



Some individual difference predictors of professional well-being and satisfaction of health professionals



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ABSTRACT

This study explored individual differences predictors of the positive facet of professional quality of life, i.e., compassion satisfaction (CS), in health care practitioners. A cross-sectional design was employed, based on 89 mental health care providers and 93 medical professional, drawn from 7 major community hospitals and 6 private clinics situation in Northern Israel. CS was significantly predicted by emotional competencies, positive affect, and problem-focused coping. In addition, problem-focused coping mediated the relationship between emotion abilities and CS. The data are explicated and discussed in light of the literature and contemporary accounts of professional quality of life.

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1. Introduction

Trauma is widely experienced by people throughout the globe, and an inherent part of human existence in modern society. For health professionals working with traumatized clients, the excessive stress helpers are exposed to may result in a condition called 'compassion fatigue, involving serious burnout and secondary traumatization (Figley, 2002; Zeidner, Hadar, Matthews, & Roberts, 2014). Yet, some helpers working with traumatized individuals have also reported remarkable feelings of well-being, satisfaction with their work, and positive growth (Radey & Figley, 2007). Whereas some health professionals report being compassion-fatigued on the job, they may concomitantly be deriving considerable satisfaction from their professional work (Stamm, 2010).

This study sets out to investigate a number of individual difference variables related to the professional satisfaction and quality of life in health care practitioners working with traumatized patients. We begin with a brief overview of conceptualization and research in the area of work satisfaction and professional quality of life and move on to discuss the role of individual difference predictors of satisfaction with the role of helper.

1.1. Compassion satisfaction

Health professionals who work with trauma survivors sometimes perceive important work-related benefits or rewards,

including satisfaction in observing the client's growth, gains in relationship skills, increased appreciation of the resilience of the human spirit, and being a part of the healing process, personal growth, and spiritual well-being (e.g., Pearlman & Saakvitne, 1995). Indeed, clinical observations suggest that working with trauma victims has enriched the lives of helpers in countless ways (McCann & Pearlman, 1990).

Professional satisfaction in the health professions is often discussed under the rubric of 'compassion satisfaction' (CS), a nascent, but increasingly important, construct emerging from the traumatic stress literature (Stamm, 2010). CS refers to the degree to which individual helpers and care providers derive benefit, pleasure, and satisfaction in helping others. Whereas compassion fatigue maps onto the affective domains of exhaustion, low efficacy, and emotional fear and anxiety, CS maps onto the domains of pleasure, self-efficacy and a sense of well-being as a helper. High CS caregivers feel satisfied and invigorated in their work and believe they can contribute to their workplace and to society through their work with people who need care (Stamm, 2010). Indeed, CS has been found to be strongly correlated with positive growth and change among health professionals (Gibbons, Murphy, & Joseph, 2011).

Furthermore, CS may serve as a buffer against the negative outcomes of working with trauma victims. Thus, CS has also been reported to be inversely related to a number of negative outcomes, including compassion fatigue, secondary traumatic stress, burnout, and PTSD (e.g., LaFauci Schutt & Marotta, 2011). In the simplest terms, CS and compassion fatigue, respectively, can be viewed as the positive and the negative aspects of helping.

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1.2. Individual difference predictors of CS

We now briefly point to a number of individual difference variables examined in this study that theory and past research suggest are associated with CS among health professionals.

- (1) *Emotional competencies.* Recent theorizing and research (Zeidner, Matthews, & Roberts, 2009) suggest that emotional intelligence (EI) is related to a wide array of adaptive outcomes, including satisfaction at the workplace and with life in general (Zeidner, Matthews, & Roberts, 2012). Trait emotional intelligence (EI) represents a constellation of emotional self-perceptions, located at the lower levels of personality hierarchies, measured via self-report (Petrides, Pita, & Kokkinaki, 2007). Trait EI has been found to be related to a wide array of adaptive outcomes at the workplace and also positively correlated with adaptive coping styles and negatively correlated with maladaptive coping styles (e.g., Mikolajczak, Nelis, Hansenne, & Quoidbach, 2008; Saklofske, Austin, Galloway, & Davidson, 2007).

Emotion regulation (ER), referring to the ability to successfully maintain, change, or modify emotions, both in self and others (Mayer, Roberts, & Barsade, 2008), may allow effective handling and repair of negative emotions following a stressful encounter, thus enabling the helper to feel more pleasure and satisfaction with helping trauma victims. Indeed, managing negative emotions experienced during therapy appears to be the most salient challenge for the therapist. Several studies (reviewed by Zeidner et al., 2009) suggest that the emotion management branch is the one typically most predictive of relevant criteria (coping, adaptive outcomes, and quality of interpersonal interaction).

- (2) *Positive affect.* According to Stamm (2010), CS is strongly linked to positive affective states. This is congenial with Fredrickson's (1998) 'broaden-and-build' theory, suggesting that positive affect in the context of trauma helpers would widen their array of thoughts and actions and generate greater flexibility and innovation in their work as helpers. A recent study by LaFauci Schutt and Marotta (2011) found that Extraversion, one of the personality factors of the Five Factor Model of Personality (McCrae et al., 2002), was positively correlated with CS in a sample of emergency management professionals. Given the strong correlation reported between Extraversion and positive affectivity (Tellegen, 1985), this finding lends support to the prediction that positive affect would be positively related to CS.
- (3) *Coping.* How practitioners cope with stress evoked by emotional encounters with trauma victims may determine adaptive outcomes (Sabin-Farrell & Turpin, 2003). Practitioners who have a richer coping arsenal (Zeidner & Saklofske, 1996) or those who have coped effectively with difficult situations in the past may also be predicted to cope better with traumatic stress (Dutton & Rubinstein, 1995) and also report greater satisfaction with their work. Thus, a number of studies among health care practitioners suggest that coping behaviors may serve as a stress buffer and impact on the development of secondary trauma in health care providers (e.g., Bleich, Gelkopf, & Solomon, 2003). Because the empirical research has yielded inconsistent results, with some studies finding significant effect for coping (e.g., Prati, Pietrantonio, & Cicognani, 2011), while others failing to find significant effects (e.g., Killian, 2008), additional work is needed to shed light on the role of coping strategies in relation to CS.

1.3. The present study

The conceptual framework of this study is grounded in recent theorizing on CS by Figley et al., rooted in positive psychology and salutogenic thinking (Radey & Figley, 2007). This conceptual model suggests that personal resources may influence the clinician's 'positivity-negativity' ratio, which in turn, may positively impact on work satisfaction. Thus, energy from CS, achieved by providing care within an optimal range that connotes goodness, flexibility, learning, growth, and resilience in the face of work demands, can lead to flourishing among health providers.

By and large, the positive impact of working with trauma clients is dominated by anecdotal reports (e.g., McCann & Pearlman, 1990), qualitative studies on small samples of helpers (e.g., Arnold, Calhoun, Tedeschi, & Cann, 2005), and theoretical discussions about the ways therapists are positively affected by their work (e.g., Radey & Figley, 2007). The number of empirical studies systematically investigating the personal antecedents of CS in health practitioners is scant. Thus, this study hopes to fill a needed gap by examining a number of personal and individual difference factors that may contribute to our understanding of CS in health care professionals. In addition to testing whether emotional intelligence correlates with compassion satisfaction, we also tested for possible mediating processes. We theorized that emotionally intelligent therapists may make more use of protective strategies such as problem-focused coping, with problem-focused coping mediating the EI-CS relationship.

Based on current theory and some past research we hypothesized that:

H₁: Trait EI and ability-based emotion regulation will be positively related to CS.

H₂: Positive affective states will be positively related to CS.

H₃: More adaptive coping strategies, i.e., problem-focused strategies in the present health care context, will be associated with CS, whereas less adaptive strategies (emotion focused, avoidance) will be negatively related to CS.

H₄: Emotional abilities (self-reported EI, ER) will work through problem-focus coping in impacting CS.

2. Method

2.1. Participants

89 mental health practitioners and 93 physicians participated in this study. Participants were drawn from seven major hospitals and six private clinics in Northern and Central Israel. The mental health care group was comprised of 25 clinical psychologists, 55 clinical social workers, and 9 psychiatrists (who we classified as mental health professionals for the purpose of this study). The medical practitioners were drawn from a range of medical units (e.g., emergency medicine, general surgery, pediatrics, neurology, anesthesia, etc.). Each of the participants was certified and actively engaged in providing psychological, psychiatric, or medical care to individuals who had experienced adverse physical and/or psychological traumatization.

Professional groups differed significantly in their gender distribution, $\chi^2(1) = 23.13, p < .001$, with women comprising about three quarters (73%) of the mental health care group, but only slightly over a third (37%) of the medical care group. Compared to mental health providers, the medical health care professionals were older, on average, $47.95 > 41.76, t(180) = -3.85, p < .001$, had more years of professional experience, $19.00 > 13.2, t(180) = -3.90, p < .001$,

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