decreased levels of BO. This finding can also mean that having insufficient levels of knowledge and experience at work causes the nurse to have an increased risk for BO. In the study by Lu (2008), having a decreased sense of being knowledgeable in the profession can contribute to nurses' exhaustion. From the findings, it can be implicated that having feelings of inferiority or not being good enough in the workplace can contribute to the development of BO among nurses.

These findings indicate that when stress from inadequate knowledge and experience is felt by the nurse, it is a very important indicator that the nurse's ProQOL may be affected in a negative way.

6. Conclusions and Recommendations

Many nurses feel a particular calling or need to take care of and protect people who are in a state of crisis or great trouble, whether they are related to physical health or their emotional and mental well-being. However, in their desire to take care of others, nurses sometimes lose sight of the need to take care of their own well-being. In conclusion, inadequate knowledge and experience are essential indicators to knowing the potential development of CF, BO and decreased CS, alongside a low sense of mastery and purpose in life and stressful nurse-patient relationships for decreased CS and traumatic experiences for CF.

Based on the findings, nursing administrators will be aware of the specific stressful situations or events that predispose staff nurses to the development of CF, BO and loss of CS and with this knowledge, they can organize programs or counseling sessions which can help the staff nurses avoid, manage and recover from these problems, which will increase the quality of care being provided by the nurses. Since inadequate knowledge and experience were determined to be a stressor that affected all of the aspects of ProQOL, it would be imperative to ensure that there are continuing education programs and other programs that enhance the staff nurse's knowledge base in order for them to be more effective and in order to increase the chances for CS and decrease the chances for

CF and BO. Counselling should also be available for the nurses in the hospital, especially for those who have experienced or witnessed very traumatic experiences or who are experiencing problems in their personal lives and need help in sorting these problems out. Not being emotionally and physically drained in their work will lead the nurses to become more satisfied with their jobs and thereby bring about a better quality of life. Increasing satisfaction in each nurse will mean efficiency in performing work, thereby improving the quality of patient care. This research can spearhead future studies towards exploring these phenomena further among Philippine nurses and conduct effective and proven programs which will help nurses become satisfied with their work and reduce the incidence of CF.

7. Further Study

This study only seeks to understand how the three components of Professional Quality of Life (ProQOL), Compassion Satisfaction (CS), Compassion Fatigue (CF) and Burnout (BO) affect the way nurses perceive their jobs and how they perform during their work, which in turn may affect the quality of care rendered to patients. Further studies were suggested to better understand the interplay between the three components of ProQOL on a larger scale.

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Conflict of Interest Statement
The authors declare no conflicts of interest. The authors whose names are listed certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; membership, employment, consultancies, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

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The authors are registered nurses working in various clinical settings in the Philippines with specializations in Medical-Surgical Nursing.

References

Abdulfattah, I. (2018). *Levels of stress experienced among Jordanian staff nurses: a comparative study between 8 and 12-hour shift work in the private sector at Amman*. Unpublished MSC thesis, Jordan University of Science and Technology, Irbid.

Abendroth M. & Flannery J. (2019). Predicting the risk of compassion fatigue. *Journal of Hospice & Palliative Nursing, 8*(6), 346– 356.

Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice, 19*, 624–631.

Aiken, L. H., Clarke, S.P., Sloane, D.M., Sochalski, J. & Silber, J.H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association, 288*,1987-1993.

Al Ashqer, N. (1995). *Sources of stress among married and unmarried working women in the private sector in Zarka*. MSc. thesis, University of Jordan, Jordan.

Alderman, M. C. (2021). *Nursing in the new millennium: challenges and opportunities, Dermatology Nursing, 13*, (1),44-45, 49-50.

Aycock N. & Boyle D. (2009). Interventions to manage compassion fatigue in oncology nursing. *Clinical Journal of Oncology Nursing, 13*(2), 183-191.

Bakker, A.B., Schaufeli, W.B., Sixma, H., Bosveld, W., & Van Dierendonck, D. (2000). Patient demands, lack of reciprocity, and burnout: a five-year longitudinal study among general practitioners. *Journal of Organizational Behavior, 21*, 425-441.

Beaton, R. & Murphy, S. (1995). *Secondary traumatic stress of crisis workers: research implications*. In C. Figley (Ed.), *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (51-81). New York: Brunner/Mazel.

Berry-Cabán C. S., Beder J., & Weagraff J. (2021). Quality of life indicators in a stateside military hospital. *The Internet Journal of Disaster Medicine.* Retrieved from https://ispub.com/IJDM/1/2/13264

Burtson P.L., & Stichler J.F. (2010). Nursing work environment and nurse caring: relationship among motivational factors. *Journal of Advanced Nursing, 66*(8), 1819–1831.

Cherniss, C. (1980). *Professional burnout in human service organizations*. New York: Praeger.

Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: Consequences for mental health-care workers—a literature review. *Journal of Psychiatric and Mental Health Nursing, 10*, 417–424.

Conrad, D. & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse and Neglect: An International Journal, 30*(10), 1071-1080.

De Carvalho, E. C., Muller, M., & Bachion, P. (2005). Stress in the professional practice of oncology nursing. *Cancer Nursing, 28*(3), 187–192.

Demir, A., Ulusoy, M., Ulusoy M. F. (2003). Investigation of factors influencing burnout levels in the professional and private lives of nurses. *International Journal of Nursing Studies, 40*(8), 807-27.

Duchscher, J. B. (2008). A process of becoming: the stages of new nursing graduate professional role transition. *The Journal of Continuing Education in Nursing. 39*(10), 441-450.

Eastburg M., Gorsuch R., Ridley C., & Williamson M. (1994). Social support, personality, and burnout in nurses. *Journal of Applied Social Psychology, 24*, (14), 1233-1250.

Figley, C. (1995). *Compassion fatigue: secondary traumatic stress*. New York: Brunner/Mazel.

Figley, C. (2002). Compassion fatigue: psychotherapists' chronic lack of self-care. JCLP/In Session: Psychotherapy in Practice, 58, 1433-1441.

Frank, D. I., & Karioth, S. P. (2006). Measuring compassion fatigue in public health nurses providing assistance to hurricane victims. *Southern Online Journal of Nursing Research, 4*(7), 1–13.

Garman, A., Corrigan, P., & Morris, S. (2002). Staff burnout and patient satisfaction: evidence of relationships at the care unit level. *Journal of Occupational Health Psychology, 7*, 235–241.

Gil-Monte P. R. (2002). Factorial validity of the Spanish adaptation of the Maslach Burnout Inventory-General Survey. *Saludpública de México. 44*(1),33–40.

Halbesleben J. R., Wakefield B. J., Wakefield D. S., &Cooper L. B. (2008). Nurse burnout and patient safety outcomes: nurse safety perception versus reporting behavior. *Western Journal of Nursing Research, 30*(5), 560-77.

Hooper, C., Craig, J., Janvrin, D. R., Wetzel, M. A., & Reimels, E. (2010). Compassion satisfaction, burnout and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *Journal of Emergency Nursing, 36*(5), 420–427.

Jayaratne, S. & Chess. W. A. (1984). Job Satisfaction, burnout and turnover: a national study. *Social Work*, 448-457.

Joinson, C. (1992). *Coping with compassion fatigue*. Nursing, 22, 116-122.

Kret, D.D. (2011). The qualities of a compassionate nurse according to the perceptions of medical-surgical patients. *Medical Surgical Nursing: Official Journal of the Academy of Medical Surgical Nurses, 20*(1), 29-36.

Akhtar S & Lee J. (2007). Job burnout among nurses in Hong Kong: implications for human resource practices and interventions. *Asia Pacific Journal of Human Resources, 45*(1), 63-84.

Lauvrud, C., Nonstad, 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).

Leiter, M. Harvie, P. &Frizzell, C. (1998). The correspondence of patient satisfaction and nurse burnout. *Social Science & Medicine, 47*(10), 1611-1617.

Lu, J. (2008). Organizational role stress indices affecting burnout among nurses. *Journal of International Women's Studies, 9*, 63-78.

Maslach C. & Jackson S. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior, 2*, 99–115.

Maslach, C. & Jackson S. (1984). Burnout in organizational settings. In S. Oskamp (Ed.), *Applied Social Psychology Annual, Vol. 5*, Beverly Hills, CA: Sage.

National Statistical Coordination Board statistics (2010). Retrieved from www.nscb.gov.ph/secstat/d_income.asp

Ozyurt, A., Hayran, O., & Sur, H. (2006). Predictors of burnout and job satisfaction among Turkish physicians. *Quarterly Journal of Medicine, 99*, 161-169.

Pando M, Bermúdez D, Aranda C, & Pérez J. (2000). Burnout syndrome in health workers. *Revista de Salud y Trabajo. 1*, 12–15.

Papadatou, D. (2000). A proposed model of health professionals' grieving process. *Omega, 41*(1), 59–77.

Pines, A. (2002). A psychoanalytical-existential approach to burnout: demonstrated in the case of a nurse, a teacher, and a manager. *Psychotherapy: Theory/Research/Practice/Training, 39*(1), 103-113.

Polit, D. F., & Beck, C. T. (2008). *Nursing research: generating and assessing evidence for nursing practice Eighth Edition*. Lippincott Williams & Wilkins. Philadelphia, Pa.

Potter P., Deshields T., Divanbeigi J., Berger J., Cipriano D., Norris L., &Olsen S. (2010). Compassion fatigue and burnout: prevalence among oncology nurses. *Clinical Journal of Oncology Nursing, 14*(5), E56-E62

Raquepaw, J. M., & Miller, R. S. (1989). Psychotherapist burnout: a componential analysis. *Professional Psychology: Research and Practice, 20*(1), 32-36.

Saakvitne, K. W., &Pearlman, L. A. (1996). *Transforming the pain: a workbook on vicarious traumatization*. New York: W.W. Norton.

Sabo, B.M. (2006). Compassion fatigue and nursing work: can we accurately capture the consequences of caring work? *International Journal of Nursing Practice, 12*, 136–142.

Sherman, D. W. (2004). Nurses' stress & burnout: how to care for yourself when caring for patients and their families experiencing life-threatening illness. *American Journal of Nursing, 104*(5), 48-56.

Stamm, B. H. (2010). The ProQOL (Professional Quality of Life Scale: Compassion Satisfaction and Compassion Fatigue). Pocatello, ID: ProQOL.org. retrieved [March 7, 2012] www.proqol.org

Stamm, B. H. (2010b). *The Concise ProQOL Manual,* 2nd Ed. Pocatello, ID: ProQOL.org

Walcott-McQuigg, J. A., & Ervin, N. E. (1992). Stressors in the workplace: Community health nurses. *Public Health Nursing, 9*(1), 65-71.

Valent, P. (2002). *Diagnosis and treatment of helper stresses, traumas and illnesses*. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 17–37). Hove, Great Britain: Brunner-Routledge.

Yoder E. (2010). Compassion fatigue in nurses. *Applied Nursing Research 23*,191–197.