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A comparative study of the Professional Quality of Life Factors in Nepali MHPSS Practitioners

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Aim: Using the Professional Quality of Life (ProQOL) scale, this study outlined the prevalence and compared the impact on trauma care professionals serving earthquake survivors and those serving other categories of trauma survivors. **Methods:** A non-experimental comparative survey study design was applied.

Results: The overall assessment outlined that Nepali professionals (N=112) are found to be at low risk of Burnout (M = 19.98, SD = 4.98), and at moderate level of risk for the Secondary Traumatic Stress (M = 21.34, SD = 5.50), whereas, the overall Compassion Satisfaction was at a moderate level (M = 41.19, SD = 5.74). The multivariate analysis determined the differences in the ProQOL measures between the groups, where, Burnout, Secondary Traumatic Stress, and Compassion Satisfaction scores among the professionals serving both categories of trauma survivors had no significant differences (F (6, 216) = 0.58, Wilk's Λ = 0.573, $p > .05$).

Conclusions: Nepali care professionals serving trauma survivors in post-earthquake contexts are moderately affected by their provision of care; however, there were no significant differences in the impact on ProQOL measures among the professionals serving different categories of trauma-affected beneficiaries.

INTRODUCTION

Since 1990, the Nepali population has faced many traumatic situations, due to political upheavals, natural disasters, migration, urbanization and human trafficking. Between 1980 and 2010, over 11,000 people died due to natural disaster (Ministry of Home Affairs, 2011). The country's ten-year-long armed conflict, which ended in 2006, took the lives of more than 16,000 people, over 1,300 went missing, and thousands of families were displaced (OHCHR, 2012; Rimal & Koirala, 2011). An earthquake (7.8 magnitude) struck in April 2015, killing nearly 9,000 people, injuring more than 2,000, and displacing around 650,000 families (Ministry of Home Affairs, 2015). The mental-health, psychological, social and cultural impacts of trauma impaired the daily functioning of survivors and increased anxiety, psychosomatic complaints, depression and self-harm (Framingham & Teasley, 2012).

Mental Health and Psychosocial Support (MHPSS) professionals in Nepal have supported survivors of the traumas of expulsion from Bhutan, the civil war, and the 2015 earthquake, as well as victims of domestic or sexual violence and human trafficking (Jordans et al., 2007; Standing et al., 2016; Upadhaya et al., 2014). Mental health professionals offer the support survivors need, listening to terrible stories of hardship. The fear, suffering, and distress of the survivors they treat have an impact on the psychological, emotional, and cognitive aspects of their personal and professional lives.

The literature reveals that MHPSS professionals working with trauma survivors face situations of increased stress, Secondary Traumatic Stress, and Burnout (Figley, 2002; Sakuma et al., 2015). Exposure to the stress of their clients affects their professional quality of life (ProQOL), leaving them experiencing both Burnout and Secondary Traumatic

Stress (Stamm, 2010). Collectively, these symptoms of Secondary Traumatic Stress and Burnout are known as "compassion fatigue" (Figley, 2002; Maslach, 2003; Stamm, 2010). Burnout exacerbates occupational hazards such as emotional exhaustion and professional incompetence, resulting in a negative working environment, devaluation of clients and deterioration of the quality of life of MHPSS professionals (Puig et al., 2014). Inversely, many MHPSS professionals also express a sense of pride, reward, and competence as benefits of providing trauma support (Lawson & Myers, 2011; McKim & Smith-Adcock, 2014; Stamm, 2010). Such positive aspects of trauma care, termed "Compassion Satisfaction" have been a major impetus to supporting colleagues in problem-solving and fostering a conducive environment for professional growth (Larsen & Stamm, 2012; Sodeke-Gregson et al., 2013).

Stamm and Figley together developed, tested, and used a professional quality-of-life (ProQOL) scale to measure the negative and positive effects of responding to trauma (Stamm, 2010). The 30-item ProQOL scale is a psychometric measure comprising Burnout, Secondary Traumatic Stress, and Compassion Satisfaction. Understanding the ProQOL of MHPSS professionals as early as possible and providing adequate support, supervision, and care are important, otherwise MHPSS professionals can face severe and debilitating consequences for their mental health and daily functioning. If the level of Burnout and Secondary Traumatic Stress is high, the professional's ability to empathize with clients in post-disaster and post-conflict situations will be impaired (Rossi et al., 2012; van der Veen et al., 2015).

The negative and positive effects on the work of trauma responders have been widely studied in post-disaster, emergency and post-conflict settings (Lawson & Myers, 2011; Stamm, 2010). After the Bam earthquake of 2003 in Iran, two-thirds of psychosocial care providers, were negatively

affected (Hagh-Shenas et al., 2005). In post-earthquake of 2001 in Gujarat, India, the level of Burnout and Secondary Traumatic Stress among service providers was high; 8% were diagnosed with Post Traumatic Stress Disorder (Shah et al., 2007). One-fifth of professionals working with survivors of the 2005 Pakistan earthquake reported clinical depression (Bilal et al., 2007; Ehring et al., 2011). Following the 2008 Wenchuan earthquake in China, doctors who responded to the trauma of earthquake survivors had increased levels of anxiety, depression, and Post-Traumatic Stress Disorder; 19% of doctors ($n = 139$) were found at high risk of Burnout (Burnett & Wahl, 2015). In their longitudinal study of 13 trauma responders after a bomb explosion in Northern Ireland, Collins and Long (2003b) found that both the resilience and Compassion Satisfaction of the professionals involved were high. A mixed-method study (James et al., 2014) of the lay mental health workers who provided care to trauma survivors of the Haiti earthquake found that, 18 months later, they reported low levels of Burnout, moderate levels of Secondary Traumatic Stress, and high levels of Compassion Satisfaction.

There is still a tremendous gap in understanding rates of Burnout, Secondary Traumatic Stress and Compassion Satisfaction (Boyle, 2010) especially in developing countries like Nepal. Comparative studies of ProQOL measures between groups of trauma responders are scarce (Smart et al., 2014). This study sought to explore Professional Quality of Life (ProQOL) measures among MHPSS professionals in Nepal. The study compared the difference in ProQOL measures between responders to earthquake survivors and those who support victims of other traumatic events such as conflict, trafficking, HIV/AIDS, domestic violence etc. The research question for this study was *'what is the current ProQOL of MHPSS professionals and what are the differences between the rate of Burnout, Secondary Traumatic Stress, and Compassion Satisfaction among MHPSS professionals who work with earthquake survivors compared to MHPSS professionals working with other categories of trauma victims affected by conflict, HIV/AIDS, trafficking, domestic violence?'*

RESEARCH DESIGN

The research was designed as a comparative cross-sectional study to measure and compare Burnout, Secondary Traumatic Stress and Compassion Satisfaction in two cohorts of MHPSS professionals: those who served earthquake survivors, and those who served survivors of other forms of trauma. Other trauma affected populations served by care professionals consisted of people affected by various traumatic events, including human trafficking, HIV/AIDS, sexual violence, and conflict. A cross-sectional design promotes understanding of the prevalence and nature of a problem at a given time (De Vaus, 2002; Mann, 2003) and can be completed within a limited timeframe with few resources (Carlson & Morrison, 2009). A longitudinal design was not possible for pragmatic reasons such as time, expenses and repeated exposure to data collection from busy trauma responders.

RESEARCH POPULATION

The Inter-Agency Standing Committee (IASC) Reference Group for MHPSS (2015) estimated that approximately 500 MHPSS professionals with different levels of training and academic qualifications work in different governmental, private, and non-governmental sectors in Nepal. The majority, about 300, have undertaken a six-month psychoso-

cial counselling training after securing a high school degree. The other 200 have bachelor's degrees in psychology or higher degrees. Of these, 50 are psychiatrists, and 16 are clinical psychologists, but more than 25% of this group live abroad (Luitel et al., 2015). About 200 MHPSS professionals served the population affected by the April 2015 earthquake in Nepal. The other MHPSS professionals have served people affected by various traumatic events, including human trafficking, HIV/AIDS, sexual violence, and conflict, some for many years.

A sample size of 120 respondents, 60 respondents in each of the two groups, those who worked with earthquake survivors and those who did not, was originally proposed using the formula $n = (z^2 \times p(1 - p))/e^2$, recommended by Daniel and Cross (2013) when the population is known. For a multivariate analysis with $\alpha = 0.05$, power = .80, and a medium-effect size, a sample of 128 was recommended (Cohen, 1992; Columb & Atkinson, 2016). All MHPSS professionals, both those who worked with earthquake survivors and those who worked with survivors of other traumas, had continuously worked since April 2015. Respondents below the age of 18, respondents who had not served trauma survivors since April 2015, and respondents who had impaired functionality due to critical mental health issues were excluded.

DATA COLLECTION

DEMOGRAPHIC SURVEY.

A self-reporting questionnaire in both English and Nepali was used to gather data. It included a demographic and a work-related information questionnaire as well as a ProQOL survey (Stamm, 2010). Participants were requested to provide which type of beneficiaries they serve – earthquake survivors, other trauma affected population or both (earthquake and non-earthquake trauma survivors). The demographic information collected included sex, marital status, qualification, years of experience, age, designation, type of organization respondents are associated with, economic status, and monthly income. Respondents were also asked about clinical supervision, and training in care-for-care-givers and types of trauma their clients had experienced.

PROFESSIONAL QUALITY OF LIFE 5 (PROQOL-5)

ProQOL-5 was used to collect data, which has 30 items designed to assess the positive and negative experiences of respondents in the last 30 days while working with survivors of traumatic incidents. Its three subscales, Burnout, Secondary Traumatic Stress and Compassion Satisfaction, has 10 items each. Respondents ranked their responses on a five-point Likert scale (Lee et al., 2015). ProQOL-5 is a tool developed by Stamm (2010) and shared with the Center for Victims of Torture (CVT) for public use. The author received permission to translate the tool into Nepali, and later contributed to the CVT with a Nepali Version of ProQOL-5 for public use following the completion of this study.

Stamm (2010) found that the internal consistency reliability estimates, Cronbach alpha (α), were 0.75, 0.8, and 0.87 for the Burnout, Secondary Traumatic Stress and Compassion Satisfaction subscales, 0.8 for the Secondary Traumatic Stress subscale and 0.87 for the Compassion Satisfaction subscale. Stamm also found that inter-scale correlations showed 2% shared variance ($r^2 = 0.23$; $\sigma = 5\%$; $n = 1187$) with Secondary Traumatic Stress and 5% shared variance ($r^2 = 0.14$; $\sigma = 2\%$; $n = 1187$) with Burnout, and that the shared variance between these two scales was 34% ($r^2 = .58$; $\sigma = 34\%$; $n = 1187$). The scales both measure nega-

tive effects but are clearly different; the Burnout scale does not address fear while the Secondary Traumatic Stress scale does (Stamm, 2010, p. 13). Bride, Radey and Figley (2007) noted that Stamm's 2005 work was "a multi-trait, multi-method approach to convergent and discriminant validity that supports the validity of ProQOL suggesting that the subscales measure different constructs" (p 159). Train and Butler (2013) concluded that the construct validity of ProQOL was good. Since the late 1990's, cultural adaptations and validations of ProQOL have been carried out in Japanese, Chinese, and Filipino, Italian and Hindi showing its reliability and validity (Bhutani et al., 2012; Cicognani et al., 2009; Cieslak et al., 2014; Fukomori et al., 2016; Shen et al., 2015; Stamm, 2010).

TRANSLATION OF PROQOL FROM ENGLISH INTO NEPALI.

Due to the non-availability of ProQOL-5 in the Nepali language, the tool was translated from English into Nepali before data collection. Maneesriwongul and Dixon (2004) suggested that multiple techniques should be used to translate a tool from one language into another. There is no consensus among researchers about what method to use, but among those methods suggested are a direct translation, back translation and piloting the tool before its wider application (Davis et al., 2013; Sousa & Rojjanasrirat, 2011; Van Ommeren et al., 1999).

ProQOL-5 was translated directly from English into Nepali by a bilingual Nepali psychologist and then reviewed by an expatriate bilingual psychologist. Some changes in the Nepali words were made for items numbers 2, 11, 26, 28 and 29. After incorporating the feedback, the tool was piloted with 25–30 university students majoring in social work and psychology. While these students had not heard words such as "Clinical Supervision," "Burnout," "Secondary Traumatic Stress," "Compassion Satisfaction," and "Care for Caregivers,". Students understood the language of the translated ProQOL-5 well. The external review and pilot test verified the face validity of the contents and constructs of the survey instrument. Validation of N-ProQOL-5 and carrying out a confirmatory factor analysis was beyond the scope of this research.

DATA COLLECTION PROCEDURES.

Three major non-governmental organizations that employed or had trained more than 50 MHPSS workers each, were asked to survey their staff anonymously with the consent of the staff. The researcher also announced the survey in online portals using different online groups, and Facebook groups of Nepali MHPSS professionals. An announcement of the research in both English and Nepali was posted and circulated to all potential respondents. A Google form was developed in the Nepali language, and the links were attached to the announcements. The respondents were also free to contact the researcher at any time to have their questions answered and to get a summary of the results.

DATA ANALYSIS PROCESS.

Demographic survey data were assigned with scores based on participants' responses. Responses were automatically registered in a worksheet, and the raw scores to the 30 items of ProQOL-5 were imported to the Statistical Package for Social Sciences (SPSS), version 23. The scores obtained were then clustered into the three subscales, Burnout, Secondary Traumatic Stress and Compassion Satisfaction using the SPSS software. The data were checked for anomalies and cleaned. No data were missing. Distribution checks via scat-

terplots, box plots, kurtosis, skewness and significant conventional testing for normality were carried out to ensure the data met the preliminary requirements for conducting the multivariate analysis. Correlations among variables and Levene's tests for the homogeneity of variances were also checked.

After the cleaning and coding, a majority of respondents also mentioned that they provide services to beneficiaries affected by both earthquake and non-earthquake related trauma. Therefore, a third group of professions serving both categories of beneficiary was created, as an adaptation to this study design, for further statistical analysis. Of the 112 responses retained, 26 respondents had worked with earthquake survivors, 25 had worked with survivors of non-earthquake related trauma and 61 professionals had served both categories of survivors. Descriptive statistics were calculated using frequency tables and percentages for the primary categorical data and mean and standard deviation for any interval data.

Initial checks on the assumptions for normality, homogeneity of variances, and differences between the three groups in the statistical analyses of scores on variables were completed. Covariates were checked using chi-squared analyses to determine if any of the demographics were significantly different between groups and needed to be co-varied in the main analyses. A stepwise multiple regression was carried out to understand the influence of socio-demographic independent variables into the ProQOL measures. A Multivariate analysis of variance (MANOVA) was applied to determine if MHPSS professionals who worked with earthquake survivors reported different levels of Burnout, Secondary Traumatic Stress and Compassion Satisfaction than those who worked with survivors of other types of trauma. Details can be found at the results section.

ETHICAL PROCEDURES.

The researcher obtained ethical clearance from the International Online Research Ethics Committee (IOREC) of the University of Liverpool, United Kingdom. Additionally, local ethics approval from the Nepal Health Research Council (NHRC) was gained before data collection.

RESULTS

PILOT STUDY

Forty-five MHPSS professionals responded to the survey initially, and these were retained based on their consent and on inclusion criteria. The Pearson correlation coefficient showed a strong correlation among and between the three subscales. Burnout and Secondary Traumatic Stress were positively and strongly correlated but both were negatively correlated with Compassion Satisfaction, as expected. The subscales Secondary Traumatic Stress and Compassion Satisfaction were not strongly correlated, at -0.252, but Burnout and Compassion Satisfaction were, at -0.420, as were Burnout and Secondary Traumatic Stress at 0.618.

The reliability of the scale was analyzed using Cronbach alpha. The overall alpha value for the Nepali version was 0.635. The reliability score for Burnout, Secondary Traumatic Stress and Compassion Satisfaction were, 0.599, 0.721, and 0.829 respectively. Ideally, the Cronbach alpha for each sub-scale should be above 0.80, which was only achieved for Compassion Satisfaction sub-scale. There were no items that would increase the value if removed; suggesting items did not need to be removed for this previously standardized measure. The study had no intention of looking at the construct validity, and so no confirmatory factor

Table 1. Socio-Demographic Information

Characteristics	N	%
SEX		
Male	40	35.7
Female	72	64.3
AGE (IN YEARS)		
18-25	21	18.8
26-45	84	75.0
45-60	6	5.4
60+	1	0.8
EDUCATION		
SLC	1	0.9
Intermediate	2	1.8
Bachelor's	41	36.6
M.A. / M.Sc.	59	52.7
M.Phil.	4	5
Ph.D.	3.6	4.5
EXPERIENCE (YEARS)		
0-1	25	22.3
1-3	37	33.0
3-5	19	17.0
5-10	25	22.3
10+	6	5.4
ORGANISATION/INSTITUTION		
NGO	80	71.4
INGO	13	11.6
Government	8	7.1
Private	11	9.8
LOCATION (WORK)		
Kathmandu Valley	69	61.6
Outside Kathmandu Valley	43	38.4
MARITAL STATUS		
Married	69	61.6
Single	42	37.5
Divorced	1	0.9
ETHNICITY		
Brahmin/Chhetri	68	60.7
Ethnic groups	40	35.7
Dalit/minorities	4	3.6

analysis was carried out. Thus, the proposed 30 items of the Nepali version of ProQOL-5 were applied in the final study.

FULL-SCALE STUDY

The researcher obtained 154 responses through the online survey between 5 September 2016, and 10 December 2016. Of these, 3 responses were excluded due to not meeting the inclusion criteria. Further, the data were assessed for normality, independence of observations, outliers and missing data. Ten more responses were removed as a result.

Of the 112 responses retained, 87 respondents had worked with earthquake survivors, and only 25 had worked

with survivors of non-earthquake related trauma. It was discovered that some participants stated that they belonged to both groups, and therefore a third group was created, called "both", resulting in 61 for this new group, 26 responses for the earthquake only, and 25 non-earthquake categories. The main analyses used this three-group comparison to determine if MHPSS professionals who served all trauma types were different from those who served earthquake only or from those who served non-earthquake survivors only.

Of the approximately 500 active MHPSS practitioners in Nepal, about 35% answered the survey. Details on their socio-economic and demographic information are in Table 1

Table 2. Overall and Group-wise Professional Quality of Life

Sub-Scales	Group	N	Mean	SD	Interpretation
Compassion Satisfaction	Earthquake	26	41.30	6.40	Average Satisfaction
	Non-Earthquake	25	41.08	5.45	Average Satisfaction
	Both	61	41.20	5.66	Average Satisfaction
	Overall	112	41.20	5.75	Average Satisfaction
Burnout	Earthquake	26	19.27	4.74	Low-to-medium risk
	Non-Earthquake	25	20.88	3.36	Low-to-medium risk
	Both	61	19.92	4.23	Low-to-medium risk
	Overall	112	19.98	4.18	Low risk
Secondary Traumatic Stress	Earthquake	26	20.46	6.22	Low risk
	Non-Earthquake	25	22.04	4.91	Low-medium risk
	Both	61	21.44	5.45	Low risk
	Overall	112	21.35	5.50	Low risk

above. About two-thirds (64.3%) of respondents were female and three-quarters (75.0%) were aged 26-45 years. Half of the respondents had a master's degree and 41.0% had a bachelor's degree. Kathmandu and surrounding areas were highly affected by the earthquake, but 38.4% of respondents were from outside Kathmandu Valley. Nearly 40% of respondents belonged to ethnic and other minority groups.

As the MHPSS sector is facilitated largely by the non-governmental sector, the vast majority (71.4%) of the participants represented that sector. The respondents comprised a diverse group, identifying their designations as psychosocial counsellors (36.6%), clinical psychologists (25.0%), diploma psychologists (12.5%), clinical supervisors (11.6%), social workers (5.4%) and others (3.6%). Psychiatric nurses, psychiatric doctors, and Ph.D. clinical psychologists were equally distributed with 1.8% each. Most respondents (85.7%) were from the middle-class followed by the lower middle class 8.9%, lower income 4.5%, and upper-class groups 0.9%.

About one-third (33.9%) of respondents provide MHPSS services to less than 10 beneficiaries per month, 44.6% served 10-25 clients per month and 12.5% were delivering services to 26-40 clients per month. The clients supported were both adults (49%) and children (22.3%). Victims of family violence (24.1%) and victims of the conflict (32%) mainly represented the non-earthquake categories of trauma. More than half (52.7%) received clinical supervision. A large majority (83.0%) of respondents received care-for-caregivers training after April 2015, but 17.0% had not.

The results of the chi-squared tests on socio-demographic categorical variables revealed that there were no significant differences between groups on any of these socio-demographic variables, which suggested that no covariates were needed in the Multivariate analysis of variance (MANOVA). Pearson correlation results showed a significant negative correlation of Compassion Satisfaction between Burnout ($r = -.69, p < 0.001$) and Secondary Traumatic Stress ($r = -.20, p < .038$), and a significant positive correlation between Burnout and Secondary Traumatic Stress ($r = .61, p < .001$), suggesting that these relationships are significant in the population and within acceptable levels to meet assumptions for use in the multivariate analysis.

A stepwise multiple regression analysis was performed to understand the influence of socio-demographic indepen-

dent variables into the dependent variables i.e. ProQOL sub-scales. The results indicated that years of experience was a significant predictor for Burnout, Secondary Traumatic Stress, and Compassion Satisfaction. Years of experience was a negative but significant predictor of Burnout [$F(1, 110) = 7.68, \beta = -.952, p = .007$] and Secondary Traumatic Stress [$F(1, 110) = 6.52, \beta = -1.164, p = .013$]. The variance explained by the model was 7% for Burnout and 6% for Secondary Traumatic Stress. Whereas, years of experience also positively and significantly predicted the Compassion Satisfaction [$F(1, 110) = 5.05, \beta = 1.073, p = .012$], in which the model was explained with 4% of the variance. Additionally, the type of clients they serve significantly but negatively predicted, [$F(1, 111) = 6.39, \beta = -.823, p = .013$], the Secondary Traumatic Stress. The model was explained with a 6% variance. The remaining socio-demographic independent variables had no significant influence on the ProQOL measures.

QUALITY OF LIFE OF NEPALI MHPSS PROFESSIONALS WORKING WITH TRAUMA SURVIVORS

Descriptive statistics were used to explore the mean scores for Burnout, Secondary Traumatic Stress and Compassion Satisfaction of the three groups of MHPSS professionals supporting trauma survivors (Table 2).

The Compassion Satisfaction subscale mean for the overall sample was 41.19 (SD = 5.74). The ProQOL manual describes cut off values (Stamm, 2010) and states a mean score of 42 or above is considered a high level of Compassion Satisfaction and a score of below 22 signifies that the professionals in the helping profession may have difficulties in finding satisfaction in their jobs. Professionals in all the three groups, those who serve earthquake survivors, those who do not and those serving both, expressed average satisfaction level of Compassion Satisfaction.

The mean scores for Burnout and Secondary Traumatic Stress for the overall population were 19.98 (SD = 4.98) and 21.35 (SD = 5.50). The ProQOL manual (Stamm, 2010) considers cut off values, that mean scores for Burnout and Secondary Traumatic Stress that are 22 or below signify low-to-moderate levels of risk and 42 or more is high risk. The means for Burnout for all the three groups was below 22, which signify low-to-moderate risk. The mean values of Secondary Traumatic Stress for the non-earthquake group of professionals was found to be slightly higher towards the

medium risk level ($M = 22.04$) while the other two groups were at low to medium risk. Tests of normality, linearity, outliers, and homoscedasticity through checking kurtosis, skewness, Shapiro-Wilk and/or Kolmogorov Smirnov, histograms, normal Q-Q plots, box plots, scatter plots, Mahalanobis Distance for the Dependent Variable and residuals, and previously obtained correlations showed that the data were within acceptable requirements to conduct the multivariate analysis of variance. This was checked for the overall sample, and within each of the three groups, all found to be within acceptable cutoffs and criteria.

The results of the overall multivariate analysis of variances (MANOVA) across the groups were found to be non-significant ($F(6, 216) = 0.58$, Wilk's $\Lambda = 0.573$, $p > .05$). In addition, there were no significant differences found between the three groups for each of the subscales: Burnout ($F(2, 109) = 16.81$, $p > .05$), Secondary Traumatic Stress ($F(2, 109) = 16.47$, $p > .05$), and Compassion Satisfaction ($F(2, 109) = 0.33$, $p > .05$).

This research aimed to investigate the measure and differences in the professional quality of life between MHPSS professionals serving different types of trauma, specifically survivors of earthquake and non-earthquake related trauma. No significant differences on the Burnout and Secondary Traumatic Stress variables of the PROQOL between these comparative groups was seen. The results show that Nepali professionals serving non-earthquake trauma survivors may have a slightly higher risk of secondary trauma in comparison with other groups. Finally, the results show that there are significant relationships between Burnout, Secondary Traumatic Stress and Compassion Satisfaction in the population, which may provide a context for strategies to mitigate potential negative outcomes. Conclusively, the positive and negative effects of trauma care to the professionals were found to be at the equal level in Nepali MHPSS professionals regardless of the type of beneficiaries they serve.

DISCUSSION

The purpose of this study was to measure and compare the ProQOLs of Nepali MHPSS professionals who serve earthquake survivors and those who help survivors of other types of trauma. The empirical evidence on the use of ProQOL to measure the negative and positive effect of trauma care, the Compassion Fatigue – Compassion Satisfaction model was chosen to be best applicable for this study (Cieslak et al., 2014; Stamm, 2010). The results of this study have shown no significant differences in the three groups of MHPSS professionals overall or on all three measures of the ProQOL. Such comparative studies among groups of MHPSS professionals are rarely carried out (Stamm, 2010), thereby creating a novel approach to understanding this problem. Two studies conducted in the United States with healthcare professionals did find ProQOL differences between different categories of health care service providers (Smart et al., 2014; Zeidner et al., 2013), specifically with mental and medical health care units in advanced medical facilities. This study does not find differences between the groups as outlined in the previous studies. Respondents of this study were found to be comparatively more resilient with less Burnout and Secondary Traumatic Stress. Possibly, the level of social ties, self-help, and mutual support among professionals in community settings are better than in the clinical settings of the developed countries (Galek et al., 2011; Kilian, 2008; Moos, 2013).

This study is unique in terms of comparing the ProQOL

of trauma responders mostly working in non-clinical settings after the mega-disaster in post-conflict situations in Low and Middle-Income Countries (LAMIC). The study population had a good level of maturity, 61.4% were married, 60% or above had masters' degrees, and over 80% were above the age of 26 years; these factors might have contributed to lower Burnout and Secondary Traumatic Stress, and higher compassion satisfaction. As over 60% of respondents were working in their home locations, family and community support structures might have provided for greater resiliency (Burnett & Wahl, 2015; Collins & Long, 2003a). Age, level of education, exposure to previous trauma, and maturity with experience (Hagh-Shenas et al., 2005; Kelly et al., 2015; Sprang et al., 2007) were correlated with the Compassion Satisfaction. The results on the additional burden of providing trauma care were comparable to studies in similar post-disaster contexts and populations affected by disasters in India, Pakistan, China, and Japan (Bilal et al., 2007; Burnett & Wahl, 2015; Sakuma et al., 2015; Shah et al., 2007).

The overall ProQOL subscale scores of trauma care professionals were found to be in low to medium level of risks of CF. There were no significant differences in socio-demographic characteristics and levels of Burnout, Secondary Traumatic Stress, and Compassion Satisfaction in this study. Stamm (2010) outlined that there were no significant differences among the professionals ($n = 1289$) out of socio-demographic categories (sex, age, ethnicity, income group, years of experiences, etc.). This study also corroborates similar findings. This study findings outlines that the number of years of experience has a significant positive affect on Compassion Satisfaction and significant negative affect on vulnerability to Burnout and Secondary Traumatic Stress. The types of clients they serve also significantly and negatively contribute to Secondary Traumatic Stress. The positive effects of providing trauma care can balance out and thereby decrease the negative effects of providing such care (Stamm, 2010). Nepali MHPSS professionals in all three groups reported relatively moderate levels of Compassion Satisfaction; the mean score was 41.0 for all. This figure is slightly higher than the study findings of Sprang et al. (2007).

The relationships between the various ProQOL factors (Bercier & Maynard, 2015) demonstrated that as Compassion Satisfaction increases, negative impacts decrease and that if Burnout increases, Secondary Traumatic Stress could also increase. Nearly half the MHPSS professionals who participated in the study (47.3%) of Framingham & Teasley (2012) reported that clinical supervision provisions were not in place. Monitoring and support factors affecting Burnout and promoting the associated positive aspects of resilience can prevent worsening the situation of Burnout (Framingham & Teasley, 2012). The mean values of Secondary Traumatic Stress for the non-earthquake group of professionals were found to be slightly higher towards the medium risk level ($M = 22.04$) compared to the other two groups working for earthquake survivors. A possible explanation for this could be that the latter group witnessed other concrete support for basic needs being met rapidly, instilling hope in both the service providers and the beneficiaries, while the former group could not experience this support due to lack of interest and focus from other service providers that focus was remained to the responders of the earthquake survivors.

The research findings suggest that Nepal's MHPSS sector needs to consider a number of measures to improve support to and the care of professionals who serve trauma survivors.

First, ProQOL should be socio-culturally validated in the Nepali context by applying it to a larger sample; the researcher proposes a Nepali version ProQOL-5 too for further validation. Second, MHPSS professionals face low to moderate levels of Burnout and Secondary Traumatic Stress, and not all experience high levels of Compassion Satisfaction. A qualitative study could understand and mitigate the causes and effects of these findings (Levin, 2006). Such studies explore ways to mitigate the underlying causes of the problem and, crucially, sustain and prevent the Burnout of the very tiny MHPSS workforce (approximately 500 in number) who serve nearly 28 million people. Third, it may also be helpful to assess additional factors that may contribute to Burnout and Secondary Traumatic Stress to see if those factors might predict the negative states, and conversely if Compassion Satisfaction can be predicted from factors beyond those examined in the present study.

Fourth, this cross-sectional study of ProQOL has provided a one-time screening of the ongoing difficulties of MHPSS professionals. It may be that time and its impact on resilience 18 months after the earthquake did, in fact, influence the results of this study. An in-depth qualitative or mixed study of whether time promotes or undermines resilience needs to be conducted. Last, the availability of clinical supervision across the population was low, 47% of respondents reported that they do not have such provisions (Trippany et al., 2004). Therefore, it is highly recommended that regular supervision, specific training in dealing with trauma survivors, and care-for-caregivers workshops be provided to all MHPSS professionals (Ben-Porat & Itzhaky, 2011).

This study has several limitations. The ProQOL tool was used for the first time in the Nepali population and the author had no time and resources to validate it. The translated version had many psychometric properties that were not up to standard. The reliability coefficient in the pilot study for Burnout and Secondary Traumatic Stress was found below 0.8, which might have impacted the final outcomes of this study. A convenience sampling technique through online responses was chosen, any socially desirable responses and an inability to measure the response rate of the participants were additional limitations. Respondents were predominantly psychosocial counselors and psychologists who worked in non-governmental sectors, where the representation of psychiatrists, psychiatric nurses, and psychiatric social workers was particularly low. A nationwide roster of MHPSS professionals may have helped attract a larger sample from the latter groups. Using online data to collect data is a potential weakness, as some of the professionals may not use computers and internet facilities (O'Neill, 2004). It was also difficult to draw a strict line between professionals serving earthquake survivors and those serving other types of survivors as some professionals worked with both. While time and the evolution of situational factors markedly shape the impact of trauma (Stamm, 2010), the time gap between designing and administering the survey was six months, long enough for the context to change. It is possible that time and environmental factors might have influenced the results (Ray et al., 2013). Finally, the desire to give the socially desirable answer by participants might have affected the study outcomes.

CONCLUSIONS

Comparative studies of MHPSS professionals who serve survivors of disasters and those who serve other survivors are rare. This is the first study of its nature conducted in Nepal

to gain insight into the ProQOL among MHPSS professionals in the Nepali context. No significant differences between groups were seen. This study paved ample avenues to use and implement the ProQOL-5 in the Nepali MHPSS populations. It recommends more longitudinal studies (Engstrom et al., 2008) to understand if these findings are similar when the time and contexts change naturally.

The results have shown significant positive correlation between the Burnout and Secondary Traumatic Stress, whereas the Compassion Satisfaction was negatively but significantly correlated with both the CF factors. The understanding is that changes to Compassion Satisfaction, Burnout or Secondary Traumatic Stress could affect other variables positively or negatively and that a balance among these interacting factors needs monitoring (Hofmann, 2008). Finally, the author hopes that this study opens the eyes of professionals, researchers and institutions to the need to understand the negative impacts of providing trauma care that were outweighed by the Compassion Satisfaction factors. It has been learned that the Nepali MHPSS professionals may be more resilient to supporting trauma survivors in comparison to other contexts (Cicognani et al., 2009; Killian, 2008; Lambert & Lawson, 2013; Moos, 2013; Sinclair et al., 2017). A further study examining this area would be of interest to sustain health practitioners in Nepal, so they can continue to assist other communities.

CONFLICT OF INTEREST

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

AUTHOR CONTRIBUTIONS

This research contributes to understanding the professional quality of life of Nepali MHPSS professionals, explores possibilities to use a translated and contextualized tool (ProQOL-5) to measure Burnout, Secondary Traumatic Stress and Compassion Satisfaction in care providing professionals, and outlines a common phenomenon of quality of life of MHPSS professionals irrespective of categories of beneficiaries they serve in the aftermath of mega-disaster situations in south Asian context.

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the completion of this study so that Nepali practitioners can use the tool freely.



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