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Compassion Fatigue in Relation to Debriefing among Intensive Care Unit Nurses: The Palestinian Case

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Compassion Fatigue in Relation to Debriefing among Intensive Care Unit Nurses: The Palestinian Case

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Dedication

All life's challenges require striving. There are people who are closed to my heart, who have supported and helped me in this study. Therefore, this thesis is proudly dedicated to my precious family, who have been my source of creativity and have given me strength when I thought of giving up, who continually provide their endless love and Support.

To my dearest friends and relatives who shared their encouragement for me to follow my dreams.

Walaa Salim Abdallah Jafare

Declaration

I certify that this thesis submitted to the degree of master is the result of my own research, except where otherwise acknowledged, and that this thesis or any of its parts has not been submitted for higher degree to any other university or institution.

Signature: Wala Jafari

Wala' Salim Abdullah Jafari

Date: 26/8/2023

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I would like to take this opportunity to express my heartfelt gratitude to all those who have supported and guided me throughout my graduation project.

Firstly, I would like to express my sincere appreciation to my academic advisor, **Dr. Maysa Al Usta**, for her guidance, encouragement, and support throughout the project. Her insightful feedback and constructive criticism have been invaluable in shaping my research and the outcome of the project.

I would also like to thank **the faculty members** of Nursing for their valuable contributions to my education and their support throughout my academic journey. Their academic and professional expertise has been instrumental in my growth and learning.

Furthermore, I would like to acknowledge the contributions of **my family, husband, children, friends**, who have been constant source of love, encouragement, and motivation throughout my academic journey. Their unwavering support and belief in me have been a source of strength and inspiration.

Lastly, I would like to express my gratitude to the **participants** of my study, who have generously shared their time and experience with me. Their contributions have been instrumental in shaping the research and the outcome of the study.

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Wala' Salim Jafari

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List of abbreviations

ICU	**Intensive care unit**
QOL	**Quality of life**
CF	**Compassion fatigue**
BO	**Burnout**
STS	**Secondary traumatic stress**
CS	**Compassion satisfaction**
CCU	**Cardiac care unit**
PICU	**Pediatric intensive care unit**
PCCU	**Pediatric cardiac care unit**
NICU	**Neonate intensive care unit**

Abstract

Background: Critical care nurses derive happiness from providing empathetic care to patients and their families, but they also face the risk of becoming overwhelmed. Professional quality of life involves maintaining a balance between fulfillment and fatigue , So manager or administrative must play role in preventing or intervening in cases of fatigue .

Study Problem and Justifications: Healthcare professionals are under significant pressure to display compassion when patients are in crisis. Critical care nurses face challenges in dealing with life-threatening situations, poor communication, and long working hours, leading to compassion fatigue (CF). Nurses often experience moral discomfort when providing end-of-life care or when care is no longer effective. A comprehensive literature review identified ten studies on CF among critical care nurses, highlighting age and experience as risk factors. However, none of these studies were conducted in the East Mediterranean region.

Aim and Objectives: This study aimed to determine the levels of compassion fatigue among Palestinian ICU nurses in relation to debriefing in their work environment.

Methodology: A cross-sectional design study was employed to answer the study questions and a convenience sample of 245 nurses was selected from 8 Palestinian hospitals ,the researcher adopted a questionnaire based on the study's model, incorporating insights from previous studies, relevant scientific research, dimensions, variables, and expert opinions. The validated Arabic version of the questionnaire was used for data collection.

Statistical Analysis: Data collection utilized the Statistical Package for Social Science (SPSS) Version (26), with answers converted to numeric values using a scoring manual. The data was checked for outliers or errors, followed by descriptive and inferential statistical analysis. Descriptive statistics (frequency, percentages, mean score) were employed to describe study variables, while inferential statistics included independent t-tests, One-Way ANOVA, chi-square tests, and binary logistic regression to assess differences among demographic variables in terms of compassion fatigue (CF), secondary traumatic stress (STS), and compassion satisfaction (CS).

Ethical Considerations: The study received approval from Al-Quds University's research committee and the Ethical Research committee (REC). Consent forms were used to ensure participants' agreement, with a full explanation of confidentiality, privacy, and their right to withdraw.

Results: The study examined demographic and professional characteristics, revealing a diverse distribution among hospitals and working hours. Most nurses resided in Hebron (54.3%), with 49.8% having 1-5 years of experience. The majority fell in the 20 to 29 years old range (57.1%), with various working hours and patient care load. Gender distribution was balanced, and 57.1% were married. Educational levels varied, with most holding a Bachelor's degree.

Nurses reported workplace stress (73.5%), with employer support (55.9%) and frequent debriefing sessions (60.2%). Formal debriefing guidelines were considered "extremely important" by 43.3% .

The study has determined that the impact of debriefing sessions as predictors for the categories of ProQoL domains was found to be insignificant (p-value > 0.05) .

Conclusion: This study provides insights into compassion fatigue among Palestinian ICU nurses, with significant considerations for the work environment, and demographic factors. The findings underscore the need for comprehensive strategies to address nurses' emotional well-being, and healthcare institutions can utilize evidence-based interventions to promote a supportive and sustainable work environment. This study contributes to the existing knowledge, reinforcing the importance of these issues in the healthcare profession.

علاقة اجهاد التعاطف مع المرضى وممارسة جلسات التفريغ النفسي لدى تمريض العناية الحثيثة: دراسة فلسطينية

إعداد: ولاء سالم عبد الله جعفري

إشراف: د. ميساء الأسطى

الملخص

خلفية الدراسة: يستمد ممرضو العناية الحثيثة السعادة من تقديم الرعاية الودية للمرضى وعائلاتهم، لكنهم يواجهون أيضًا خطر التعرض للإجهاد .تتضمن الجودة المهنية للحياة الحفاظ على التوازن بين الإنجاز والإجهاد، لذلك يجب على المدير أو الإداري أن يلعب دورًا في منع إرهاق الرحمة أو التدخل فيه.

مشكلة الدراسة ومبرراتها: يتعرض موظفين الرعاية الصحية لضغوط كبيرة لإظهار التعاطف عندما يكون المرضى يعانون أو معرضين للخطر .يواجه ممرضو العناية الحثيثة تحديات في التعامل مع المواقف التي تهدد الحياة، وضعف التواصل، وساعات العمل الطويلة، مما يؤدي إلى إجهاد التعاطف. غالبًا ما يشعر الممرضين بعدم الراحة الأخلاقية عند تقديم الرعاية في نهاية العمر أو عندما لا تكون الرعاية فعالة .حددت مراجعة شاملة لعشر دراسات حول إجهاد التعاطف بين ممرضين العناية الحثيثة أن العمر والخبرة هي عوامل مؤثرة .ومع ذلك، لم يتم إجراء أي من هذه الدراسات في منطقة شرق البحر الأبيض المتوسط.

الهدف الرئيسي: تهدف هذه الدراسة إلى تحديد مستويات إجهاد التعاطف بين ممرضي وحدة العناية الحثيثة الفلسطينيين فيما يتعلق بممارسة جلسات التفريغ النفسي في بيئة عملهم.

منهجية الدراسة: تم استخدام دراسة تصميمية مقطعية للإجابة على أسئلة الدراسة وتم اختيار عينة مستشفيات فلسطينية 8 ممرض وممرضة من 245 ملائمة مكونة منو طور الباحث استبانة تستند إلى نموذج الدراسة، متضمنة الرؤى من الدراسات السابقة، والبحوث العلمية ذات الصلة، والأبعاد، والمتغيرات، وآراء الخبراء .النسخة العربية من الاستبيان استخدمت في جمع البيانات.

الاعتبارات الأخلاقية: حصلت الدراسة على موافقة لجنة الأبحاث :العلمية والدراسات العليافي جامعة القدس، تم أخذ الإ ذن بإجراء الدراسة التي تم الحصول عليها من وزارة الصحة الفلسطينية والمستشفيات الخاصة التي تشمل المشاركين في الدراسة، تم استخدام نماذج الموافقة لضمان موافقة الانسحاب المشاركين، مع شرح كامل للسرية والخصوصية وحقهم في.

النتائج: فحصت الدراسة البيانات الشخصية والمهنية، وكشفت عن توزع متنوع بين المستشفيات وساعات العمل .حيث يقيم معظم الممرضين في الخليل (54.3)٪ ، مع (49.8)٪ لديهم خبرة 5-1 سنوات .بحيث كانت أعمار الاغلبية منهم ما بين 20إلى 29سنة (57.1)٪، مع ساعات عمل مختلفة وأعباء رعاية المرضى. كان التوزيع بين الجنسين متوازنًا، وكان (57.1)٪ متزوجين .و لديهم تفاوت في المستويات التعليمية ومعظمهم حاصل على درجة البكالوريوس. أبلغ الممرضين عن ضغوط في مكان العمل (73.5)٪ ، بدعم من صاحب العمل (55.9)٪ وجلسات تفريغ نفسي متكررة (60.2)٪ .واعتبر المشاركين في البحث أن الإرشادات الرسمية لجلسات التفريغ النفسي" مهمة للغاية "بنسبة (43.3)٪، لكن المشاركة بالجلسات كانت محدودة (31.8)٪.

الخلاصة: تقدم هذه الدراسة نظرة ثاقبة لإرهاق التعاطف بين ممرضي وحدة العناية الحثيثة الفلسطينيين، مع اعتبارات مهمة لبيئة العمل، والعوامل الديموغرافية، تؤكد النتائج على الحاجة إلى استراتيجيات شاملة لمعالجة الرفاهية العاطفية للممرضين، ويمكن لمؤسسات الرعاية الصحية الاستفادة من التدخلات القائمة على الأدلة لتعزيز بيئة عمل داعمة ومستدامة .تساهم هذه الدراسة في ردف وإغناء المعرفة الحالية، مما يعزز أهمية هذه القضايا في مهنة الرعاية الصحية.

CHAPTER 1

INTRODUCTION

1.1 Background

A person may experience stress when work demands and pressures exceed their coping abilities. Workplace stress is inevitable in today's high-demand, fast-paced environment. Depending on their abilities, resources, and personality, workers who tolerate pressure may remain alert, motivated, and receptive to learning. However, stress develops when the strain becomes intolerable, and can negatively impact both the health and productivity of employees (World Health Organization [WHO], 2020).

Healthcare employee well-being and burnout are major concerns that are related to compromised patient safety and satisfaction (Hall et al., 2016). High expectations, excessive responsibility, and minimal authority have been identified as the main stressors in the nursing profession, which is well-known for its stressful reputation due to the complexity of the job's demands and requirements (Jacobs & Lourens, 2016). Intensive care unit (ICU) nurses are typically the first to respond to life-threatening situations and initiate basic life support while awaiting the arrival of the advanced support team (McMeekin et al., 2017). Post-code stress, activation of coping behaviors, and symptoms of post-traumatic stress disorder (PTSD) may be caused by nurses' involvement in resuscitation cases (Mealer et al., 2007). Psychological trauma frequently results from the frequent and cumulative exposures to unsuccessful life-saving care that critical care nurses receive (Stokes & Zoucha, 2021).

It is known that nurses experience high levels of job stress, which can negatively impact their quality of life and caring behaviors (Babapour et al., 2022). Compassion is an integral component of nursing practice that nurses must uphold in both their personal and professional lives. The quality of a caregiver's professional life has a substantial effect on indicative of a positive professional quality of life (QOL) for nurses, whereas compassion fatigue, which can be subdivided into burnout and secondary traumatic stress, is indicative of a negative professional quality of life (Kim et al., 2014).

Compassion fatigue is a term that describes the physical, emotional, and psychological impact of helping others, basically those who experience stress or trauma (Mathieu , 2012). Compassion fatigue is typically associated with occupations or attitudes that place people in stressful situations and may impair people's capacity to carry out their

daily activities. Compassion fatigue is also known as secondary stress reaction, secondhand shock, secondary traumatic stress, or empathetic trauma (Figley & Ludick, 2017).

The administration can prevent burnout by monitoring staff conflicts, promoting positive relations through support and discussion groups, and developing counseling skills. Stress inoculation training, inservices, workshops, and one-to-one conferences can help address conflicts. If uncomfortable, an outside professional councilor can be used (Keidel, G. C. (2002)).

The nursing leadership team plays an important role in managing incidences of CF through support and being engaged during their presence on units, which can increase job satisfaction and reduce turnover (Moss et al., 2016).

1.2 Problem Statement

Healthcare providers are under a lot of pressure as they try to meet the needs of a system that is already stretched to its limits. These pressures can make it difficult for nurses to provide nurturing care during patients' most vulnerable times of health and illness. Since the difficulties of working in the health care industry have become more obvious in recent decades, the concept of compassion fatigue has received a great deal of attention (Sorenson et al., 2016).

Critical care is one of the most challenging areas of medical practice since patients are frequently in a life-threatening condition and are unable to communicate with the care team. This places nurses, patients, and their families in morally ambiguous and stressful situations. In addition, critical care nurses must contend with strenuous physical labor, long hours, and stressful patient interactions. In my work experience at CCU, I observed nurses leaving the institution and the profession for reasons expressed was BO, high level of emotional stress and lack of leadership support, all of which are components of CF.

When morally distressing situations arise in critical care, and when they face multiple other stresses, it is easy for nurses to become overwhelmed (Henrich et al., 2017). In critical care nursing, there are numerous potential sources of moral distress; however, nurses frequently experience moral distress when providing end of-life care or when care is no longer effective. Moral distress may arise when there are disagreements or a lack of communication among the members of the healthcare team (IRAJ. A, 2015). If nothing is

done to alleviate moral distress, it can lead to feelings of helplessness, exhaustion, and even resignation over time (Karanikola et al., 2013).

A recent systematic review of the literature found 10 studies primarily focused on compassion fatigue (CF) among critical care nurses and the factors that may have contributed to the onset of CF, as well as the consequences associated with three overarching themes: 1) the rate of CF among ICU nurses, 2) the factors, such as age and years of experience, that can increase or decrease CF risk among ICU nurses, and 3) the factors, such as coping strategies, that can lessen the impact of CF on ICU nurses (Alharbi et al., 2019). Nonetheless, none of these studies was done in the East Mediterranean region (EMR) or in Palestine, where the ongoing confrontations, and violations that the Palestinians face from the Israeli occupation affect the different aspects of healthcare workers health and well-being.

Techniques for coping with anxiety could help individuals better manage stress under heavy workloads (American Nurses Association, 2022). One can develop moral resilience by enhancing their: (1) self-awareness, (2) social connections, (3) ethical competence, and (4) future-oriented action plans. Debriefing is the process of analyzing an incident to determine what transpired, who was affected, and whether any lessons were learned (Hanna & Romana, 2007). Independently, one-on-one, or in a group, debriefing can be an effective tool for many health care professions. Debriefing could be an effective method for dealing with moral distress in the intensive care setting (Rogers et al., 2008).

The retention of staff nurses in the critical care sectors is suffering due to staff nurse absenteeism, tardiness, and retention issues, which is a secondary effect of CF (Boyle, 2011). Given the worldwide nursing shortage and the critical need for intervention, the Doctor of Nursing Practice (DNP) initiative is crucial for nursing practice (Nolte et al., 2017). The DNP project's main objectives were to promote leadership interventions to increase worker happiness through leadership rounding on the units and to educate leaders on the effects of CF.

1.3 Significance of the study

In Palestine, as in many other countries, the shortage of registered nurses is increasing the workload of those who work in the field. In addition, nurses' stress levels can increase when they engage in activities outside of nursing. According to a study of Palestinian nurses, "workload," "conflict with other nurses," and "inadequate preparation to meet the emotional

demands of the patients and their families" are reported as stress-inducing factors (Amro, 2013).

Being aware of CF and burnout and dealing with them, may aid ICU nurses in maintaining their capacity to feel fulfilled at work and improve patient satisfaction. In a small pilot study, researchers compared participants' reports of moral distress before, during, and after four 30-minute debriefing sessions with their reports immediately following the sessions (Fontenot & White, 2019). Participants likely grew in self-awareness as a result of being given time to investigate their own distress, discuss their distress with colleagues, and acknowledge their feelings. Awareness of one's own actions can help prevent the accumulation of moral residue and the escalation of tension (Epstein & Hamric, 2009).

The study was designed to boost employee retention and work happiness, which would eventually enhance patient care quality. The desire of healthcare practitioners to leave the industry has an influence on both patients and the healthcare system (Asegid, Belchew, & Yimam, 2014).

Nurses should be assisted to develop a planned approach for managing compassion fatigue. “Employers have some responsibility to help nurses recognize and deal with this because it is going to happen, based on the nature of our work” (Maytum et al., 2004).

Some nurses changed jobs and/or decreased hours of practice to deal with compassion fatigue. The job changes were usually due to something viewed as more positive and where there was less patient suffering (Austin et al., 2009). Leadership and role modelling by more senior staff were identified as notable with one nurse stating the importance of “observing senior experienced nurses dealing with [those] reactions” (Drury et al., 2013).

1.4 Research aim and objectives

1.4.1 The aim

The aim of this study was to determine the levels of compassion fatigue among Palestinian intensive care unit nurses in relation to Debriefing in their work environment.

1.4.2 Specific objectives

1. To determine the levels of compassion fatigue (Burnout [BO] and Secondary traumatic stress [STS]) and compassion satisfaction among ICU nurses in Palestine.
2. To examine whether there is a difference in compassion fatigue (BO and STS) and compassion satisfaction and sociodemographic factors (age, marital status, place of residency, level of education, years of experience, working place, number of patients cared for per day and work hours).
3. Assess the perceptions of ICU nurses regarding the significance of debriefing as a method for releasing compassion fatigue (BO and STS).
4. To examine the practice of debriefing based on workplace in Palestine.
5. To assess the difference in the levels of perceptions of ICU nurses regarding the significance of debriefing in relation to sociodemographic factors (age, marital status, place of residency, level of education, years of experience, working place, number of patients cared for per day and work hours).
6. To examine the association between compassion fatigue (BO and STS) and the practice of debriefing.

1.5 Research questions

1. What are the levels of compassion fatigue and compassion satisfaction among ICU nurses in Palestine?
2. Is there a difference in compassion fatigue and compassion satisfaction and sociodemographic factors (age, marital status, place of residency, level of education, years of experience, working place, number of patients cared for per day and work hours)?
3. What are the perceptions of ICU nurses regarding the significance of debriefing as a method for releasing compassion fatigue?
4. To how extent the debriefing is practiced Palestinian hospitals?
5. What is the difference in the levels of perceptions of ICU nurses regarding the significance of debriefing in relation to sociodemographic factors (age, marital status, place of residency, level of education, years of experience, working place, number of patients cared for per day and work hours)?

6. Is there a relationship between compassion fatigue and perceptions of ICU nurses regarding the significance of debriefing as a method for releasing compassion fatigue?
7. Is there a relationship between the practice of debriefing and the presence compassion fatigue?

1.6 Conceptual definitions

1.6.1 Professional quality of life

Professional quality of life is the extent to which an individual enjoys and benefits from their helping occupation. The quality of one's professional life is affected by both the gratifying and frustrating aspects of work. People who make a living assisting others may be called upon to respond to emergencies ranging from the individual to the national to the international level. Health care workers, social service workers, educators, attorneys, law enforcement officers, firefighters, clergy, airline and other transportation employees, disaster site cleanup crews, and others who provide aid either immediately after an incident or later on are examples of those who provide assistance. Components of one's professional quality of life are both positive (Compassion Satisfaction) and negative (in nature (Compassion Fatigue) (Stamm, 2010).

1.6.1 Compassion fatigue (CF)

Two aspects of compassion fatigue exist. Burnout is characterized by a variety of negative emotions, including those described in the first section. Workplace anxiety and trauma may contribute to secondary traumatic stress. (Stamm, 2010).

1.6.1.1 Burnout

Burnout, is one of the many unintended outcomes of providing care. The concept of burnout is familiar to the majority of individuals. According to Maslach's definition, burnout is characterized by a lack of motivation and an inability to effectively manage or perform at work. Typically, these negative emotions sneak up and may be the result of having an excessive amount of work to complete or working in an uninspiring environment (Maslach et al., 2016).

1.6.1.2 Traumatic Stress (STS)

Involvement in traumatic events may result in CF, also known as Secondary CF. STS refers to workplace exposure to individuals who have experienced extreme or traumatic stress. Some of the negative outcomes of STS include sleep disturbances due to fear, intrusive images, and avoiding reminders of one's traumatic experiences. (Paiva-Salisbury, . & Schwanz, 2022). Marie et al.'s (2020) literature review findings show that a sizeable portion of Palestinians are dealing with serious problems that are caused by a variety of obstacles, such as the occupation, inconsistent medication availability, a lack of multidisciplinary teamwork, a shortage of specialists, and a fragmented mental health system. The occupation must be seen as the primary preventer of anxiety and other mental health illnesses in Palestine. In addition, there is a need to put in place a system of mental health treatment via collaborative efforts and increased awareness of the incidence of mental problems (Marie et al.,2020).

1.6.1.3 Compassion satisfaction CS

CS refers to the pleasure nurses derive from performing their duties competently. For instance, they find it rewarding to help others through their work. They may have a favorable opinion of their coworker’s contribution to the workplace or even the greater good of society (Sodeify et al., 2013) .

1.6.2 Debriefing

A debriefing's objectives can include learning more about a recent event or potential future scenario as well as addressing concerns about potential threats to patient safety and care. Gaining understanding of and improving performance at the individual, team, and system levels can be accomplished through debriefing (Krogh et al., 2016). It is one of the key teaching tools in simulation training and is advised following significant clinical occurrences like a code, adverse patient event, or medical error. Debriefing has many applications, including therapy, research, and education (Bajaj et al., 2018).

"What happened?" is the question that starts the debriefing process. Its objectives are to explore the actions and ideas present in a specific clinical scenario, promote reflection, and factor improvement into upcoming performance. The actions and results of a code blue event

can be discussed with the personnel who were present, or a one-on-one conversation with a healthcare professional who committed a medical error can serve as an example (Cheng et al., 2021; Harder et al., 2019).

The Role of Leadership in Identifying and Managing Compassion Fatigue

The warning symptoms of CF, which include a mix of cognitive, emotional, physical, spiritual, or interpersonal reactions or activities, must be understood by leaders in order to prevent inadequate coping. Healthcare leadership teams must be conscious of the fact that their presence on nursing units is viewed as support by nursing staff members, which raises staff morale and lowers the incidence of CF (Dempsey & Reilly, 2016).

According to Dempsey and Reilly (2016), there is a negative correlation between CF and high-quality care; as CF incidences rise, nurse involvement, which is essential for high-quality treatment and positive patient outcomes, decreases. A CF episode is distinguished by a significant, outwardly expressed emotional reaction to an event.

For instance, a nurse who has just witnessed a patient die rushes into the break room sobbing uncontrollably. Dempsey and Reilly (2016) talked on the necessity for prompt and proper leadership involvement after a CF occurrence to prevent such incidences at work.

In order to create a healthy work environment by including the carers, leadership teams must appreciate, support, and meet the needs of everyone who provides care, according to Dempsey and Reilly (2016).

Early intervention in CF is crucial for staff and institutions, and proactive leadership can reduce its impact, engage staff, and increase retention (Crocker & Joss, 2016).

By encouraging experienced and new nurses alike and recognizing efforts that foster a feeling of teamwork and make people feel valued, mandatory leadership rounds on critical care units can help stop CF. The nursing leadership team's deliberate actions can increase staff nurse engagement, which can reduce incidents of CF, uncontrolled emotional outbursts, mood swings, anxiety, oversensitivity, and physical symptoms like headaches and high blood pressure (Lombardo & Eyre, 2011). Leaders can use the ProQOL tool to assess staff members' levels of CF and the scores to strategize interventions (Sacco et al., 2015).

1.7 Conceptual Framework

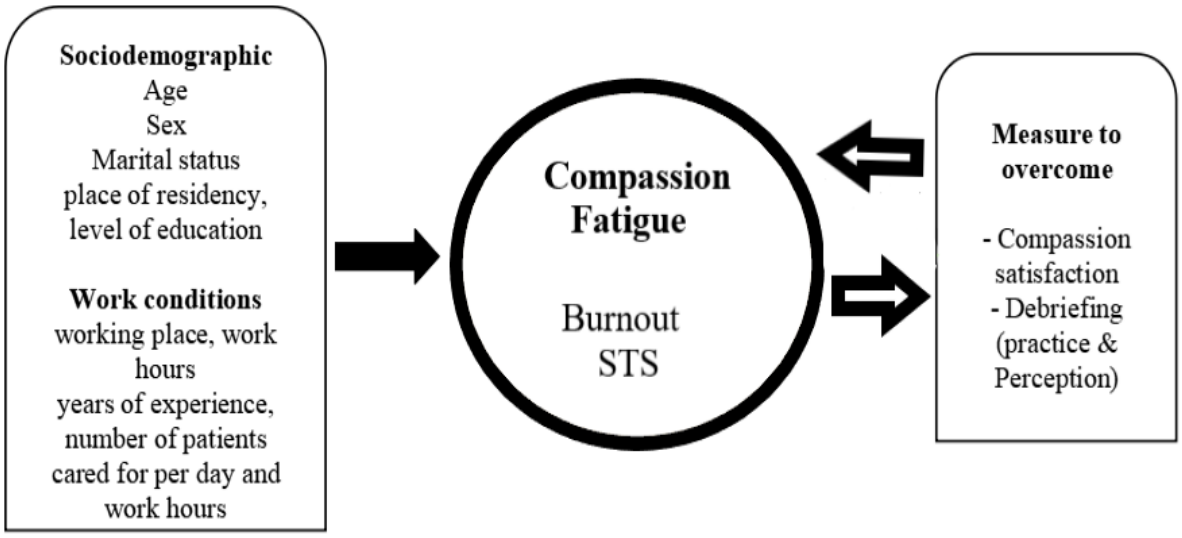


Figure 1: A conceptual framework for the risk factors of compassion fatigue and their relationship to debriefing as a measure to overcome.

The above Conceptual Framework of this study was developed based on understanding of the literature review related to the theories (Harder et al., 2019; Drury et al., 2013;Mohammadi et al., 2017;Sorenson et al., 2016). The researcher suggests this conceptual model to define and establish the relationship between research variables:

1.7.1 Risk factors (Sociodemographic and work-related factors): explains the condition of lessened capacity for compassion that arises from having to deal with other people's pain. Different sociodemographic characteristics and job conditions (age, marital status, location of residence, educational attainment, years of experience, working environment, number of patients cared for per day, and work hours) affect compassion fatigue, compassion satisfaction, and secondary traumatic stress.

1.7.2 Compassion Fatigue: explains the condition of lessened capacity for compassion that arises from having to deal with other people's pain. Different sociodemographic characteristics and job conditions (age, marital status, location of residence, educational attainment, years of experience, working environment, number of patients cared for per day, and work hours) affect compassion fatigue, compassion satisfaction, and secondary traumatic stress.

1.7.3 Measures to overcome CF:

According to the literature, the researcher will evaluated the ICU nurses' perception and practice of debriefing and relate it to their degree of compassion fatigue. The researcher will also assessed the relationship between the compassion satisfaction scale and the compassion fatigue scale as part of the professional quality of life questionnaire. (See Measures in Chapter 3)

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter delves into the existing body of knowledge surrounding the concept of compassion fatigue and its implications in the context of healthcare, with a particular focus on intensive care unit (ICU) nurses. The chapter begins by exploring the occupational stress experienced by healthcare workers, particularly nurses, within the dynamic and demanding healthcare environment. The prevalence and consequences of compassion fatigue among healthcare professionals, including ICU nurses, are then thoroughly examined. The significance of peer and family support as well as debriefing sessions in mitigating compassion fatigue is highlighted. This literature review provides a comprehensive understanding of the factors that contribute to compassion fatigue among healthcare workers, the coping strategies employed, and the potential role of interventions like debriefing. By synthesizing the existing knowledge in this field, this chapter sets the stage for the subsequent discussion of the research's findings and their implications in the Palestinian context.

2.1 Nurses Occupational stress

Job stress is an interactive situation between the job situation and the working person in that job, which leads to changes in the individual’s psychological and physiological status and affects normal performance. Workplace stress can be significantly increased when employees are asked to do more work than they have time for, according to a number of studies (Cassar & Tattersall, 1998; Falco, et al., 2013).

Nursing is one of the most stressful jobs in healthcare (Golshiri, et al., 2012) . The strain of their profession has had a significant impact on nurses, Due to the stress they experience from caring for patients, some nurses are unable to adopt (Munro et al., 1998). In the United States, the average number of days missed in 1997 was approximately four times greater than the number of days missed due to other nonprofessional damages and professional disorders (Topf .M, 1989).

Work environment plays a crucial rule on human quality of life. Gray-Toft and Anderson – The developers of the Nursing Stress Scale (NSS) measure the effects of various

sources of stress on nurses' job performance. These stressors were summarized in the nurse's immediate physical environment and immediate psychological and social networks (Gray-Toft & Anderson, 1981).

Several studies demonstrate that the risk of physical violence is a significant source of stress for healthcare workers, particularly nurses and clinic staff, and that this risk is exacerbated in emergency rooms with numerous difficulties in coping with stress combined with psychological or emotional instability could lead to violence (Banovcinova & Baskova, 2014; McVicar, 2003).

2.2 The Israeli occupation's and Palestinian nurses challenging

The Israeli occupation's enduring impact on the Palestinian medical sector is characterized by a distressing pattern of attacks on healthcare facilities and professionals, creating an environment of heightened psychological stress and tension. The wide distribution of these attacks across the Gaza Strip and the West Bank, often during periods of confrontations and military escalations, underscores the pervasive challenge faced by healthcare workers. These attacks, coupled with ongoing political and security challenges, result in a state of Compassion Fatigue among healthcare professionals, marked by emotional exhaustion and burnout. This cycle of stress has far-reaching implications, not only for the well-being of healthcare workers but also for the quality of care provided to the population. Urgent interventions are needed to address the psychological strain faced by healthcare workers and ensure the preservation of both their mental health and the well-being of the patients they serve (World Health Organization. WHO, 2023).

Survey among two Palestinians communities' mental health centers which describe the challenges faced by community mental health nurses (CMHNs),Face-to-face interviews were completed with fifteen participants. Thematic analysis was used across all data sources resulting in four main themes . CMHNs were concerned by unrest in the whole of their lives not just while on duty: F: You know I was discharged from my job because of my husband's political activity… You definitely know about the military barriers and the difficulties that we face if we decide to go to Jerusalem, for example .

The significance of the findings in this study is that the challenges faced by nurses in Palestine are of a much greater magnitude than those found in many other parts of the world (Marie et al., 2017).

2.3 Compassion Fatigue

Joinson (1992) was the first to use the term "compassion fatigue" to describe the state of diminished capacity for compassion that results from being exhausted from dealing with the suffering of others (Mathieu, 2012). Compassion fatigue is defined as the emotional and mental exhaustion that results from dealing with a high volume of traumatized clients while maintaining a strong empathic orientation. People who work in caring professions have a higher risk of developing compassion fatigue because they are more emotionally vulnerable, as noted by Figley (1995), a prominent early researcher on the disease (Figley & Stamm,1996).

Humans' innate capacity for empathy makes it difficult to care for others without sacrificing one's own well-being (Figley, 2013*)*.

Helping someone who has been traumatized or is experiencing extreme suffering may cause caregivers to experience stress, and this stress may lead to the development of CF as a protective mechanism (Figley & Stamm, 1996).

2.3.1 Prevalence of CF among nurses

The prevalence of CF among critical care nurses is reported differently across studies. For Specifically, Hunsaker et al. (n=278) wanted to determine the prevalence of Compassion Fatigue (CF) among emergency department nurses in the United States. The authors discovered that approximately 66% of emergency room nurses had a mild form of CF (Hunsaker et al., 2015). Another study in the United States surveyed 67 emergency nurses working in general hospitals to look for signs of CF risk factors, including arousal (irritability) symptoms, avoidance symptoms, and intrusion symptoms. The authors noted that this contributed to emotional exhaustion and job loss as a result of the fact that nearly all nurses (85%) reported experiencing at least one CF symptom in the previous week (Dominguez-Gomez & Rutledge, 2009).

On the other hand, a survey among nurses working in intensive care units in Queensland to determine the prevalence of CF among them. The authors report that the average compassion satisfaction score among ICU nurses was 36.13 out of 50, which indicates a low prevalence of CF (Vann & Coyer, 2014). Lastly, Elkonin and Van der Vyver found a low prevalence CF

among their sample (n=75) of intensive care nurses in private health care settings in the United Kingdom (Elkonin & Van der Vyver, 2011).

2.3.2 Risk factors of CF

Reported risk factors for CF are (Powell, 2020):

1. Ways of dealing with emotions and problems

Workers who are resilient in the face of personal challenges are less likely to burn out due to the stress of their work. The emotionality of the work, including the fact that it can be extremely painful at times, must be acknowledged, despite the fact that there are cultural differences in the expression of emotions. Negative coping strategies, such as denying feelings, assigning blame, or making fun of others, accomplish nothing. It's preferable to seek help, to communicate feelings in a healthy way, and to take initiative when dealing with problems.

2. Personal history

Adults have likely all experienced heartbreak, disappointment, and possibly trauma. Without processing, these memories and emotions can have a negative impact. If they have successfully integrated into us, they may make us more empathetic and understanding of the experiences of others. This work can be completed independently, with a trusted friend or family member, or with professional assistance. But if we haven't dealt with them, we may be less resilient in the face of adversity, and our ability to cope and perform at work may be hindered by flashbacks triggered by current events.

3. Work and organizational environment

The emotional toll of work can be significantly reduced by providing employees with a welcoming and supportive workplace. This includes being welcoming and kind to one another regardless of their background. People may have difficulty keeping up with their work if they are in an environment that fosters discrimination or harassment. Foreign employees must also adapt to a new culture, which can leave them feeling alienated and out of place. Foreign and domestic cultural differences can also have an impact. It's possible that local employees have more direct experience hearing about and coping with traumatic events due to their daily interactions with such occurrences. They may have to balance work with caring for close family and friends. To achieve our objectives and assist one another and the

people for whom this mission was established, each of us must practice mindfulness and compassion. The diversity of our people contributes to our prosperity (Gilbert, 2021).

4. Current life

Divorce, the death of a loved one, or a serious illness can all put us in a vulnerable position because they represent competing needs. The manner in which we handle the stresses of daily life also plays a role. Maintaining a healthy lifestyle is essential, and this includes things like establishing work limits, scheduling downtime, getting regular exercise, and sticking to a nutritious diet. A lack of high-quality social support increases vulnerability because it lessens our capacity to manage the challenging aspects of our lives and careers. Although it's important to have a support system, we must recognize that loved ones who aren't directly involved in our work may not always be equipped to deal with the challenges we face due to their own problems (Thomas et al., 2017).

2.3.3 The consequences of CF

Several consequences of CF have been documented in the literature, including:

- A change in one's sense of self, whether as a friend or colleague; a reappraisal of one's views on security, command, values, religion, etc.
- Alterations in behavior, including but not limited to: making snap decisions, working too much, taking on too much responsibility, failing to complete work assignments, taking too much time off, withdrawing socially, becoming more irritable, intolerant, abusing food, etc.
- Changes in outlook, like feeling helpless or blaming others, or becoming extremely cynical, depressed, or unmotivated (because, after all, "why don't they do something to help themselves?" or "I only have another four weeks until my next RandR, so I won't bother going to work on time"). (Powell, 2020)

2.3.4 Measures to overcome CF

Arabic article provide an overview of theoretical perspectives and practical research knowledge in relation to 'resilience', the resilience of Palestinians in particular and the related concept of 'Sumud'. '

show that resilience is a prerequisite to 'Sumud', meaning that the individual has to be resilient in order to stay and not to leave their place, position or community.

The article consists of several sections: the history of the concept of resilience, the social ecology of resilience, resilience in the Arabic and Islamic context, resilience among Palestinians and 'Sumud' as a social ecological idea (Marie et al.,2017).

Resilience may be seen as a requirement for comprehending and achieving "Sumud" in Arabic culture, and more especially in Palestinian culture. This means that an individual needs to be resilient in order to stay steady in the face of everyday adversities and not to quit their place or position. There is a void in the body of knowledge about resilience, particularly in developing nations like Palestine. A current wave of "new voices" researching resilience as rooted in the cultural environment, however, may help us understand experiences better. Remember that each person experiences resilience in a different way (Ungar et al., 2007). Qualitative research can help us understand this (Ungar, 2003, 2004). People may choose what they want in each cultural environment (Marie et al.,2017).

"Who has my back?" question in several studies demonstrated that nurses found multiple ways to cope with managing compassion fatigue.

2.3.4.1 Peers and Family

One major factor that has been reported as exacerbating CF is a lack of family support. A qualitative study of clinical oncology nurses in Canada found that perceived lack of support was linked to the onset of CF. Nurses expressed a desire for assistance from their peers, colleagues, and administrators (Perry et al., 2011). The ongoing perception of a lack of support seemed to amplify the CF experience over time. some nurse quotes were reported "I supported "my" families. But did I support myself? Did anyone support me? Looking back, I think not." And "Somehow I viewed myself as… "Super nurse." I had the ability to do more, withstand more, help more... more, more, more without help... It took its toll." (Perry et al., 2011). According to nurses, their families and friends are the most encouraging group of people in their lives, a nurse from Australia said "[I] talk to my mum a lot, who had just recently retired—she was a midwife" (Drury et al., 2013). another Canadian nurse reported, "I work with a great team and we take care of each other. This makes all the difference" (Perry et al., 2011). on the other hand, CF and burnout in nurses may be related to feeling unsupported by management (Hunsaker et al., 2015).

2.3.4.2 Administrative role in release compassion fatigue

A jackson survey found limited information on interventions to manage compassion fatigue. By recognizing the risks of inattention and utilizing existing workplace options, oncology nurses can enhance their recognition and management of this critical work-related issue.

Organizations should periodically inventory support and lobby for workplace interventions to address this critical issue (Aycock et al.,2009)

2.3.4.3 Debriefing reviewing an incidence or phenomenon to determine what happened, who was affected, and whether any lessons can be learned. When executed properly, it can serve as a place where participants can speak openly about their experiences and emotions, much like in counseling (Smith et al., 2014).

"We work hard together and when we have a particularly difficult case, we grieve together too" was indicated as an overcome measure by nurses (Perry et al., 2011). "when there is a clinical incident then we come out as seniors to help take the pressure off them...." was also reported as seniors support for debriefing (Drury et al., 2013).

Unexpectedly, a pilot study that examined whether debriefing sessions helped participants develop strategies to alleviate their moral distress revealed that the mean distress scores were lowest at the beginning of the study and increased after debriefing sessions 1 through 3. Eventually, it was determined that this contradiction may be a normal part of the process of developing self-awareness and resiliency. Self-awareness may actually result in higher reported stress scores. By giving participants time to explore their own moral distress, discuss it with coworkers, and acknowledge their feelings, they became more self-aware, the researchers concluded Exercise and other forms of self-care were also mentioned as coping mechanisms (Fontenot & White, 2019) . Other methods of dealing with stress included having conversations with coworkers, engaging in self-reflection and analysis, striking a healthy work-life balance, fostering mutually supportive relationships, and, if necessary, consulting a therapist (Maytum et al., 2004).

Nurses should be assisted to develop a planned approach for managing compassion fatigue. "Employers have some responsibility to help nurses recognize and deal with this because it is going to happen, based on the nature of our work" (Maytum et al., 2004).

Some nurses changed jobs and/or decreased hours of practice to deal with compassion fatigue. The job changes were usually due to something viewed as more positive and where there was less patient suffering (Austin et al., 2009). Leadership and role modelling by more senior staff were identified as notable with one nurse stating the importance of "observing senior experienced nurses dealing with [those] reactions" (Drury et al., 2013).

CHAPTER THREE

METHODS

This chapter outlines the research methodology. It starts by explaining the research design and methods used which include the study population and its eligibility criteria, sample size, sampling technique used, recruitment process, the method of data collection used, data analysis methods, validity and reliability of the research instrument and ethical considerations.

3.1 Research Design

A research design is a blueprint for conducting a study that maximizes control over factors that could interfere with the validity of the findings. (Burns & Grove, 2010).
A quantitative, cross-sectional, analytical design was employed to conduct the study.

3.2 Settings

The study was carried out in eight hospitals that represent the diversity of healthcare services provided in Palestine. Namely, Bethlehem Arab Society for Rehabilitation hospital, Beit-Jala Governmental Hospital, Caritas Baby Hospital, and Holy Family Hospital in Bethlehem. Al-Ahli Hospital, Al-Mizan Hospital, and Hebron Governmental Hospital in Hebron. In addition to Palestine Medical Complex in Ramallah.

Beit Jala Governmental Hospital or Al-Hussein Governmental Hospital is a government hospital in the Beit Jala city, West Bank. It was built in 1955 and has 131 beds. The employees in the hospital are 363, including doctors, nurses, pharmacists, physiotherapists, laboratory technicians, radiologist and others. The number of ICU and NICU nurses is 25 (Palestinian Ministry of Health, 2021).

Caritas Baby Hospital (CBH) was founded in Bethlehem in 1953 by Swiss priest Father Ernst Schnydrig. CBH is the only children's hospital in the West Bank, and it provides medical and social care to children of all backgrounds and faiths. Each year, approximately 50,000 outpatient and inpatient services are provided to Palestinian children under the age of 18. CBH treats common childhood illnesses, in addition to congenital conditions and those that are shortly diagnosed after birth. Also served are patient populations with genetic, neurological, and metabolic disorders. The hospital's strategic plan for 2018-2023 reflects the

growing demand for neurology, pulmonology, and neonatal and pediatric intensive care. More than half of patients come from the southern West Bank, specifically Bethlehem and Hebron governorates. It serves over 400,000 children, or 42% of the total population residing in the region. The hospital has a PICU with 17 nurses (Caritas Baby Hospital, 2022).

The Bethlehem Arab Society for Rehabilitation (BASR) hospital has been providing a wide variety of medical and surgical treatments and rehabilitation services since the year 2000. The construction of the Apartheid Wall restricted the movement of residents of Bethlehem and other Palestinian cities, making it more difficult for them to travel to Jerusalem for medical care. Ophthalmic surgery, orthopedic surgery, neurosurgery, and ear, nose, and throat (ENT) surgery are just some of the specialized services now offered by BASR. This is in addition to its many other rehabilitation services, such as physical therapy, occupational therapy, audiology and speech and language therapy, vision rehabilitation, mental health and psychosocial support, neuro-psychological interventions, and the distribution of various assistive devices for people with disabilities. When it comes to vision assessment and rehabilitation, as well as cochlear implant surgery, BASR incorporates an ICU and a CCU supervised by 38 nurses. [Bethlehem Arab Society for Rehabilitation. (2022)].

The holy family hospital offers obstetrics and gynecology care, with 45 beds available (including 6 in the hospital's day care center). There are seven private delivery rooms, an emergency Caesarean section operating room, and a two-bed recovery/intensive care unit at this cutting-edge maternity ward. Two additional ops for elective procedures are available in the division. Holy Family Hospital's Neonatal Intensive Care Unit (NICU) is a regional hub for the most complex prenatal and neonatal care cases. There are 18 beds in the neonatal intensive care unit (NICU) include 17 nurses, and they all take care of premature babies, including the extremely frail "micro-preemies" who weigh as little as 450 grams (16 ounces) at birth [Holy Family Hospital Bethlehem. (2022)].

Al-Ahli Hospital (Patient’s Friends Society [P.F.S] hospital) started in Hebron in 1976 as a non- governmental, non-profit and non- political organization interested in health services in the Southern Part of the West Bank (Hebron District in particular) , Today Al Ahli Hospital which was Built by donations from all over the world is the largest in Palestine, it is the main and only project that belongs to P.F.S. in Hebron, the hospital works with a capacity of (250) beds which will be (304) beds by finishing and expanding the remaining departments, this number of beds can easily rise to(500) Beds in case of disasters or urgent needs . The

hospital deals with over (160,000) patients a year including about (28,000) admissions, have ICU, CCU, NICU and PICU include 83 nurses [Patient's Friends Society. (2022)].

Al-Mizan Specialized Hospital was established in 1996 in the city of Hebron, Palestine, and began practicing its medical activities in 1999. On 1/9/2008, a group of doctors under the name of "Al-Ghad Company for Medical Services" agreed with Al-Mizan management to operate and manage the hospital, hoping to achieve the goals of the hospital. By providing distinguished medical and hotel services and working to develop new departments that are not available in Palestine, in order to reduce the burden of traveling abroad on the patient through cooperation with medical agencies from abroad. The hospital consists of 7 floors on a surface area of 9198 square meters. It operates under a patient capacity of 50 beds licensed by the Ministry of Health. The capacity can be increased to 85 beds in emergency cases.

A group of distinguished specialists and resident doctors work in the hospital, where the number of resident doctors is 10 doctors distributed over the hospital departments, in addition to 89 male and female nurses. The hospital workers deal with their various tasks annually with approximately 16,000 patients, including admission and review cases, have ICU, CCU, PICU & NICU include 75 nurses [Mizan Specialist Hospital (Hebron). (2023)].

Princess Alia Governmental Hospital or Hebron Governmental Hospital is a government hospital in the Hebron city, West Bank, Palestine. It is managed by the Palestinian Ministry of Health. It was built in 1957 and has 237 beds. It employs 596 staff, including a doctor, nurse, pharmacist, physiotherapist, laboratory technician, radiologist and others, have ICU , CCU and NICU include 72 nurses [Princess Alia Governmental Hospital, Hebron. (2023)].

Palestine Medical Complex is the largest Palestinian government hospital operating in the West Bank. It has a clinical capacity of 250 beds and employs 805 staff members. They are distributed as follows: specialist physicians 91, Resident physicians 108, Pharmacists: 13, Allied health professionals: 85, "Nurses: 318, Administrative staff 90. The hospital was founded in 1963 to provide medical services to the residents of the area, in response to the population increase and the community's need for modern medical services. Originally known as the 'Ramallah Governmental Hospital,' it was later renamed in 2010 by presidential decree to 'Palestine Medical Complex.' This change aimed to establish it as a central government specialized hospital complex." The Palestine Medical Complex consists of several buildings, with each structure serving as a specialized and well-equipped hospital

equipped with the latest devices and equipment. These include the Ramallah Sons Pavilion (formerly Ramallah Hospital), the Children's Pavilion (Bahraini Hospital), the Cardiology and Specialized Surgeries Pavilion (Kuwaiti Hospital), the Emergency Pavilion (Sheikh Zayed Hospital), the Kidney Dialysis Pavilion, the Laboratories and Blood Bank Pavilion.
These pavilions encompass numerous departments, including: Emergency, Pediatric Emergency, Outpatient Clinics, Industrial College, General Surgery, Internal Medicine, Cardiology, Orthopedics, Specialized Heart Surgeries, Catheterization, Kidney, Pediatric Cardiology, Intensive Care, Critical Care, Obstetrics and Gynecology, Physical Therapy, Radiology, and Pharmacy. In 2015, the Palestine Medical Complex was awarded the Arab Hospitals Federation Prize as the best hospital in the Arab world in the field of crisis and emergency management. The hospital has achieved several accomplishments, highlighted by performing quality operations with a success rate of 97% in kidney transplant surgeries. Additionally, the hospital has successfully conducted joint replacement surgeries, ICU, CCU, NICU, PICU& PCCU contain totally 117 nurses. [Palestine Medical Complex. (2023)].

3.3 Population and Sampling

The target population for this study was all nurses who worked in the intensive care units (ICU) ,Coronary care units (CCU) , Pediatric ICU (PICU) , Pediatric CCU (PCCU) and Neonate ICU (NICU) in eight different hospitals in the West Bank. Namely, Bethlehem Arab Society for Rehabilitation hospital, Beit-Jala Governmental Hospital, Caritas Baby Hospital, and Holy Family Hospital in Bethlehem. Al-Ahli Hospital, Al-Mizan Hospital and Hebron Governmental Hospital in Hebron and Palestine Medical Complex in Ramallah.

Rationale for Selecting ICU Nurses as the Study Population:

The rationale for selecting ICU nurses as the study population is rooted in the recognition of the challenging and intricate nature of their work environment. Job stress, as defined by the U.S. National Institute of Occupational Safety and Health, arises when job demands exceed employee capabilities and resources. This is particularly pronounced in roles marked by low autonomy and high physical and psychological demands, a characteristic prominent in the healthcare field, especially within the intensive care unit (ICU) setting (Kable et al., 2011).

ICU nursing is a notably demanding profession, requiring nurses to navigate numerous stress-inducing factors. The ICU operates as a specialized domain within hospitals, dedicated to the continuous care of critically ill patients. In this technologically advanced realm, ICU

nurses face rapid decision-making while managing critical patient conditions. The relentless nature of ICU patient care exposes nurses to physical, psychological, and moral stressors. These stressors encompass caring for terminally ill patients, engaging in physically taxing tasks like lifting, and confronting the fear of errors amidst heavy workloads and interpersonal conflicts. Additionally, the expanding role of ICU nurses necessitates both clinical expertise and technological proficiency (T, 2021).

Stress within the ICU environment can significantly impact both the quality of nursing care and overall health outcomes. Occupational stress has been linked to anxiety, depression, insomnia, and compromised decision-making abilities. It can lead to job dissatisfaction, absenteeism, high turnover rates, and nurse burnout, thereby jeopardizing both healthcare services' effectiveness and the well-being of nurses. Despite these challenges, the ICU setting also offers a unique platform for collaboration and teamwork, which may serve as a supportive framework for nurses to mitigate stress (Akhter, 2021).

3.3.1 Inclusion and Exclusion criteria

Nurses who work on any shift in the selected intensive care units on a full-time basis, those who directly interact with patients for at least 20 hours a week, and those who have a minimum of one-year experience in any of the selected units were eligible to participate in the study. The rationale for including a minimum of at least one-year experience in the ICU and working at least 20 hours per week was the consideration of having experience and having frequently enough exposure to critical events that contribute to the development of CF. Full-time hospital nurses who temporarily serve in ICU’s have been excluded from the study sample, because of the possibility of not experiencing critical events.

3.4 Sampling process

In this study, the convenience sampling technique was employed to collect the necessary data for answering the study questions and testing the study hypotheses. All ICU nurses who met the inclusion criteria were invited to participate in the study. The nurses who volunteered to participate had been asked to complete the study questionnaire. The total number of the eligible nurses (population) was 444, and 380 questionnaires were distributed, power analysis done, response rate was 64.47 %, and the recommended sample size was 198.

3.5 Study Instrument

A self-administered questionnaire was constructed, after conducting a literature review. The purpose of the questionnaire was to determine the levels of compassion fatigue among Palestinian intensive care unit nurses in relation to debriefing in their work environment.

The questionnaire consisted of the following three sections:

Section one - Demographic characteristics and work environment

This section will included items that aimed to provide data about the participants' sociodemographic characteristics such as age, gender, education, marital status, age, place of residence, level of education, years of experience, working place, number of patients cared for per day and work hours per week .

Section two - Debriefing

The second section contained items that aimed to evaluate nurses' perceived debriefing needs following a stressful event. Participants were asked to respond to some questions by selecting yes or no Ex.Does your employer help you cope with stress at work? , and to others by selecting numbers from a likert scale Ex.How adequate do you feel this is in reducing your stress levels? (Healy & Tyrrell, 2013) .

1. Do you experience stress in your workplace? -If yes, how often do you experience stress at work?
2. Does your employer help you cope with stress at work?
3. How adequate do you feel this is in reducing your stress levels?
4. Does your employer offer debriefing after stressful situations at work? If yes, how often?
5. Are there formal guidelines in your hospital on debriefing?
6. How important do you feel are hospital guidelines on debriefing?
7. In your opinion how important is debriefing after a stressful incident?
8. Have you ever taken part in a debriefing session after a stressful incident?

Section three - Professional Quality of Life 5 tool (ProQoL-5) / measure stress and fatigue size.

The data was collected using a translated Arabic version of the English version of the standard Professional Quality of Life 5 tool (ProQoL-5), a 30-item questionnaire with 5-point Likert scale responses ranging from 1 (never) to 5 (very often) . (Stamm, 2010)

Compassion satisfaction (as measured by a 10-item scale), compassion fatigue (burnout, also measured by a 10-item scale), and secondary traumatic stress are all quantified by the ProQoL-5, a reliable and valid instrument. All three scales have a range of points from 43 to 57, based on the median (the 50th percentile) score. Over 200 scholarly articles and 100,000+ online references affirm to the ProQOL 5's good construct validity, and the scale's reported psychometric properties show a reliability of.84–.90 on its three subscales (Stamm, 2010).

The questionnaire has a reliability coefficient of 0.92 for compassion satisfaction, 0.84 for burnout, and 0.87 for secondary traumatic stress, and can be completed in only 15 minutes (Hemsworth et al., 2018) .

The questionnaire indicates that "When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last **30 days".**

The scores on the Likert scale range from 1 to Never. 2=Rarely 3=Sometimes 4 = Often and 5=Very Often for the following statements:

1. I am happy.
2. I am preoccupied with more than one person I [help].
3. I get satisfaction from being able to [help] people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I [help].

7. I find it difficult to separate my personal life from my life as a [helper].

8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
9. I think that I might have been affected by the traumatic stress of those I [help].

10. I feel trapped by my job as a [helper].

11. Because of my [helping], I have felt "on edge" about various things.

12. I like my work as a [helper].

13. I feel depressed because of the traumatic experiences of the people I [help].

14. I feel as though I am experiencing the trauma of someone I have [helped].

15. I have beliefs that sustain me.

16. I am pleased with how I am able to keep up with [helping] techniques and protocols.

17. I am the person I always wanted to be.

18. My work makes me feel satisfied.

19. I feel worn out because of my work as a [helper].

20. I have happy thoughts and feelings about those I [help] and how I could help them.

21. I feel overwhelmed because my case [work] load seems endless.

22. I believe I can make a difference through my work.

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
24. I am proud of what I can do to [help].

25. As a result of my [helping], I have intrusive, frightening thoughts.

26. I feel "bogged down" by the system.

27. I have thoughts that I am a "success" as a [helper].

28. I can't recall important parts of my work with trauma victims.

29. I am a very caring person.

30. I am happy that I chose to do this work.

The Professional Quality of Life 5 tool (ProQoL-5) questionnaire consists of three sections:

Compassion Satisfaction: This section assesses nurses' positive experiences and feelings related to caregiving. It measures the level of satisfaction and fulfillment derived from the ability to help others and make a positive impact on their lives, Ex. “I get satisfaction from being able to [help] people”. Contain questions 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30. Scores between 43 and 50 indicate high levels of satisfaction, while scores of 22 or less suggest low levels of satisfaction. Scores between 23 and 41 indicate an average level of compassion satisfaction.

Burnout: This section evaluates nurses' feelings of emotional exhaustion, depersonalization, and reduced personal accomplishment. Burnout is a significant aspect of compassion fatigue and occurs when nurses experience overwhelming stress and emotional fatigue from their caregiving responsibilities, Ex “I am not as productive at work”. Contain questions 1, 4, 8, 10, 15, 17, 19, 21, 26, and 29 (reverse scored e.g., items 1, 4, 15, 17, and 29)). Scores between 43 and 50 indicate a higher risk of burnout, while scores of 22 or less suggest a lower risk of burnout. Scores between 23 and 41 indicate an average level of burnout.

Secondary Traumatic Stress: This section examines nurses' reactions to indirect exposure to traumatic events through their work. Nurses in the ICU often witness and care for patients who have experienced severe trauma, which can lead to secondary traumatic stress. This section measures the extent to which they experience distress and symptoms related to the traumatic experiences of others , Ex “I am preoccupied with more than one person I [help]”.Contain questions 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28. Scores between 43 and 50 indicate a higher level of secondary traumatic stress, while scores of 22 or less suggest a lower level of secondary traumatic stress. Scores between 23 and 41 indicate an average level of secondary traumatic stress.

3.6 Validity and reliability

The developed questionnaire was translated into Arabic from English and then reviewed by three mental health experts. The final draft questionnaire was piloted on 20 participants, who was subsequently excluded from the sample. The reliability of this instrument was determined using two methods of calculating internal consistency by Cronbach's alpha coefficient and intraclass correlation coefficient (ICC) by test-retest on 20 nurses.

Table 3.1 shows the reliability coefficients of scales. The Cronbach's Alpha for the BO items was 0.745 , STS was 0.623 and CS was 0.729 .

Table 3.1 : Correlation coefficients

Variable	**No. of item**	**Cronbach's Alpha**
BO	10	0.745
STS	10	0.623
CS	10	0.729

3.7 Ethical consideration and accessibility

The proposal was submitted to Al Quds University-School of nursing research committee for discussion and approval and ethical approval obtained from Al Quds University Ethical Research committee (REC). Ministry of Health and other hospitals approval and permission will be obtained.

Consent form used to ensure the agreement of nurse's participation in the study after full explanation about confidentially, privacy and their right to withdraw any time during the filling of questionnaire.

3.8 Statistical methods and data analysis

After completing data collection, entering of data started by using the Statistical Package for Social Science (SPSS) Version (26). The Answers of participants converted to

numeric values and the scoring manual for the tool will be used to guide the statistical analysis.

Data entry was performed by the researcher and double-checked for outliers or errors.

Data analysis of descriptive and inferential statistics was conducted. Regarding descriptive statistics (frequency, percentages, mean score) were used to describe the study variables. Regarding inferential statistics, independent t-test and One Way ANOVA and chi-square test and binary logistic regression were used to assess the differences between demographic variables in terms of both CF, STS and CS.

CHAPTER FOUR

RESULTS

This chapter provides the descriptive and analytical results of the current study, where the descriptive results show the frequencies and percentages of the participants' categorical characteristics and their responses to the statements related to aspects of debriefing and Professional Quality of Life (ProQoL) scale, as well as the mean and standard deviation of the scale variables and scores of ProQoL scale. Additionally, the analytical results show the results related to the investigation of the relationship between the study's independent and dependent variables, in order to achieve the study's specific objectives.

Part one: Demographic and professional characteristics of the ICU nurses

Our study composed of 245 questionnairs with 64.47% response rate ,the distribution of demographic and professional characteristics among ICU nurses was examined in the study. The hospitals where the nurses worked varied, with Al-Ahli Hospital having the highest representation at 22.9%, followed by Al-Mizan Hospital (19.2%) and Palestine Medical Complex (18.0%). Most of the nurses resided in Hebron (54.3%), while Bethlehem and Ramallah accounted for 28.2% and 15.1% respectively. In terms of experience, 49.8% of nurses had 1 to 5 years of experience, followed by 29.8% with 6 to 10 years, and 19.2% with over 10 years. Working hours per week showed a normal distribution, with 48.6% working 41 to 100 hours, 48.2% working 25 to 40 hours, and 3.3% working 1 to 24 hours.

Nurses typically cared for a varying number of patients daily, with 45.7% responsible for 3 to 6 patients, 42.4% for 1 to 3 patients, and 11.8% for 7 to 10 patients. Regarding age, the majority fell in the 20 to 29 years old range (57.1%), followed by 30 to 39 years old (29.0%), and 11.0% aged 40 or older. Gender distribution was almost equal, with 49.8% male and 49.8% female nurses, while marital status indicated that 57.1% were married, 36.7% were single, and 4.5% were divorced or widowed. In terms of academic level, 76.7% held a Bachelor's degree, 11.8% had a Diploma degree, and 8.2% had a Master's degree or higher.

These highlighted percentages underscore the diversity among ICU nurses in terms of experience, age, gender, and academic qualifications, showcasing the complex makeup of the workforce in different hospitals and regions. The following figures illustrate the distribution of the nurses' demographic and professional characteristics, taking into consideration that

valid percentages were illustrated, while missing percentages were excluded from the illustration.

Table 4.1: Distribution of the demographic and professional characteristics of the ICU nurses in frequencies and percentages

Variables	**Values**	**Frequency**	**Percentage**
Place of work	Al-Mizan Hospital	47	19.2%
	Alia Governmental Hospital	21	8.6%
	Beit Jala Hospital	19	7.8%
	Arab Society Hospital	32	13.1%
	Caritas Baby Hospital	16	6.5%
	Holy Family Hospital	10	4.1%
	Al-Ahli Hospital	56	22.9%
	Palestine Medical Complex	44	18.0%
Place of residence	Hebron	133	54.3%
	Bethlehem	69	28.2%
	Ramallah	37	15.1%
	Missing	6	2.4%
Years of experience	1 – 5 years	122	49.8%
	6 – 10 years	73	29.8%
	> 10 years	47	19.2%
	Missing	3	1.2%
Working hours per week	1 – 24 hours	8	3.3%
	25 – 40 hours	118	48.2%
	41 – 100 hours	119	48.6%
Number of cared patients per day	1 – 3 patients	104	42.4%
	3 – 6 patients	112	45.7%
	7 – 10 patients	29	11.8%
Age in complete years	20 – 29 years old	140	57.1%
	30 – 39 years old	71	29.0%
	40 years or older	27	11.0%
	Missing	7	2.9%

Gender	Male	122	49.8%
	Female	122	49.8%
	Missing	1	0.4%
Marital status	Single	90	36.7%
	Married	140	57.1%
	Divorced / widowed	11	4.5%
	Missing	4	1.6%
Academic level	Diploma degree	29	11.8%
	Bachelor's degree	188	76.7%
	Master's degree or above	20	8.2%
	Missing	8	3.3%

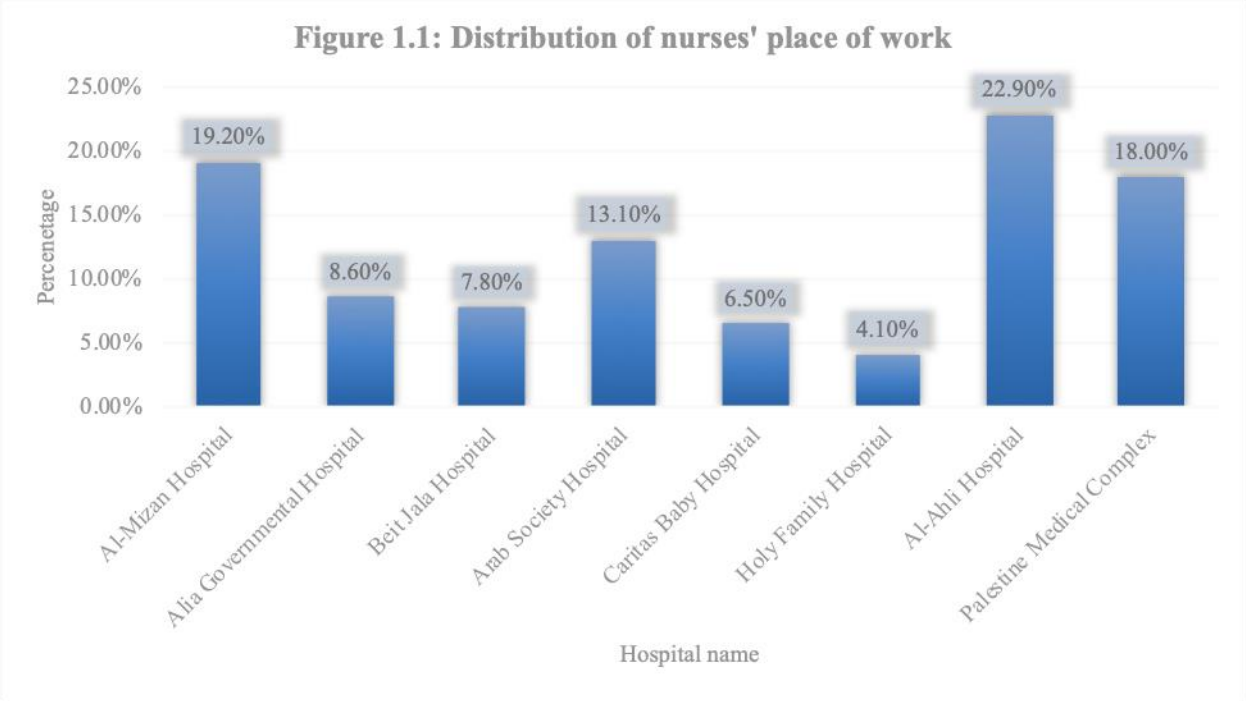


Figure 1.2: Distribution of nurses' place of residence

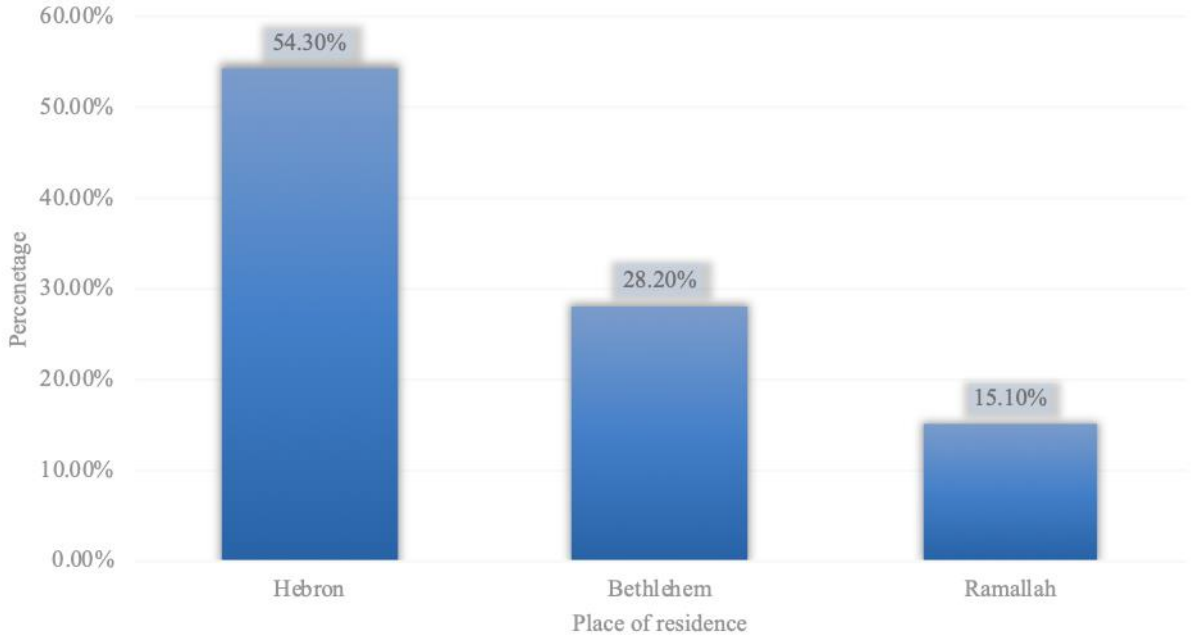


Figure 1.3: Distribution of nurses' expeience years

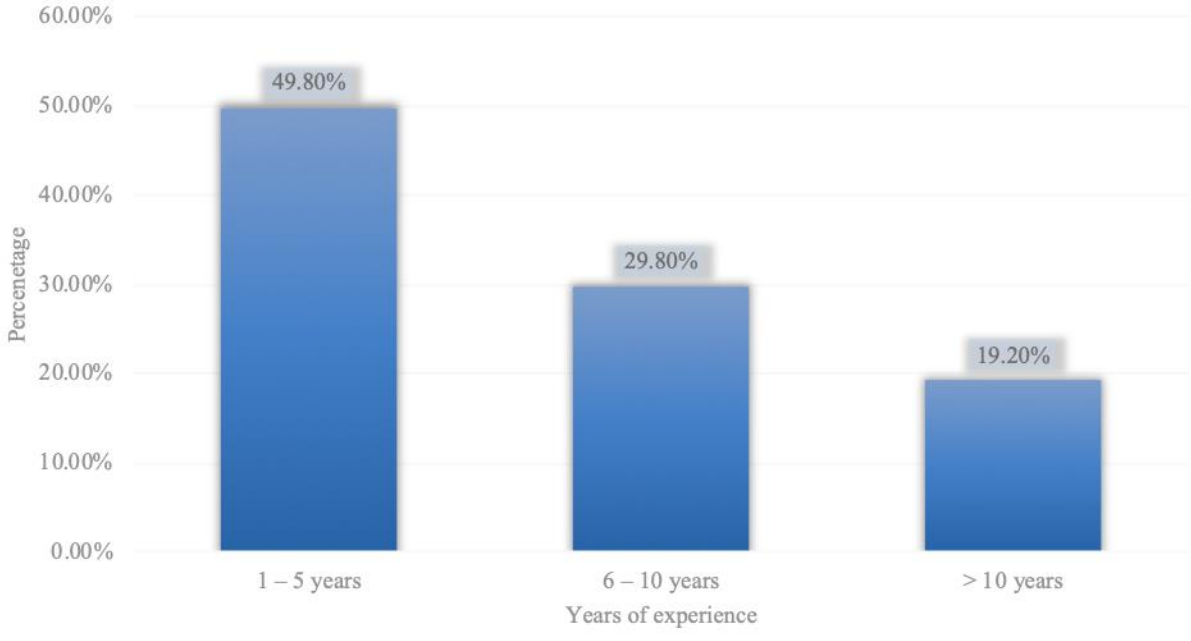


Figure 1.4: Distribution of nurses' working hour per week

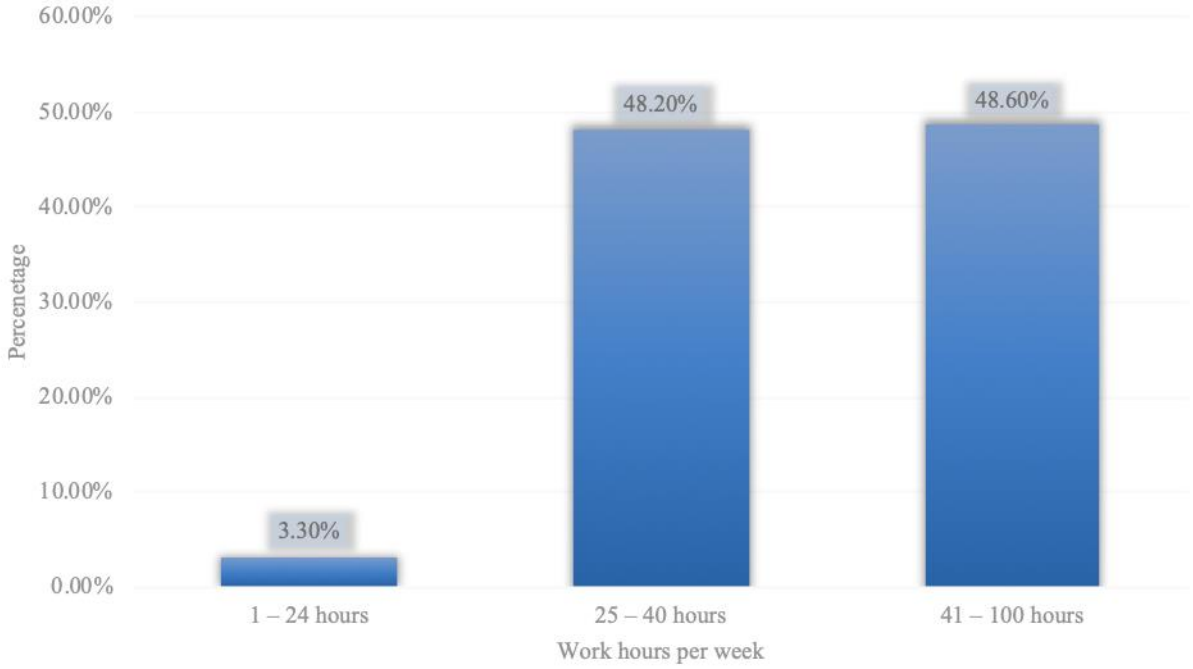


Figure 1.5: Distribution of nurses' cared patients per day

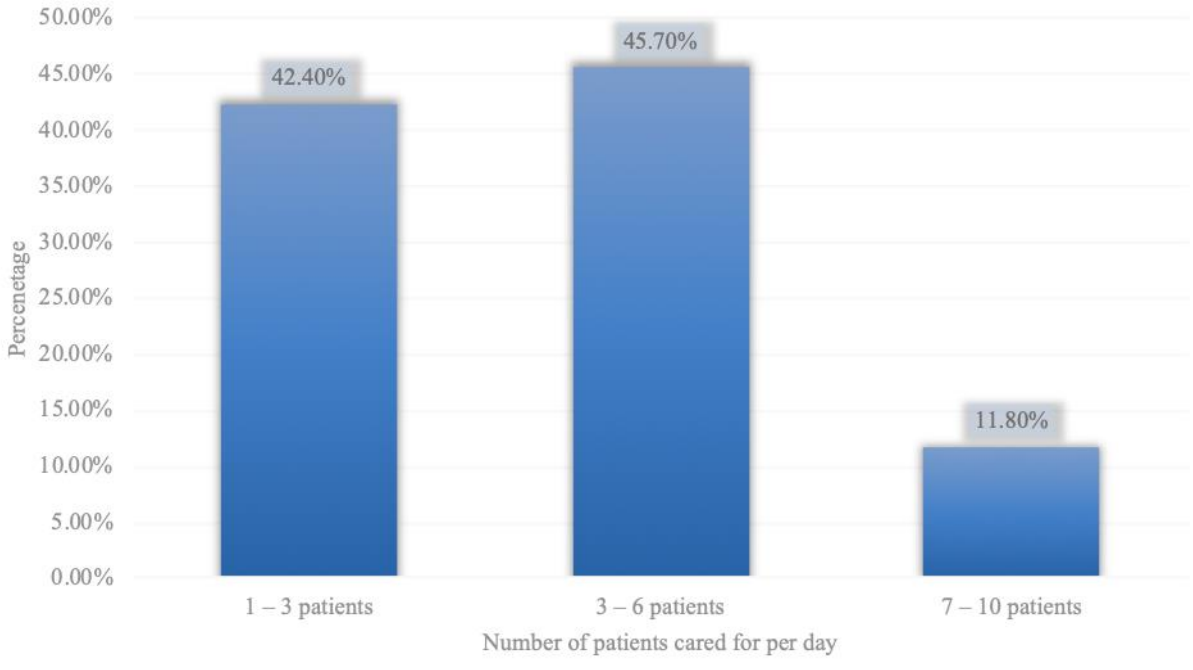


Figure 1.6: Distribution of nurses' age categories

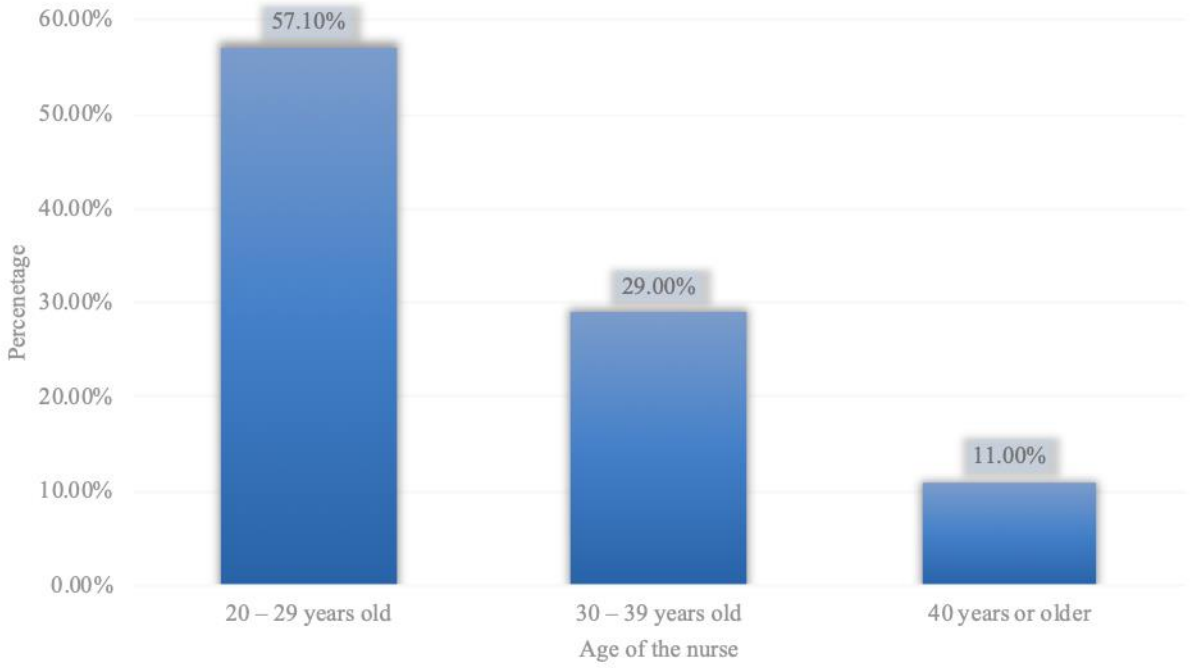


Figure 1.7: Distribution of nurses' genders

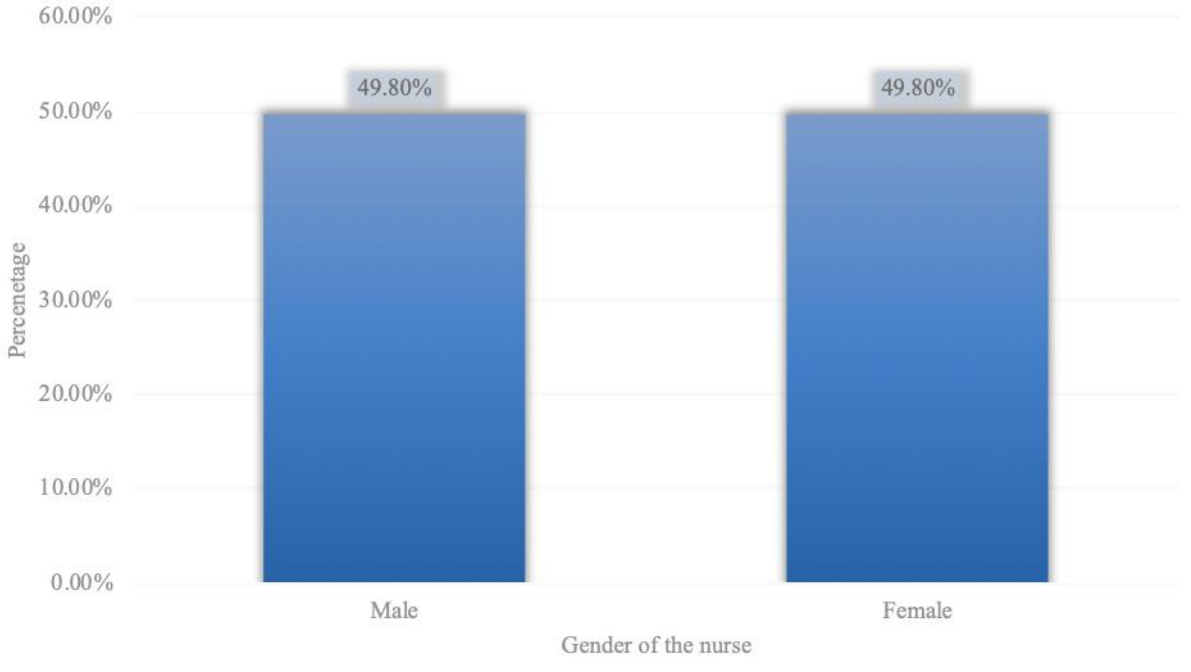


Figure 1.8: Distribution of nurses' marital status

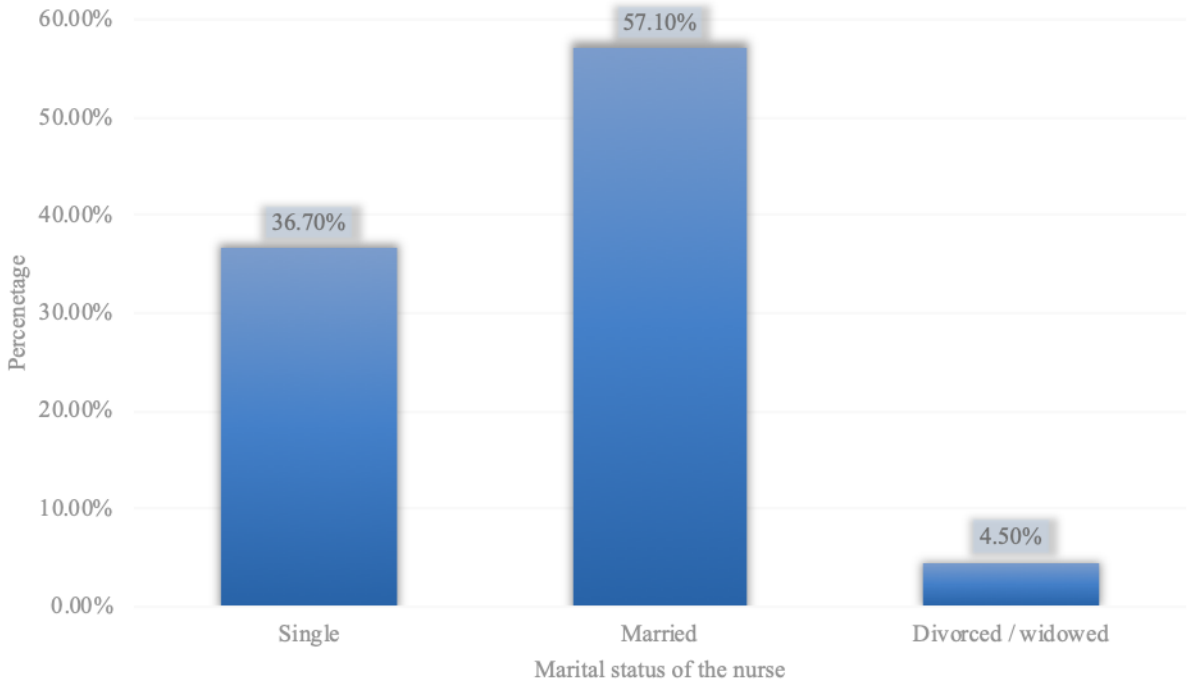
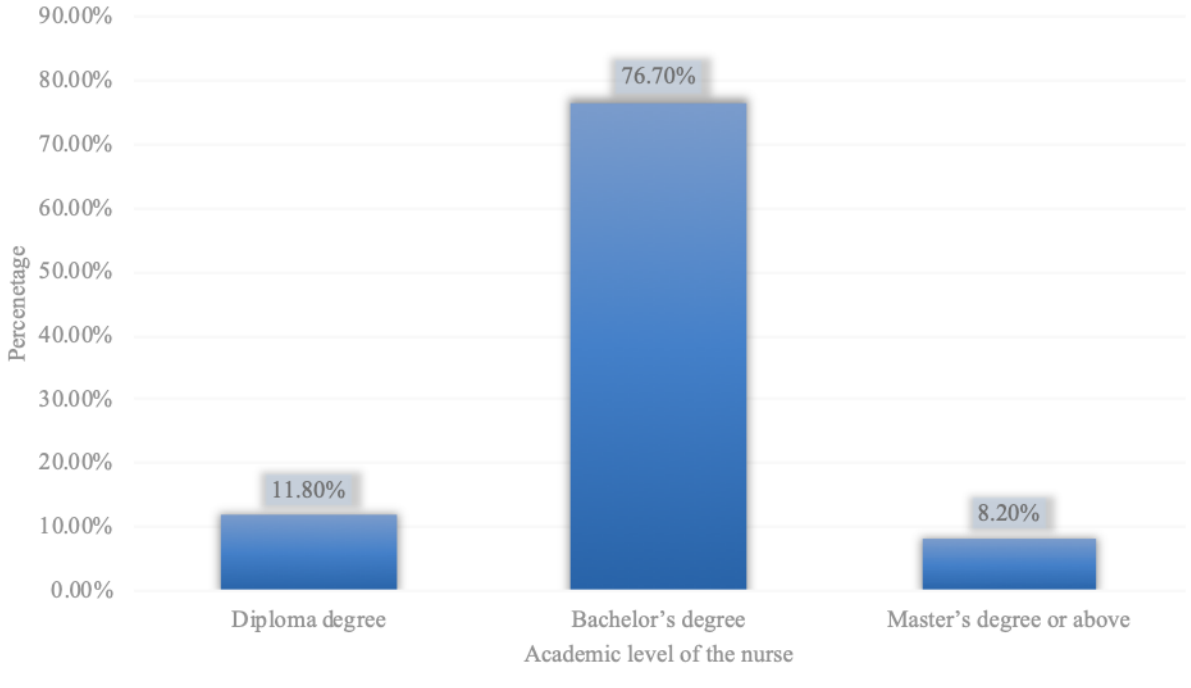


Figure 1.9: Distribution of nurses' academic level



Part 2: Nurse’s perception and practice of debriefing

The nurses' responses to debriefing as a method of fatigue release were analyzed, revealing insights into their experiences and perceptions. Among the participants, 73.5% reported experiencing stress in their workplace, while 26.5% did not. For those who experienced stress, the frequency varied, with 31.1% feeling "big" stress, 50.6% experiencing "moderate" stress, and 12.8% dealing with a "High" stress load.

The role of employers in helping nurses cope with stress was examined, with 55.9% stating that their employers do offer support, while 44.1% did not find such assistance. In terms of adequacy, 52.2% felt that the peers support was "fair enough" in reducing stress levels. Regarding debriefing after stressful situations, 45.3% reported that their peers did offer debriefing sessions, and among those, 60.2% indicated these sessions occurred "often."

The existence of formal guidelines for debriefing within hospitals was found among 32.7% of respondents, and among all the nurses, 43.3% believed these guidelines to be "extremely important." On a broader scale, when asked about the importance of debriefing after a stressful incident, 51.8% stated it was "extremely important." Interestingly, 31.8% of nurses reported having participated in debriefing sessions after stressful incidents, whereas 68.2% had not taken part.

These highlighted percentages highlight the varying perspectives of nurses on stress, employer support, debriefing, and its importance. It becomes evident that a significant portion of nurses experience stress, with differing opinions on the effectiveness of support and the value of debriefing, showcasing the need for tailored approaches to address the well-being of healthcare professionals. The following figures illustrate the distribution of the nurses’ responses to questions related to stressors and debriefing, taking into consideration that valid percentages were illustrated, while missing percentages were excluded from the illustration.

Table 4.2: Distribution of nurses' responses to items of debriefing as a method of fatigue release .

Items	**Answers**	**Frequency**	**Percentage**
Do you experience stress in your workplace?	Yes	180	73.5%
	No	65	26.5%
If yes, how often do you experience stress at work?	Very big	23	12.8%
	Big	56	31.1%
	Moderate	91	50.6%
	Little	9	5.0%
	Very little	1	0.6%
Does your employer help you cope with stress at work?	Yes	137	55.9%
	No	108	44.1%
How adequate do you feel this is in reducing your stress levels?	Very adequate	12	8.8%
	Fair enough	71	52.2%
	Help a bit	46	33.8%
	Not adequate	7	5.1%
Does your employer offer debriefing after stressful situations at work?	Yes	111	45.3%
	No	134	54.7%
If yes, how often?	Always	6	5.6%
	Often	65	60.2%
	Little	36	33.3%
	Rarely	1	0.9%
Are there formal guidelines in your hospital on debriefing?	Yes	80	32.7%
	No	165	67.3%
How important do you feel are hospital guidelines on debriefing?	Extremely Important	106	43.3%
	Somewhat Important	66	26.9%
	Somewhat unimportant	42	17.1%
	Not Important at all	26	10.6%
	Missing	5	2.0%
In your opinion how important is debriefing after a stressful incident?	Extremely Important	127	51.8%
	Somewhat Important	60	24.5%
	Somewhat unimportant	49	20.0%
	Not Important at all	6	2.4%
	Missing	3	1.2%
Have you ever taken part in a debriefing session after a stressful incident?	Yes	78	31.8%
	No	167	68.2%

Figure 2.1: Do you experience stress in your workplace?

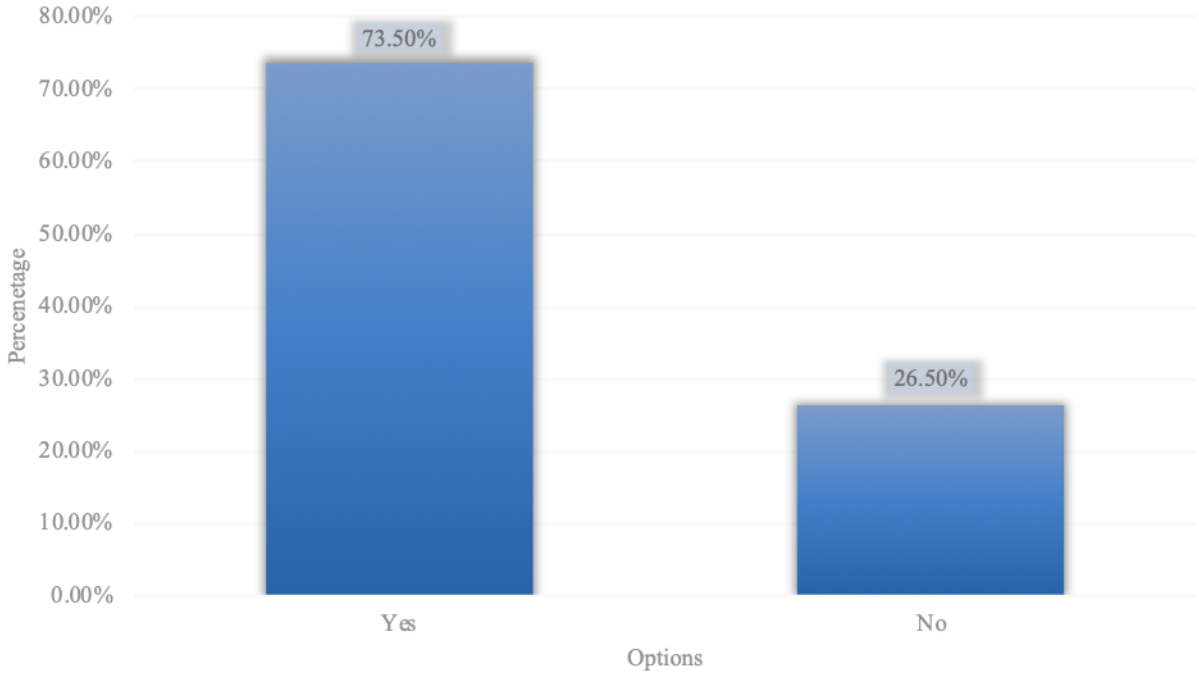


Figure 2.2: If yes, how often do you experience stress at work?

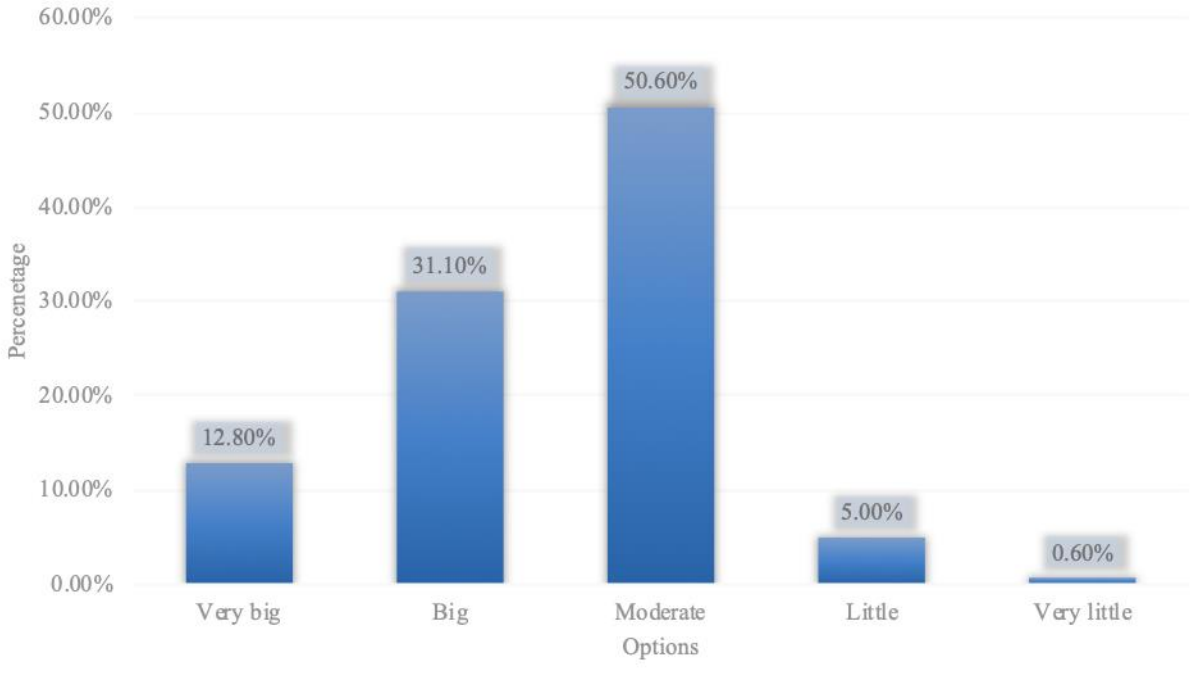


Figure 2.3: Does your employer help you cope with stress at work?

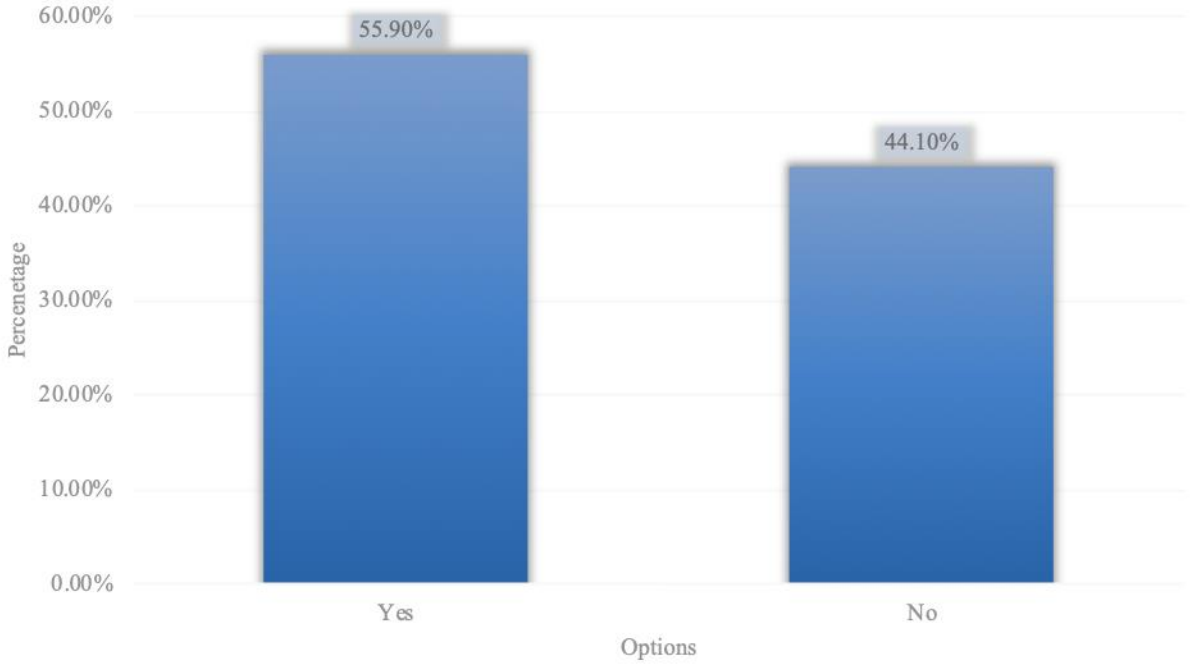


Figure 2.4: How adequate do you feel this is in reducing your stress levels?

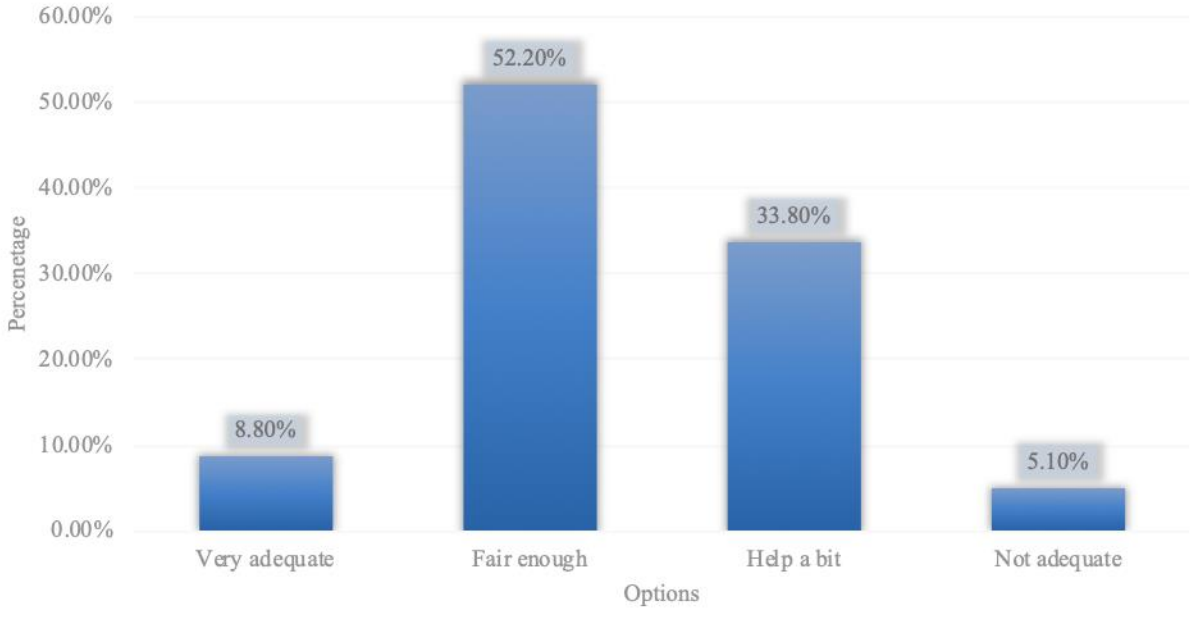


Figure 2.5: Does your employer offer debriefing after stressful situations at work?

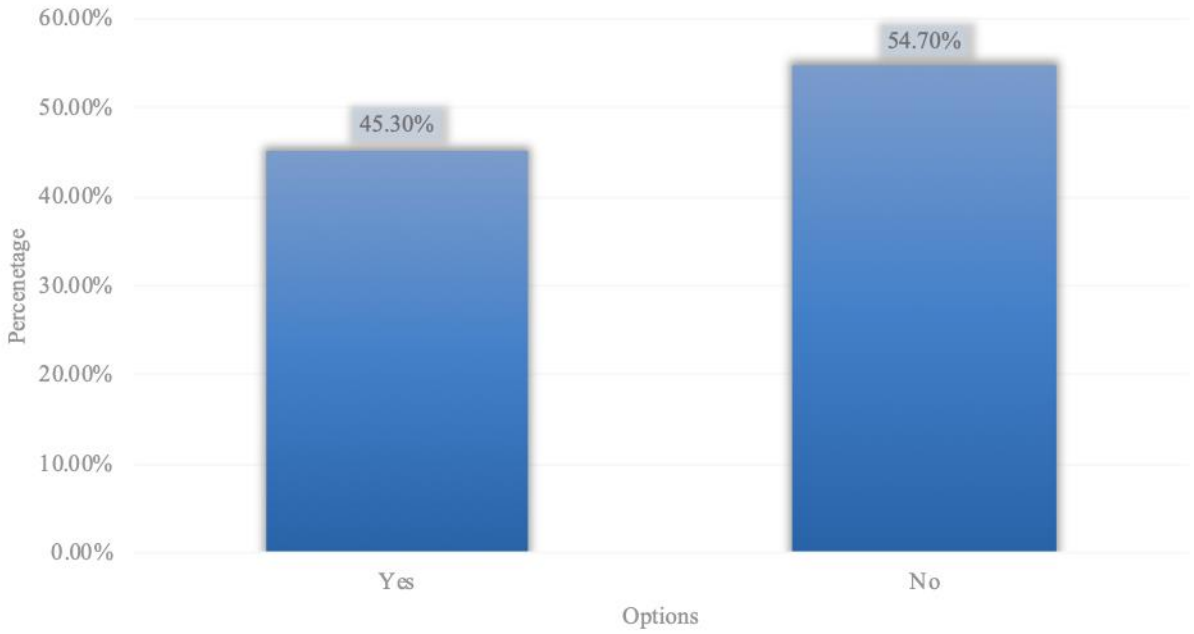


Figure 2.6: How often does your employer offer debriefing after stressful situations at work?

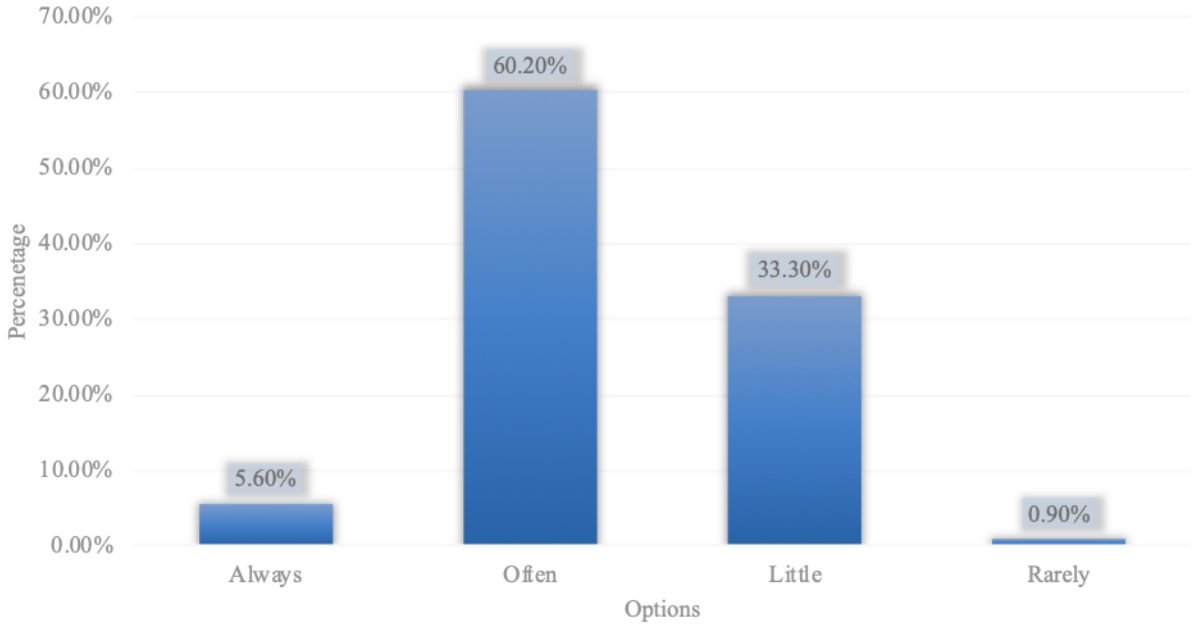


Figure 2.7: Are there formal guidelines in your hospital on debriefing?

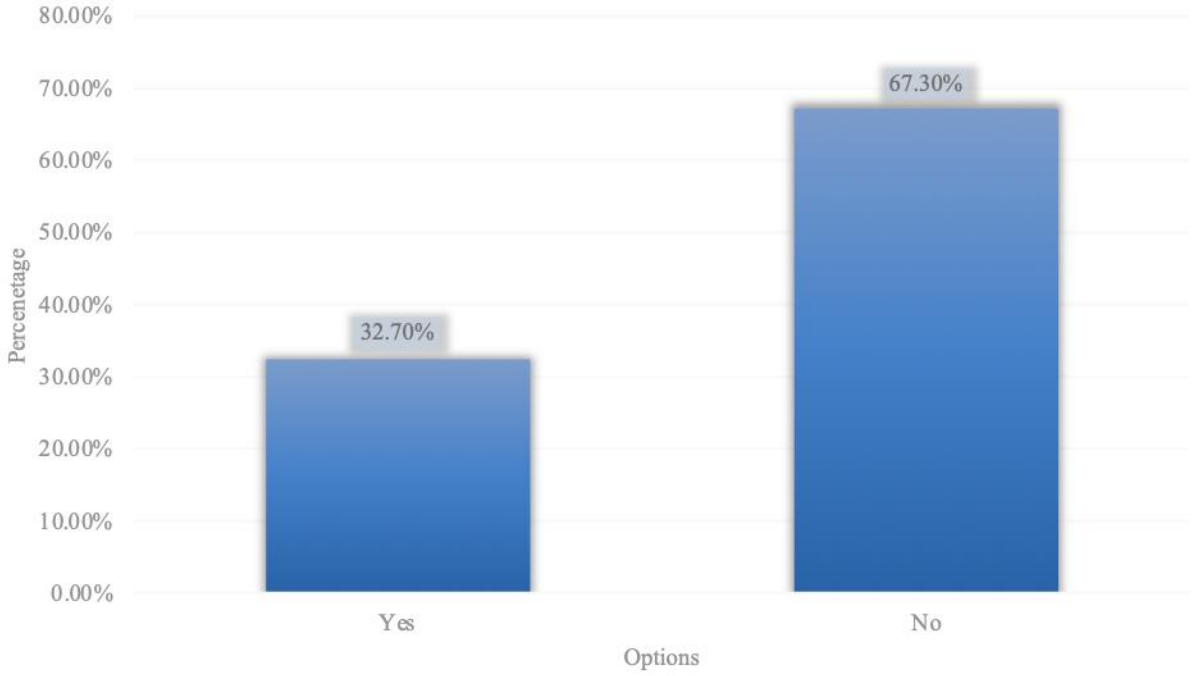
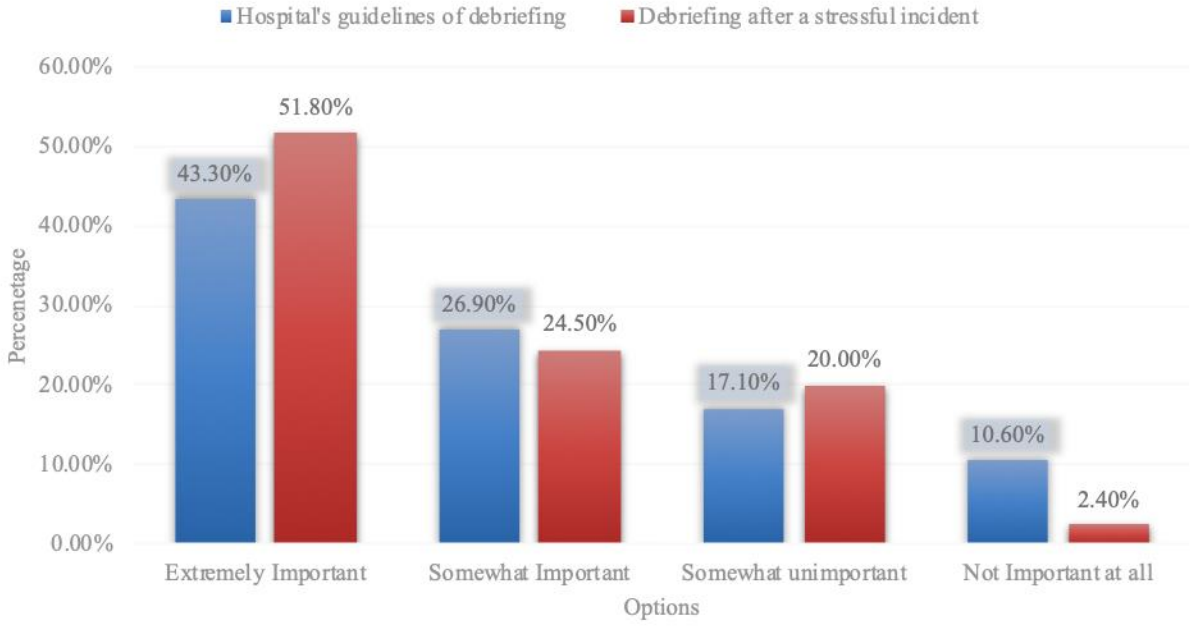
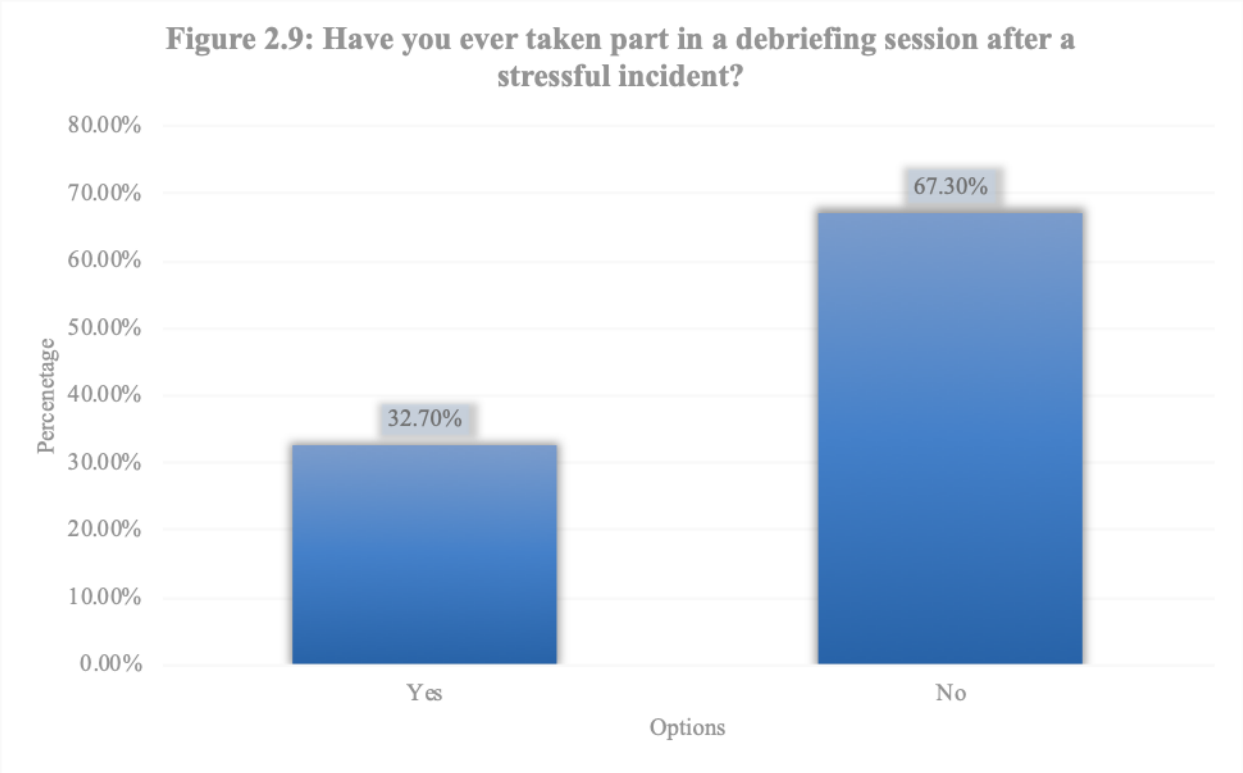


Figure 2.8: How much is debriefing important?





Part 3: Professional Quality of Life (ProQoL) Scale

The distribution of nurses' responses to the ProQoL scale revealed diverse levels of happiness, with 37.1% indicating they were "Often" happy and 20.0% feeling "Very often" happy. 46.5% of nurses expressed being preoccupied with multiple individuals they aided, categorizing this sentiment as "Very often," revealing potential challenges in managing multiple responsibilities. A sense of satisfaction from aiding people was reported by 41.6% "Sometimes" and 35.9% "Often," reflecting the rewarding aspects of their work, while feeling connected to others was resonated with 40.0% of nurses, marked "Often," and 26.1% marked "Very often," indicating strong interpersonal connections.

The response to unexpected sounds varied, with 38.8% of nurses jumping "Often" and 28.6% reacting "Very often," reflecting heightened startle responses. After helping, nurses experienced invigoration in varying degrees, with 34.7% feeling this "Often" and 34.3% feeling it "Sometimes," suggesting a range of emotional outcomes. The challenge of separating personal life from their helping role was evident for 35.1% of nurses, labeled as "Sometimes," and an additional 21.6% felt this "often," highlighting potential work-life boundary struggles.

31.8% of nurses reported a decline in productivity due to sleep loss over traumatic experiences, categorized as "Never," indicating varying degrees of impact on work

performance. Nurses' recognition of being affected by traumatic stress fluctuated, with 36.7% acknowledging this "Sometimes" and 31.0% recognizing it "Often," revealing different levels of perceived impact. A sense of entrapment due to their role as helpers was shared by 35.9% "sometimes" and 31.4% "often," indicating potential challenges in managing job-related stress.

The feeling of being "on edge" due to helping was noted by 32.7% "sometimes," underlining the emotional strain associated with their work. Liking their role as helpers was evident for 37.6% "often" and 26.1% "very often," reflecting high job satisfaction levels. Nurses experiencing depression due to traumatic experiences varied, with 32.7% feeling this "Sometimes" and 32.2% "Often," indicating fluctuating emotional responses.

Also, 30.6% of nurses reported experiencing the trauma of those they helped "Rarely," suggesting that vicarious trauma was a significant emotional challenge, while an approximate percentage (32.7%) felt this "Sometimes.". A notable 41.6% of nurses held sustaining beliefs "Often," and 24.9% experienced this "Sometimes," revealing fluctuations in their emotional resilience. Satisfaction with keeping up with techniques was voiced by 40.4% "Often" and 26.9% "Very often," reflecting their commitment to professional growth.

The sentiment of being their desired selves was strong, with 37.6% feeling this "Often" and 36.3% "Very often," indicating positive self-identification. Also, 41.2% of nurses felt satisfied with their work "Often," while 28.6% expressed this "Very often," underscoring the fulfillment they found in their roles. Work-related exhaustion affected 42.9% of nurses "Often," and 23.7% felt this "Very often," highlighting the prevalence of burnout.

Positive thoughts about helping and its potential were prevalent, with 38.0% experiencing this "Often" and 30.6% "Sometimes," showcasing the presence of positive emotional associations. The feeling of being overwhelmed by workload was shared by 33.5% "Often" and an equal percentage "Sometimes," indicating the ongoing challenge of managing responsibilities. A strong belief in making a difference was held by 44.5% "Often," and 26.9% "Sometimes," reflecting their motivation and sense of impact.

Avoidance of certain triggers due to frightening experiences was reported by 33.1% "Often," and 29.8% "Sometimes," revealing strategies to cope with distressing emotions. A sense of pride in their helping work was evident for 37.1% "Often" and 30.2% "Very often," reflecting their positive self-perception. Intrusive thoughts due to helping were experienced

by 30.2% "Often," and 25.7% "Sometimes," illustrating the psychological impact of their roles.

Feeling "bogged down" by the system was acknowledged by 31.0% "Sometimes" and less percentage “Often, 26.5%" revealing frustrations with administrative aspects. The notion of being a "success" as a helper was significant for 38.8% "Often," indicating their positive self-assessment. Additionally, 30.2% of nurses reported not being able to recall important parts of their work with trauma victims "Sometimes," suggesting the potential impact of emotional strain on memory.

A caring disposition was present in 36.7% of nurses "Often," and 33.5% "Very often," reflecting their strong empathetic qualities. The contentment of choosing their current work path was strong, with 31.0% feeling this "Very often" and 29.8% "Often," highlighting their overall satisfaction with their career choice.

Table 4.3: Distribution of nurses’ responses to items of ProQoL scale

Statement	**Never**		**Rarely**		**Sometimes**		**Often**		**Very often**	
	F	**%**	**F**	**%**	**F**	**%**	**F**	**%**	**F**	**%**
1. I am happy.	4	1.6%	19	7.8%	82	33.5%	91	37.1%	49	20.0%
2. I am preoccupied with more than one person I help.	2	0.8%	7	2.9%	33	13.5%	89	36.3%	114	46.5%
3. I get satisfaction from being able to help people.	2	0.8%	7	2.9%	46	18.8%	102	41.6%	88	35.9%
4. I feel connected to others.	6	2.4%	25	10.2%	64	26.1%	98	40.0%	52	21.2%
5. I jump or am startled by unexpected sounds.	10	4.1%	17	6.9%	70	28.6%	95	38.8%	53	21.6%
6. I feel invigorated after working with those I help.	12	4.9%	23	9.4%	84	34.3%	85	34.7%	41	16.7%
7. I find it difficult to separate my personal life from my life as a helper.	24	9.8%	46	18.8%	86	35.1%	53	21.6%	36	14.7%
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.	78	31.8%	54	22.0%	39	15.9%	57	23.3%	17	6.9%
9. I think that I might have been affected by the traumatic stress of	14	5.7%	34	13.9%	90	36.7%	76	31.0%	31	12.7%

those I help.										
10. I feel trapped by my job as a helper.	10	4.1%	36	14.7%	88	35.9%	77	31.4%	34	13.9%
11. Because of my helping, I have felt "on edge" about various things.	20	8.2%	43	17.6%	80	32.7%	66	26.9%	36	14.7%
12. I like my work as a helper.	14	5.7%	21	8.6%	54	22.0%	92	37.6%	64	26.1%
13. I feel depressed because of the traumatic experiences of the people I help.	19	7.8%	36	14.7%	80	32.7%	79	32.2%	31	12.7%
14. I feel as though I am experiencing the trauma of someone I have helped.	42	17.1%	75	30.6%	80	32.7%	31	12.7%	17	6.9%
15. I have beliefs that sustain me.	3	1.2%	21	8.6%	61	24.9%	102	41.6%	58	23.7%
16. I am pleased with how I am able to keep up with helping techniques and protocols.	5	2.0%	11	4.5%	64	26.1%	99	40.4%	66	26.9%
17. I am the person I always wanted to be.	3	1.2%	19	7.8%	42	17.1%	92	37.6%	89	36.3%
18. My work makes me feel satisfied.	5	2.0%	16	6.5%	53	21.6%	101	41.2%	70	28.6%
19. I feel worn out because of my work as a helper.	6	2.4%	19	7.8%	57	23.3%	105	42.9%	58	23.7%
20. I have happy thoughts and feelings about those I help and how I could help them.	7	2.9%	7	2.9%	75	30.6%	93	38.0%	63	25.7%
21. I feel overwhelmed because my case workload seems endless.	5	2.0%	25	10.2%	82	33.5%	82	33.5%	51	20.8%
22. I believe I can make a difference through my work.	8	3.3%	9	3.7%	66	26.9%	109	44.5%	53	21.6%
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.	22	9.0%	39	15.9%	73	29.8%	81	33.1%	30	12.2%
24. I am proud of what I can do to help.	9	3.7%	16	6.5%	55	22.4%	91	37.1%	74	30.2%

25. As a result of my helping, I have intrusive, frightening thoughts.	32	13.1%	46	18.8%	63	25.7%	74	30.2%	30	12.2%
26. I feel "bogged down" by the system.	20	8.2%	39	15.9%	76	31.0%	65	26.5%	45	18.4%
27. I have thoughts that I am a "success" as a helper.	10	4.1%	15	6.1%	47	19.2%	95	38.8%	78	31.8%
28. I can't recall important parts of my work with trauma victims.	29	11.8%	44	18.0%	74	30.2%	62	25.3%	36	14.7%
29. I am a very caring person.	9	3.7%	16	6.5%	48	19.6%	90	36.7%	82	33.5%
30. I am happy that I chose to do this work.	14	5.7%	18	7.3%	64	26.1%	73	29.8%	76	31.0%

The following table shows the descriptive statistics of the subscales that are derived from ProQoL scale, which are compassion satisfaction (CS) scale, burnout (BO) scale and secondary traumatic stress (STS) scale, in which they were calculated according to the provided guidelines for their calculation, by summing up the scores of the individual items for each nurse, giving a total score out of 50 (10 of 5-Likert scale statements for each subscale), with a classification of the scores into three levels (low, average and high). The table shows that majority of the nurses were in the average classification of compassion satisfaction (68.6%), burnout (88.2%) and secondary traumatic stress (91.8%) scores, with 0% of the nurses experiencing a high level of burnout, while only 1.2% and 3.7% of the nurses experiencing low levels of compassion satisfaction and secondary traumatic stress levels, respectively. The following figures illustrate the description of the subscales of ProQoL.

Table 4.4: Descriptive statistics of the ProQoL subscales

Subscale	***Low***		***Average***		***High***		***Mean***	***SD***
	F	**%**	**F**	**%**	**F**	**%**		
Compassion Satisfaction (CS)	3	1.2%	168	68.6%	74	30.2%	38.045	6.310
Burnout (BO)	29	11.8%	216	88.2%	0	0.0%	27.559	4.036
Secondary Traumatic Stress (STS)	9	3.7%	225	91.8%	11	4.5%	32.935	5.277

Figure 3.1: Distribution of ProQoL subscales classification

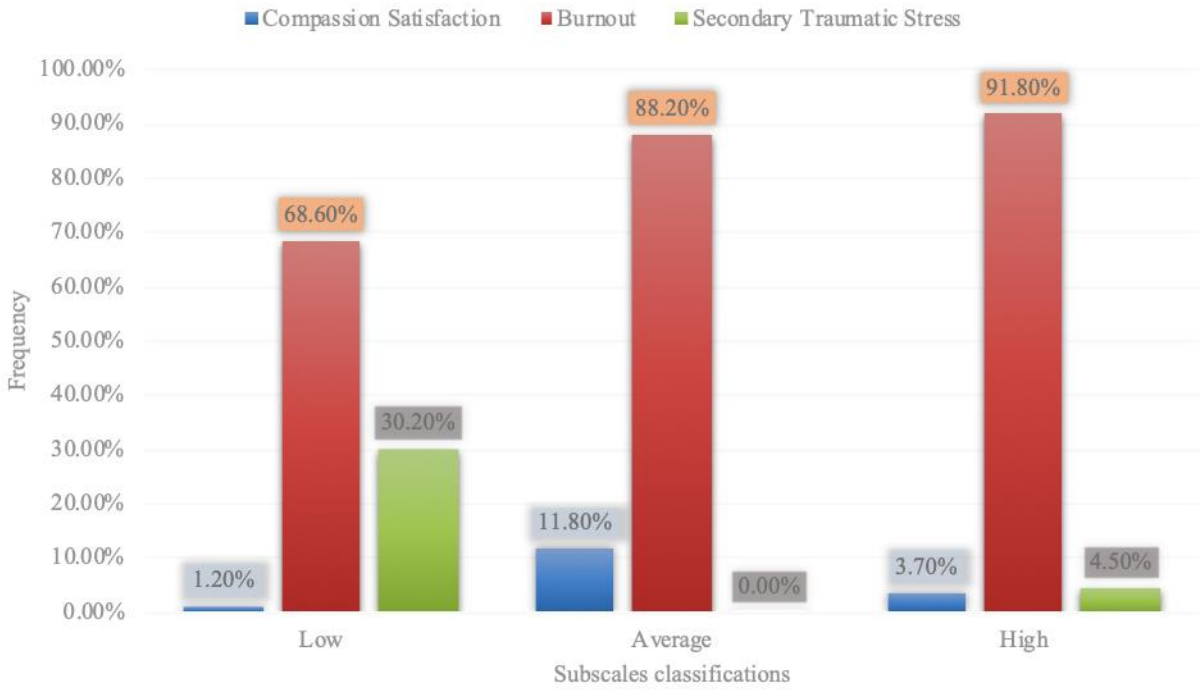
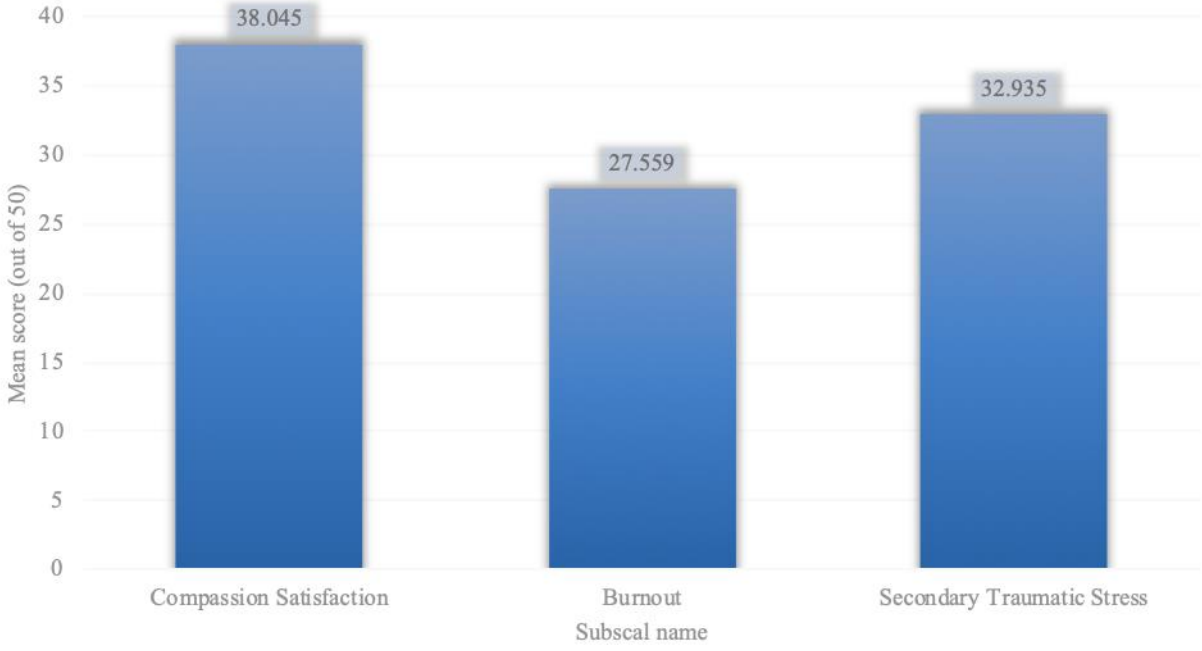


Figure 3.2: Description of mean scores of ProQoL subscales



Part 4: Analytical results

This section is dedicated to investigating the relationship between study's independent and dependent variables to achieve the study's objectives, using the suitable inferential test.

The following table investigated the differences in the practicing of debriefing sessions among the ICU nurses according to their demographic and professional factors, and showed that higher percentages of ICU nurses who practice debriefing sessions are found among nurses who work for more hours per week (p-value = 0.044), where 39.5% of the nurses who work for 41 – 100 hours per week practice debriefing sessions, compared to 24.6% of the nurses who work 25 to 40 hours per week. Also, significantly higher percentages of nurses who practice debriefing sessions were found when they care for more patients (p-value 0.007), as 22.3% of the nurses who care for 3 – 6 patients, compared to 48.3% of the nurses who care for 7 – 10 patients, practice debriefing sessions.

Additionally, significantly higher percentages of practicing debriefing sessions were found among divorced (72.7%) nurses, compared to both married (30.7%) and single (27.8%) nurses (p-value = 0.010). Lastly, lower percentages of debriefing session practices were found among nurses with bachelor's degree (27.7%), compared to who hold diploma (44.8%) or master's and above (45.0%) degrees, but the difference was found to be insignificant (p-value = 0.068), as well as the rest of the demographic and professional factors (p-value > 0.05).

Table 4.5: Differences in the practice of debriefing sessions among the nurses according to their demographic and professional factors (percentages are within the values of factors)

Factor	**Values**	**Debriefing sessions**				**X^2**	**p-value**
		Yes		**No**			
		F	**%**	**F**	**%**		
Place of work	Al-Mizan	13	27.7%	34	72.3%	12.021	0.100
	Alia Governmental	3	14.3%	18	85.7%		
	Beit Jala	4	21.1%	15	78.9%		
	Arab Society	8	25.0%	24	75.0%		
	Caritas Baby	7	43.8%	9	56.3%		
	Holy Family	4	40.0%	6	60.0%		
	Al-Ahli Hospital	26	46.4%	30	53.6%		

	PMC	13	29.5%	31	70.5%		
Place of residence	Hebron	44	33.1%	89	66.9%	0.520	0.771
	Bethlehem	20	29.0%	49	71.0%		
	Ramallah	13	35.1%	24	64.9%		
Years of experience	1 – 5 years	44	36.1%	78	63.9%	2.830	0.243
	6 – 10 years	18	24.7%	55	75.3%		
	> 10 years	14	29.8%	33	70.2%		
Working hours per week	1 – 24 hours	2	25.0%	6	75.0%	6.255	0.044
	25 – 40 hours	29	24.6%	89	75.4%		
	41 – 100 hours	47	39.5%	72	60.5%		
Number of cared patients per day	1 – 3 patients	39	37.5%	65	62.5%	9.821	0.007
	3 – 6 patients	25	22.3%	87	77.7%		
	7 – 10 patients	14	48.3%	15	51.7%		
Age in complete years	20 – 29 years old	45	32.1%	95	67.9%	1.834	0.400
	30 – 39 years old	19	26.8%	52	73.2%		
	40 years or older	11	40.7%	16	59.3%		
Gender	Male	39	32.0%	83	68.0%	0.019	0.890
	Female	38	31.1%	84	68.9%		
Marital status	Single	25	27.8%	65	72.2%	9.277	0.010
	Married	43	30.7%	97	69.3%		
	Divorced	8	72.7%	3	27.3%		
Academic level	Diploma degree	13	44.8%	16	55.2%	5.379	0.068
	Bachelor’s degree	52	27.7%	136	72.3%		
	≥ Master’s degree	9	45.0%	11	55.0%		

Table 4.6 investigates the differences in compassion satisfaction subscale scores according to various demographic and professional factors among ICU nurses. The mean compassion satisfaction scores for different groups are showcased, accompanied by their standard deviations, and the table highlights the presence or absence of significant differences through pertinent statistical tests.

Although "Years of experience" might be expected to correlate with compassion satisfaction, the differences were not statistically significant ($F = 2.090$, $p = 0.126$), implying

that nurses' length of experience doesn't substantially affect their compassion satisfaction levels.

In contrast, the "Marital status" factor emerges as noteworthy. The significant difference ($F = 3.588$, $p = 0.029$) in compassion satisfaction scores among different marital statuses suggests that nurses who are divorced experience notably lower levels of compassion satisfaction compared to their single or married counterparts.

In summary, Table 4.6 reveals that while several factors were examined in relation to compassion satisfaction scores among ICU nurses, only the "Marital status" factor yielded a statistically significant difference. This implies that divorced nurses experience lower levels of compassion satisfaction, underlining the importance of considering personal circumstances when assessing job-related emotional well-being. Other demographic and professional factors, such as place of work, place of residence, years of experience, working hours per week, number of cared patients per day, age, gender, and academic level, do not seem to significantly impact compassion satisfaction scores among ICU nurses.

Table 4.6: Differences in compassion satisfaction subscale scores according to the demographic and professional factors of the ICU nurses

Factors	***Values***	***Mean CS***	***SD***	***Test value***	***p-value***
Place of work	Al-Mizan	39.064	5.936	$F = 1.513$	0.163
	Alia Governmental	38.095	6.395		
	Beit Jala	34.895	5.858		
	Arab Society	37.188	5.270		
	Caritas Baby	38.250	7.095		
	Holy Family	41.900	5.782		
	Al-Ahli Hospital	37.804	6.800		
	PMC	38.273	6.442		
Place of residence	Hebron	37.820	6.635	$F = 0.239$	0.787
	Bethlehem	38.464	5.994		
	Ramallah	37.892	6.199		
Years of experience	1 – 5 years	37.656	6.527	$F = 2.090$	0.126
	6 – 10 years	37.781	6.438		
	> 10 years	39.787	5.336		

Working hours per week	1 – 24 hours	35.000	7.270	$F = 0.969$	0.381
	25 – 40 hours	38.102	5.949		
	41 – 100 hours	38.193	6.593		
Number of cared patients per day	1 – 3 patients	37.865	6.545	$F = 0.245$	0.783
	3 – 6 patients	38.018	6.081		
	7 – 10 patients	38.793	6.494		
Age in complete years	20 – 29 years old	37.479	5.918	$F = 1.221$	0.297
	30 – 39 years old	38.831	6.594		
	40 years or older	38.630	7.581		
Gender	Male	37.525	6.234	$t = - 1.174$	0.242
	Female	38.467	6.309		
Marital status	Single	38.178	6.556	$F = 3.588$	0.029
	Married	38.343	6.180		
	Divorced	33.091	5.319		
Academic level	Diploma degree	32.966	5.691	$F = 1.325$	0.268
	Bachelor's degree	33.255	4.974		
	≥ Master's degree	30.500	6.902		

The next table investigated the differences in burnout subscale according to nurses' demographic and professional factors. It shows that both place of work and place of residence are significantly related to differences in burnout subscales (p-value < 0.001), where the highest burnout subscale scores were found among nurses who work in Palestine Medical Complex (mean = 28.321 ± 4.006) compared to others, with higher burnout scores among nurses who resides in Ramallah city (mean = 28.874 ± 3.952) compared to Bethlehem (mean = 26.087 ± 4.361) and Hebron (mean = 27.957 ± 3.748).

Additionally, the number of patients that the nurse cares for is significantly associated with the burnout score, where nurses who cared for 7 – 10 patients per day had a higher mean burnout score (29.448 ± 2.910) than who cared for 1 – 3 patients (27.606 ± 3.878), as an example (p-value = 0.015). Also, male nurses tend to significantly have higher mean burnout scores (28.148 ± 3.800) than female nurses (26.951 ± 4.199). The rest of the factors had no significant relationship with the mean burnout subscale scores.

Table 4.7: Differences in burnout subscale scores according to the demographic and professional factors of the ICU nurses

Factors	***Values***	***Mean BO***	***SD***	***Test value***	***p-value***
Place of work	Al-Mizan	27.234	4.345	$F = 3.676$	< 0.001
	Alia Governmental	27.952	3.090		
	Beit Jala	27.474	3.893		
	Arab Society	27.750	3.759		
	Caritas Baby	24.375	4.288		
	Holy Family	23.900	5.043		
	Al-Ahli Hospital	28.321	3.358		
	PMC	28.636	4.006		
Place of residence	Hebron	27.947	3.748	$F = 7.155$	< 0.001
	Bethlehem	26.087	4.361		
	Ramallah	28.784	3.952		
Years of experience	1 – 5 years	27.254	4.024	$F = 1.798$	0.168
	6 – 10 years	28.260	3.771		
	> 10 years	27.064	4.420		
Working hours per week	1 – 24 hours	28.250	2.765	$F = 0.126$	0.882
	25 – 40 hours	27.508	4.348		
	41 – 100 hours	27.563	3.802		
Number of cared patients per day	1 – 3 patients	27.606	3.878	$F = 4.270$	0.015
	3 – 6 patients	27.027	4.301		
	7 – 10 patients	29.448	2.910		
Age in complete years	20 – 29 years old	27.664	3.960	$F = 0.207$	0.813
	30 – 39 years old	27.704	3.867		
	40 years or older	27.148	4.905		
Gender	Male	28.148	3.800	$t = 2.334$	0.020
	Female	26.951	4.199		
Marital status	Single	27.422	3.952	$F = 0.117$	0.890
	Married	27.636	4.024		
	Divorced	27.909	5.127		
Academic level	Diploma degree	27.414	4.255	$F = 1.108$	0.332
	Bachelor's degree	27.670	3.818		
	≥ Master's degree	26.250	5.884		

Lastly, the secondary traumatic stress subscale scores were compared according to the demographic and professional factors of the nurses, and showed that significantly higher mean STS scores were found among nurses who reside in Ramallah (mean = 34.243 ± 5.214) compared to who reside in Hebron (33.203 ± 5.314) and Bethlehem (31.638 ± 5.236, p-value = 0.035). Also, a greater number of patients that the nurse care for daily is associated with higher mean STS scores (p-value = 0.012), as the mean score was higher when the number is 7 – 10 patients (mean = 35.552 ± 5.214) compared to 1 – 3 patients (mean 32.894 ± 5.304). Moreover, male nurses significantly have higher STS scores (mean = 33.598 ± 4.827) than

female nurses (mean = 32.164 ± 5.514, p-value = 0.032), while the rest of the factors where not significantly related to significant differences in mean STS subscale scores.

Table 4.8: Differences in secondary traumatic stress subscale scores according to the demographic and professional factors of the ICU nurses

Factors	**Values**	**Mean STS**	**SD**	**Test value**	**p-value**
Place of work	Al-Mizan	32.851	4.399	F = 2.018	0.054
	Alia Governmental	34.381	4.353		
	Beit Jala	31.526	4.551		
	Arab Society	33.219	4.301		
	Caritas Baby	29.750	5.235		
	Holy Family	30.800	5.308		
	Al-Ahli Hospital	32.946	6.443		
	PMC	34.364	5.392		
Place of residence	Hebron	33.203	5.314	F = 3.392	0.035
	Bethlehem	31.638	5.236		
	Ramallah	34.243	5.214		
Years of experience	1 – 5 years	32.516	5.148	F = 0.760	0.469
	6 – 10 years	33.356	5.623		
	> 10 years	33.362	5.235		
Working hours per week	1 – 24 hours	32.875	6.334	F = 0.655	0.520
	25 – 40 hours	32.542	5.092		
	41 – 100 hours	33.328	5.403		
Number of cared patients per day	1 – 3 patients	32.894	5.304	F = 4.520	0.012
	3 – 6 patients	32.295	5.104		
	7 – 10 patients	35.552	5.214		
Age in complete years	20 – 29 years old	32.750	4.867	F = 0.722	0.487
	30 – 39 years old	33.521	5.374		
	40 years or older	32.296	6.866		
Gender	Male	33.598	4.827	t = 2.162	0.032
	Female	32.164	5.514		
Marital status	Single	32.189	4.990	F = 2.651	0.073
	Married	33.564	5.379		
	Divorced	31.000	5.899		
Academic level	Diploma degree	32.966	5.691	F = 2.494	0.085
	Bachelor’s degree	33.255	4.974		
	≥ Master’s degree	30.500	6.902		

The following table investigated the impact of debriefing sessions as predictors for the categories of ProQoL domains , using a regression model. The table shows that none of the domains were predicted by the practicing of debriefing sessions among the Palestinian ICU nurses in a significant way (p-value > 0.05).

Table 4.9: Investigation of debriefing as a predictor for the ProQoL domains among Palestinian ICU nurses (reference category is low ProQoL domain category)

Domain	***Category***	***B***	***Wald***	***p-value***	***OR***	***95% CI***
CS	Average	- 1.413	1.308	0.253	0.243	0.022 – 2.742
	High	- 1.619	1.673	0.196	0.198	0.017 – 2.303
BO	Average	0.042	0.010	0.921	1.043	0.452 – 2.409
	High	-	-	-	-	-
STS	Average	- 0.123	0.029	0.865	0.885	0.215 – 3.640
	High	0.875	0.884	0.347	2.400	0.387 – 14.881

CHAPTER FIVE

DISCUSSION

5.1 Introduction

In the following discussion, we embark on a profound exploration of the findings from the study "Compassion Fatigue in Relation to Debriefing among Intensive Care Unit Nurses: The Palestinian Case." Our journey unfolds through the lens of compassion fatigue, a pervasive challenge in the nursing profession. As we weave the intricate threads of workplace stress, employer support, debriefing practices, and coping mechanisms, we illuminate the dynamic interplay between these elements within the Palestinian healthcare context. By aligning our results with existing research and delving into their implications, this chapter serves as a bridge between empirical discovery and the quest for enhanced emotional well-being among ICU nurses, ultimately contributing to the evolution of compassionate patient care.

5.2 Summary of the results

The analysis of the study data revealed no significant correlation between years of experience and compassion satisfaction among ICU nurses. However, the "Marital status" factor significantly impacted compassion satisfaction scores, suggesting that divorced nurses experience lower levels. Other factors, such as place of work, residence, years of experience, working hours, and academic level, did not significantly impact compassion satisfaction scores among ICU nurses.

The study reveals significant differences in burnout subscales among nurses based on demographic and professional factors. Workplace and residence are significantly related, with higher burnout scores found in nurses working in Palestine Medical Complex and Ramallah city. The number of patients cared for also affects burnout scores, with male nurses having higher mean scores than female nurses. No other factors had a significant relationship with burnout subscale scores.

The study compared secondary traumatic stress subscale scores among nurses in Ramallah, Hebron, and Bethlehem , and showed that significantly higher mean STS scores were found among nurses who reside in Ramallah . Also, a greater number of patients that the nurse care for daily is associated with higher mean STS scores , as the mean score was

higher when the number is 7 – 10 patients . Moreover, male nurses significantly have higher STS scores .

5.3 Demographic and professional characteristics of the ICU nurses

In terms of demographic characteristics, our study highlighted the diverse makeup of ICU nurses in terms of age, experience, gender, academic qualifications, and other factors. While our study indicated that the majority of nurses were in the 20 to 29 years old range (57.1%), McFadden & Harms(2022) categorized nurses based on years of experience and found that the age group with 0-2 years of experience had the highest frequency. Additionally, our study presented specific details about patient load distribution and working hours, which McFadden & Harms did not provide in their study. Interestingly, both studies (our study and McFadden & Harms) revealed a similar trend in compassion fatigue scores, with McFadden & Harms reporting that almost all age groups demonstrated "mild" levels of compassion fatigue. It's noteworthy that while our study examined compassion fatigue in relation to debriefing, McFadden & Harms focused on the interplay between compassion fatigue, compassion satisfaction, specialty nursing, years of experience, and working with COVID-19 patients in the ICU setting. Overall, these two studies collectively shed light on the multifaceted nature of compassion fatigue among ICU nurses, with each study offering unique insights into various aspects of this critical issue.

5.4 Nurse’s perception and practice of debriefing

In our study, a substantial portion of nurses reported experiencing workplace stress (73.5%), and this aligns with previous research where stressors in healthcare settings have been acknowledged (Golshiri et al., 2012) . The variation in the frequency of stress experienced, ranging from "big" to "very big," mirrors the complex nature of stressors in the nursing profession (Smith et al., 2014). The availability of employer support was noted by 55.9% of our study participants, echoing the importance of organizational assistance in managing stress, as highlighted in previous studies (Banovcinova & Baskova, 2014; McVicar, 2003). However, our study found that 44.1% did not receive such support, underlining the potential for improvement in this aspect.

The concept of debriefing, as defined in our study, resonates with its purpose of discussing experiences and emotions, akin to counseling. This aligns with the description of

debriefing in previous research (Smith et al., 2014). The existence of formal guidelines for debriefing in hospitals (32.7%) and nurses' recognition of its importance (43.3%) parallel the emphasis on structured debriefing sessions in previous studies as well (Fontenot & White, 2019; Maytum et al., 2004). The discrepancy between the belief in the importance of debriefing (51.8%) and the actual participation rate (31.8%) indicates a potential gap that might be addressed through tailored interventions and increased awareness.

Our study's emphasis on the diverse coping mechanisms nurses employ to manage stress aligns with the findings from previous research (Smith et al., 2014; Melvin, 2012; Perry et al., 2011). While some nurses seek solace in mutual support and conversations with coworkers, others engage in self-reflection, maintain a work-life balance, and even seek therapy if needed. These coping strategies echo the multifaceted approaches mentioned in previous studies (Fontenot & White, 2019; Maytum et al., 2004). The notion that self-awareness might lead to higher reported stress scores after debriefing sessions also reflects the intricate dynamics of managing stress and emotional well-being.

The importance of employer involvement in managing compassion fatigue, as highlighted in previous studies, resonates with our findings. The idea that employers play a role in assisting nurses to recognize and cope with compassion fatigue underscores the shared responsibility in healthcare organizations (Maytum et al., 2004). Additionally, the observed shift in job roles or hours due to compassion fatigue, as mentioned in previous studies, suggests the significant impact of this phenomenon on career decisions and underscores the need for comprehensive support mechanisms (Austin et al., 2009).

The role of senior staff as role models, as highlighted in previous research, resonates with the concept of leadership in coping with challenging situations (Drury et al., 2013). In summary, the alignment between our study and previous research emphasizes the universality of challenges faced by healthcare professionals, the importance of employer support and structured interventions, and the multifaceted strategies employed to manage stress and its effects on well-being. Our study's unique contribution lies in its focus on the context of Palestinian ICU nurses, shedding light on their perspectives and experiences in relation to debriefing and stress management.

5.5 Professional Quality of Life

5.5.1 Occupational Stress Among Nurses:

The findings of our study resonate with a substantial body of previous research that has extensively explored occupational stress within the nursing profession (Hunsaker et al., 2015, FDA study on stress-related health disorders; 1989, Powell, 2020; Resilience BC; Melvin, 2012; Perry et al., 2011). As evidenced by the ProQoL scale measurements, our study highlights the intricate interplay between compassion satisfaction, burnout, and secondary traumatic stress among ICU nurses. This aligns with earlier investigations that underscore the complex nature of nursing roles and the resulting psychological and physiological consequences (Cassar & Tattersall, 1998; Falco et al., 2013). The identification of these distinct dimensions of occupational stress serves to reaffirm the challenges faced by healthcare professionals, particularly nurses, in maintaining their emotional well-being while providing critical care to patients.

5.5.2 Compassion Fatigue and its Prevalence:

Our study's exploration of compassion fatigue mirrors the conceptual framework introduced by Joinson (1992) and later researchers. The concept of compassion fatigue as emotional and mental exhaustion resulting from prolonged exposure to traumatized patients' suffering finds alignment with our findings on the varying prevalence rates of compassion fatigue among ICU nurses. These findings correlate with previous studies that have reported different prevalence rates across different settings (Hunsaker et al., 2015; Vann & Coyer, 2014). This consistency underscores the persistence of compassion fatigue as a prevalent issue among nurses, particularly in high-stress environments such as intensive care units.

5.5.3 Coping Strategies and Support Mechanisms:

Our study's discussion of coping strategies for managing compassion fatigue resonates with the coping mechanisms identified in earlier research. The emphasis on the role of peers, family, and senior staff in providing support aligns with the findings of Perry et al. (2011) and Melvin (2012). The inclusion of debriefing sessions as a coping mechanism aligns with the recognition of these sessions as a valuable tool for nurses to address the emotional challenges they face (Smith et al., 2014). These shared coping strategies suggest a consensus within the field on the significance of social support and professional outlets for addressing the toll of compassion fatigue.

Implications and Future Interventions:

The integration of our study results with the broader context of previous research offers several implications for nursing practice and intervention strategies. The validation of coping strategies through the convergence of our findings and earlier studies underscores the importance of prioritizing initiatives that foster a supportive work environment. Institutions could focus on implementing peer support programs, facilitating debriefing sessions, and promoting open communication channels to enable nurses to navigate the emotional demands of their profession effectively.

Targeted Interventions for Demographic Factors:

The significant associations observed between demographic and professional factors and compassion satisfaction, burnout, and secondary traumatic stress offer a pathway for targeted interventions. For instance, our study's identification of marital status as a factor impacting compassion satisfaction aligns with previous research (Perry et al., 2011) , and gender as a factor impacting burnout and STS , This insight could inform tailored support strategies for nurses who are divorced and male nurses , recognizing their unique emotional challenges and designing interventions that promote their emotional well-being.

Strengthening Resilience and Well-being:

In conclusion, the synergy between our study's results and the rich body of previous research contributes to a more nuanced understanding of occupational stress and compassion fatigue among nurses. By grounding our findings in the context of existing knowledge, we reinforce the significance of these issues and the urgent need for comprehensive strategies that address the emotional well-being of healthcare professionals. Moving forward, informed by these insights, healthcare institutions can formulate evidence-based interventions that strengthen nurses' resilience, alleviate compassion fatigue, and promote a more supportive and emotionally sustainable work environment.

5.6 Limitation:

The study on compassion fatigue in relation to debriefing among Palestinian ICU nurses faces several limitations.

Firstly, the scarcity of prior research in the East Mediterranean region regarding compassion fatigue and debriefing restricts the availability of comparative context for the findings.

Additionally, the cross-sectional design limits the establishment of causal relationships and tracking changes over time, potentially overlooking dynamic variations in compassion fatigue and debriefing practices.

Furthermore, challenges in data collection due to security events affecting mobility between provinces and the the response rates from participating nurses further constrain the study's comprehensiveness and generalizability.

The Israeli occupation's impact on the Palestinian medical sector is characterized by frequent attacks on healthcare facilities and professionals, causing psychological stress and tension. These attacks, often during confrontations, highlight the challenge faced by healthcare workers. Compassion Fatigue and emotional exhaustion are prevalent, impacting both workers' well-being and patient care quality.

5.7 Conclusion

The current is the first study about compassion fatigue in relation to debriefing among ICU nurses in Palestine.

In order to answer the study questions, Data analysis of descriptive and inferential statistics was conducted.

Results show higher percentages of debriefing sessions among nurses working more hours per week. Debriefing sessions are also more prevalent among nurses caring for more patients. Divorced nurses have higher percentages of practicing debriefing sessions, while master's degrees have higher percentages of debriefing session practices.

However, the "Marital status" factor significantly impacted compassion satisfaction scores, suggesting that divorced nurses experience lower levels. Other factors, such as place of work, residence, years of experience, working hours, and academic level, did not significantly impact compassion satisfaction scores among ICU nurses.

Workplace and residence are significantly related, with higher burnout scores found in nurses working in Palestine Medical Complex and Ramallah city. The number of patients cared for also affects burnout scores, with male nurses having higher mean scores than female nurses. No other factors had a significant relationship with burnout subscale scores.

significantly higher mean STS scores were found among nurses who reside in Ramallah. Also, a greater number of patients that the nurse care for daily is associated with higher mean STS scores. Moreover, male nurses significantly have higher STS scores.

none of the domains(BO ,STS & CS)were predicted by the practicing of debriefing (value > 0.05-sessions among the Palestinian ICU nurses in a significant way (p).

5.8 Recommendations:

Based on the results and findings presented in the previous sections, several recommendations can be proposed to address compassion fatigue and enhance the well-being of intensive care unit (ICU) nurses in the Palestinian context:

1. Strengthen Debriefing Practices: The study's results highlight the significance of debriefing sessions in alleviating the effects of compassion fatigue. Hospitals and healthcare institutions should establish formal guidelines for debriefing after stressful incidents and ensure that debriefing sessions are conducted regularly. Providing opportunities for nurses to reflect on their experiences and share their feelings in a supportive environment can enhance emotional resilience and mitigate the impact of stressors.
2. Tailored Support for Divorced Nurses: Given the significant association between marital status and compassion satisfaction, hospitals should pay special attention to the emotional well-being of divorced nurses. Designing support mechanisms and interventions that acknowledge and address the unique challenges faced by this group can contribute to enhancing their job satisfaction and overall well-being.
3. Address Gender Disparities in Secondary Traumatic Stress: The study's findings indicate that male nurses experience higher levels of secondary traumatic stress. Healthcare institutions should explore the underlying reasons for this disparity and implement strategies that offer additional support to male nurses, such as specialized training on coping with emotional challenges and promoting open discussions about mental health.
4. Promote Work-Life Balance: To address the impact of work-related exhaustion and the challenge of separating personal life from the helping role, hospitals should emphasize the importance of work-life balance. Implementing policies that encourage adequate rest, provide resources for managing stress, and promote self-care can contribute to preventing burnout and improving nurses' overall quality of life.
5. Training in Coping Strategies: Healthcare institutions should offer training programs that equip ICU nurses with effective coping strategies to manage the emotional toll of their work. These programs could include stress management techniques, resilience-building exercises, and strategies for maintaining emotional boundaries when caring for traumatized patients.

6. Strengthen Peer Support Networks: Creating and fostering peer support networks can play a vital role in mitigating compassion fatigue. Healthcare institutions can facilitate the formation of support groups among ICU nurses, providing a platform for sharing experiences, offering advice, and building a sense of camaraderie that contributes to emotional well-being.

7. Promote Education and Professional Growth: Encourage and provide opportunities for continuous education and professional growth. Supporting nurses in staying updated with the latest techniques and developments in their field can boost their confidence and job satisfaction, leading to higher levels of compassion satisfaction and overall well-being.

8. Regular Assessments and Interventions: Healthcare institutions should consider conducting regular assessments of nurses' emotional well-being using tools like the Professional Quality of Life (ProQoL) scale. Based on the findings of these assessments, targeted interventions can be designed and implemented to address specific challenges and support nurses in managing their emotional experiences effectively.

9. Collaboration with Psychologists and Mental Health Professionals: Collaborating with psychologists and mental health professionals can provide valuable insights and expertise in addressing compassion fatigue. Developing a network of mental health resources within healthcare institutions can ensure that nurses have access to appropriate support when facing emotional challenges.

10. Cultural Sensitivity and Inclusivity: Given the diverse cultural and regional backgrounds of ICU nurses in Palestine, interventions should be culturally sensitive and inclusive. Understanding the cultural context and tailoring interventions to align with local beliefs and practices can enhance their effectiveness.

In conclusion, the study's results shed light on the complex interplay between debriefing practices, compassion fatigue, and the overall quality of life of ICU nurses in Palestine. Implementing the above recommendations can contribute to creating a more supportive and resilient work environment for nurses, ultimately improving their well-being and enhancing the quality of care they provide to patients.

Recommendation for future studies:

The study's findings point to several promising avenues for future research. Firstly, a longitudinal study tracking ICU nurses over an extended period could reveal enduring effects of debriefing on compassion fatigue, involving monitoring changes in fatigue levels, coping methods, and overall well-being. Secondly, investigating diverse debriefing formats, such as

group sessions versus one-on-one interactions, could elucidate which approach better mitigates compassion fatigue in ICU nurses, while acknowledging cultural influences on outcomes. Furthermore, exploring the connection between nurses' compassion fatigue and patient outcomes underscores its systemic relevance, highlighting the need for comprehensive approaches. Additionally, extending research beyond ICUs to various healthcare settings offers a holistic grasp of compassion fatigue's impact, aiding tailored interventions. Lastly, qualitative methods like in-depth interviews or focus groups can provide richer insights into nurses' experiences, yielding a comprehensive understanding of emotional and psychological dynamics.

The role of health and nursing administrative representatives is crucial in managing and mitigating stress and compassion fatigue among ICU nurses, especially in relation to debriefing practices. These representatives play a significant role in creating a supportive work environment, implementing effective debriefing protocols, and promoting the well-being of nurses. Here's how they can contribute to reducing stress and compassion fatigue through debriefing:

Implementing Formal Debriefing Protocols: Health and nursing administrators can establish formal guidelines and protocols for conducting debriefing sessions after critical incidents or emotionally challenging situations. These protocols should outline the process, timing, and participants involved in debriefing sessions.

Advocating for Debriefing: Administrative representatives can actively advocate for the importance of debriefing sessions among the nursing staff. They can emphasize how debriefing contributes to emotional processing, reduces stress, and enhances overall job satisfaction.

Providing Resources: Administrators should ensure that the necessary resources, including trained facilitators and appropriate spaces, are available for conducting effective debriefing sessions. This shows a commitment to supporting nurses' emotional well-being.

Ensuring Regular Debriefing Opportunities: Administrators can work with unit managers to schedule regular debriefing sessions within the ICU setting. Consistent opportunities for debriefing allow nurses to address stressors and emotional challenges in a timely manner.

Creating a Safe Space: Health and nursing administrative representatives can create a culture that encourages open communication and psychological safety during debriefing

sessions. Nurses should feel comfortable sharing their experiences, emotions, and concerns without fear of judgment.

Monitoring Debriefing Practices: Administrators can monitor the implementation of debriefing practices and gather feedback from nurses. This feedback can be used to assess the effectiveness of debriefing sessions and make necessary improvements.

Tailoring Support: Understanding that different incidents may have varying emotional impacts, administrators can ensure that debriefing sessions are tailored to the specific context. This shows sensitivity to nurses' emotional needs.

Promoting Peer Support: Administrators can facilitate peer support networks among ICU nurses, where experienced nurses can provide emotional support and share coping strategies with their colleagues.

Training and Education: Health and nursing administrative representatives can organize training programs that educate nurses and facilitators about the benefits of debriefing, how to effectively conduct sessions, and how to address common challenges.

Addressing Organizational Factors: Administrators can work to address any organizational factors that contribute to stress and compassion fatigue, such as workload management, staffing issues, and communication barriers.

Leading by Example: Administrative representatives can demonstrate the importance of emotional well-being by actively participating in debriefing sessions themselves. This sets a positive example for the nursing staff.

Feedback and Improvement: Regularly seeking feedback from nurses about the debriefing process and its impact on their emotional well-being allows administrators to make continuous improvements.

In essence, health and nursing administrative representatives have a vital role in fostering a supportive culture of debriefing within the ICU setting. By prioritizing emotional well-being, providing necessary resources, and advocating for debriefing, they can contribute to reducing stress, preventing compassion fatigue, and enhancing the overall job satisfaction of ICU nurses.

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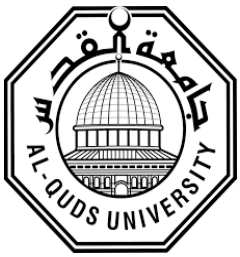
Appendix 1: The study questionnaire



علاقة اجهاد التعاطف مع المرضى وممارسة جلسات التفريغ النفسي لدى تمريض العناية الحثيثة: دراسة فلسطينية

عزيزي المشارك عزيزتي المشارك/ة

يسعدني أن اتقدم اليكم بجزيل الشكر على مشاركتكم في اكمال هذه الرسالة التي هي جزء من دراسة الماجستير في إدارة التمريض – جامعة القدس.

الهدف من هذه الدراسة هو تحديد مستويات إجهاد التعاطف بين ممرضي وحدة العناية الحثيثة الفلسطينيين فيما يتعلق بممارسة جلسات التفريغ النفسي ومدى وعيهم بأهميتها في بيئة عملهم.

ولذا نستأذنكم بتخصيص 10-15 دقيقة من وقتكم لتعبئة الاستبانة. علماً أننا نقدر ونثمن وقتكم

وأن الاجابات ستعامل بسرية تامة بحيث لن يكون بالإمكان التعرف على إجابات المشترك , البيانات التي يدلي بها المشارك ستعامل بشكل جماعي , وان المشارك لن يتضرر سواء على المستوى الشخصي او المهني نتيجة للمشاركة في الدراسة , وهي مخصصه لخدمة البحث العلمي فقط، ولكم كامل الحرية في المشاركة أو عدمها ولكن مشاركتكم لها دور في إنجاح هذه الدراسة.

شاكرين لكم حسن تعاونكم وتقبلوا فائق الاحترام

الطالبة: ولاء الجعفري

إشراف: د. ميساء الأسطى

الاستبيان

الجزء الأول: البيانات الشخصية					
مكان العمل	.....				
مكان السكن	.....				
سنوات الخبرة	.....				
ساعات العمل (في الأسبوع)	.....				
معدل عدد المرضى الذين ترعاهم يوميا	.....				
العمر	.....				
الجنس	ذكر □	انثى □			
الحالة الاجتماعية	أعزب\ عزباء □	متزوج\ة □	مطلق\ة□	أرمل\ة □	
المستوى الدراسي	دبلوم □	بكالوريوس □	ماجستير أو أكثر □		

الجزء الثاني: إجراء جلسات التفريغ النفسي ومدى الوعي بأهميتها **"هذا الجزء يحتوي أسئلة تتعلق بإجراء جلسات التفريغ النفسي. يرجى الإجابة على الأسئلة التالية باختيار الجواب الأنسب لك"**					
هل تعاني من التوتر في مكان عملك؟1)	□ نعم	لا □			
إذا كانت الإجابة نعم في السؤال رقم (1)، فكم مرة تقدر حجم التوتر في العمل؟					
كبير جدا □	كبير □	متوسط □	□	قليل جدا	□قليل
2)هل يساعدك صاحب العمل في التغلب على ضغوط العمل؟	□ نعم	لا □			
ما مدى ملاءمة هذه المساعدة في تقليل مستويات التوتر لديك؟ 3)					
□ملائم بشكل كافي	□ملائم	يساعد قليلا □	□غير كافي		
4) هل يقدم صاحب العمل فرصة التفريغ النفسي بعد المواقف العصيبة في العمل؟	□ نعم	لا □			
إذا كانت الإجابة نعم في السؤال رقم (4)، كم تتكرر هذه الفرصة؟					
□كثيرا	غالبا □	قليلا□	**نادرا** □		
5) هل توجد قوانين معتمدة في المستشفى الخاص بك بشأن جلسات التفريغ النفسي لدى الموظفين؟	□ نعم	لا □			
6) ما مدى أهمية وجود القوانين المعتمدة في المستشفى بشأن جلسات التفريغ النفسي من وجهة نظرك؟					
□مهم جدا	م	□مهم نوعا ما	□غير مهم		
7) برأيك ما مدى أهمية جلسات التفريغ النفسي للممرض بعد التعامل مع حالة صعبة؟					
□مهم جدا	م	□مهم نوعا ما	□غير مهم		
8) **هل سبق لك أن شاركت في جلسة تفريغ نفسي بعد التعامل مع حالة صعبة؟**	□ نعم	لا □			

الجزء الثالث: **

(Professional Quality of Life 5 (ProQoL-5أداة

عندما يكون عملك مع الناس لديك اتصال مباشر بحياتهم فإن تعاطفك مع مرضاك يمكن أن يؤثر عليك بطرق إيجابية وسلبية. فيما يلي بعض الأسئلة حول تجاربك، الإيجابية والسلبية، بصفتك [مسؤول عن مرضى]. ضع في اعتبارك كل من الأسئلة التالية عنك وعن وضع عملك الحالي. حدد الرقم الذي يعكس بصدق مدى تكرار تجربة هذه الأشياء في آخر **30 يومًا**

الجملة		5= كثيرا	4= غالبا	3= بعض الأحيان	2= نادرا	1= ابدا
1.	انا سعيد					
2.	أستلم أكثر من مريض في الدورية الواحدة.					
3.	أحس بالرضى كون عملي مرتبط بمساعدة الناس					
4.	أحس بالارتباط بالناس					
5.	أشعر بالتيقظ والتوتر من أي أصوات غير متوقعة					
6.	أشعر بالنشاط بعد العمل مع مرضاي					
7.	أشعر بالصعوبة في الفصل بين حياتي الاجتماعية وعملي					
8.	أنا غير منتج بالعمل					
9.	أظن انني مضغوط من التعامل مع الحالات الموجعة في مرضاي					
10.	أحس بأنني مضغوط بعملي في العناية المكثفة					
11.	بسبب عملي بالعناية الحثيثة – أحس أنني أعاني في كل شيء					
12.	أحب عملي في العناية الحثيثة					
13.	أحس بالاكتئاب من الحالات الموجعة التي اتعامل معها					
14.	أحس أنني اتعامل مع الحالات الموجعة كأنني جزء منها					
15.	لدي معتقدات تدعمني					
16.	يسعدني كيف يمكنني مواكبة التقنيات والبروتوكولات في عملي					
17.	انا راض عن نفسي					
18.	عملي يشعرني بالرضى					
19.	أشعر بالإرهاق بسبب عملي					
20.	لدي أفكار ومشاعر سعيدة حول مرضاي وكيف يمكنني مساعدتهم					
21.	أشعر بالإرهاق لأن عبء عملي يبدو بلا نهاية					
22.	أعتقد أنه يمكنني إحداث فرق من خلال عملي					
23.	أتجنب أنشطة أو مواقف معينة لأنها تذكرني بالتجارب المخيفة لمرضاي					
24.	أنا فخور بما يمكنني القيام به في العمل					
25.	نتيجة عملي، لدي أفكار دخيلة ومخيفة					
26.	أشعر انني عاجز عن التقدم بسبب النظام					
27.	أفكر انني ناجح كممرض\اة عناية حثيثة					
28.	لا أستطيع أن أتذكر أجزاء مهمة من عملي مع ضحايا الصدمات					
29.	أنا شخص يهتم بالآخرين					
30.	أنا سعيد لأنني اخترت القيام بهذا العمل					

شكرا لتعاونكم،