The protective role of compassion satisfaction for therapists who work with sexual violence survivors: an application of the broaden-and-build theory of positive emotions

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Therapists who work with trauma survivors, such as survivors of sexual violence, can experience compassion satisfaction while experiencing negative effects of trauma work, such as secondary traumatic stress. We examined whether the negative effects of secondary traumatic stress on therapist adjustment would be buffered by compassion satisfaction and whether the broaden-and-build theory of positive emotions could be applied to examine the factors (positive emotions and positive reframing) that relate to compassion satisfaction. Sixty-one therapists who work with sexual violence survivors completed measures of secondary traumatic stress, compassion satisfaction, adjustment, positive emotions and positive reframing. Hierarchical multiple regression analyses found that compassion satisfaction buffered the negative impact of secondary traumatic stress on therapist adjustment when adjustment was conceptualised as anxiety. Using non-parametric bootstrapping, we found that the relationship between greater positive emotions and greater compassion satisfaction was partially mediated by positive reframing. The findings indicate that compassion satisfaction is likely to be helpful in ameliorating the negative effects of secondary traumatic stress on anxiety in therapists who work with sexual violence survivors and that the broaden-and-build theory of positive emotions may provide a strong theoretical basis for the further examination of compassion satisfaction in trauma therapists.

Keywords: compassion satisfaction; secondary traumatic stress; adjustment; therapists; sexual violence; broaden-and-build theory of positive emotions

Sexual violence is prevalent (Mouzos & Makkai, 2004) and linked to higher rates of post-traumatic stress disorder relative to many other traumas (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Consequently, therapists frequently work with sexual violence survivors (Frazier & Cohen, 1992), and through their work, they are themselves at risk for negative outcomes (Johnson & Hunter, 1997; Kassam-Adams, 1999). For example, therapists who work with survivors of sexual violence have reported secondary traumatic stress symptoms (Baird & Jenkins, 2003), which include fear, sleeping difficulties, intrusive images and avoiding reminders of clients’ traumatic experiences (Stamm, 2010). Such negative effects of trauma work can create feelings of anxiety and depression (Conrad & Kellar-Guenther, 2006). Because therapist self-care is paramount for quality delivery of mental health services (Neumann & Gamble, 1995), there is a focus in the literature on the negative effects...
Empirical research that examines the positive effects from helping work has been increasing in recent years (e.g., Linley & Joseph, 2007; O’Sullivan & Whelan, 2011; Samios, Rodzik, & Abel, 2012); however, this research focuses primarily on one type of positive effect from trauma work – post-traumatic growth or the positive changes reported by therapists. The other key type of positive effect is compassion satisfaction (Craig & Sprang, 2010; Larsen & Stamm, 2008), which refers to the sense of fulfillment or pleasure that therapists derive from doing their work well, such as feeling pleasure from helping others (Stamm, 2005). Compassion satisfaction is considered unique to therapists because it focuses on the powerful experience of emotional engagement necessary for successful therapeutic work (Figley, 2002). Preliminary research by Conrad and Kellar-Guenther (2006) provides support for the role that compassion satisfaction may play in mitigating the negative effects of trauma work. Specifically, they found that child protection staff who reported greater compassion satisfaction had lower levels of secondary traumatic stress. To our knowledge, no study has examined the moderating role of compassion satisfaction on the relationship between secondary traumatic stress and adjustment outcomes, such as depression and anxiety. Thus, we were interested in whether compassion satisfaction would buffer the negative effects of trauma work for therapists who work with survivors of sexual violence.

Although post-traumatic growth has been found to buffer the negative effects of trauma work for therapists (Samios et al., 2012), compassion satisfaction and post-traumatic growth are different constructs (Larsen & Stamm, 2008), and in fact were found to be unrelated in a sample of professionals who work with torture victims (Birck, 2001). Thus, the buffering role found for post-traumatic growth may not necessarily be found for compassion satisfaction. In the case of post-traumatic growth and other similar constructs that tap into positive changes following trauma and adversity such as adversarial growth (Linley & Joseph, 2004), there are a number of strong theoretical frameworks that may account for the protective role of post-traumatic growth for therapists. For example, meaning making theories, which were integrated by Park (2010), indicate that the post-traumatic growth identified by therapists may help therapists reinterpret the threatening aspects of their work, such as their own perceived loss of innocence and difficulties dealing with the emotions of their clients (Neumann & Gamble, 1995), which in turn may lessen the impact of secondary traumatic stress symptoms on adjustment. Unlike post-traumatic growth, which is thought to arise from a search for meaning triggered by distress (Park, 2010), compassion satisfaction is thought to occur as a result of positive feelings arising from helping others, especially clients exposed to trauma (Larsen & Stamm, 2008). The literature on positive emotions may provide a theoretical basis to help understand how compassion satisfaction arises in the presence of the negative effects of exposure to clients’ trauma and why compassion satisfaction may play a protective role for therapists.

Although positive and negative emotions are known to coexist during stressful events (Folkman & Moskowitz, 2000) and have independent relationships with adjustment outcomes (e.g., Lyubomirsky, King, & Diener, 2005), the stress and coping literature largely neglected the study of positive emotions until the
The publication of Fredrickson’s broaden-and-build theory of positive emotions in 1998. The broaden-and-build theory proposes that positive emotions, such as joy, interest and contentment, are more than simply markers of optimal wellbeing (Fredrickson, 2004). Rather, positive emotions broaden a person’s attentional focus and behavioural repertoires and build his or her enduring personal resources (Fredrickson, 1998, 2004). There is now a strong empirical foundation for the broaden-and-build theory. Correlational research has found that over time positive emotions build personal resources (e.g., Fredrickson, Tugade, Waugh, & Larkin, 2003), and a randomised controlled trial found that inducing positive emotions over time in a sample of working adults produced increases in a range of personal resources, such as mindfulness, purpose in life and social support, which were related to greater life satisfaction and less depression (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008). Thus, by applying broaden-and-build theory, we propose that compassion satisfaction is a personal resource that can help protect therapists from the ongoing exposure to client trauma, and that a key factor contributing to this resource is the broadening of a person’s mindset that results from a build-up of positive emotions.

Broadening of a person’s mindset can be conceptualised as positive reframing or “positive meaning finding” (e.g., Garland, Gaylord, & Fredrickson, 2011; Tugade & Fredrickson, 2004), which is also a key component of meaning making theories. Positive reframing refers to a type of meaning focused coping in which the meaning of an event is reinterpreted in a more positive way. Evidence has been found for the critical role that positive emotions play in the search for positive meaning in negative situations (Tugade & Fredrickson, 2004). In fact, positive reframing is one of the few ways of coping that has consistently been found to be related to positive emotionality (e.g., Folkman, 1997; Sears, Stanton, & Danoff-Burg, 2003). Thus, we expect that positive emotionality will broaden the therapists’ mindset through positive reframing, which will be positively related to compassion satisfaction. According to broaden-and-build theory, this cycle will continue in an “upward spiral” towards better adjustment for therapists (Fredrickson & Joiner, 2002).

The lack of empirical research that has examined the protective role that compassion satisfaction may play for trauma therapists, including sexual violence therapists, suggests the need for greater research in this area. As compassion satisfaction is thought to be an important factor in continued work in the presence of the negative effects of trauma work (Larsen & Stamm, 2008), the present study examined the moderating role of compassion satisfaction in the relationship between secondary traumatic stress and both depression and anxiety in a sample of 61 therapists recruited from agencies, where therapists frequently work with sexual violence survivors. We hypothesised that compassion satisfaction would act as a buffer against the negative effects of secondary traumatic stress on both depression and anxiety. Owing to the lack of theory-driven research into the factors that may enhance compassion satisfaction, we also examined the applicability of the broaden-and-build theory of positive emotions to compassion satisfaction in trauma therapists. Specifically, we were interested in whether positive emotionality works through positive reframing to “cause” compassion satisfaction. Thus, we tested the hypothesis that positive reframing would mediate the relationship between positive emotionality and compassion satisfaction.
Methods

Participants and recruitment

The data used for this study are part of a larger data set on therapists who work with sexual violence survivors (see Samios et al., 2012). The key form of recruitment involved the contacting of organisations that offer sexual violence support to their clients and inviting therapists from these organisations to participate in the study. These organisations included five sexual assault services, one family planning service and two drug rehabilitation centres. Some organisations consented to questionnaire packages being sent to them so that therapists could complete and return a hard copy of the survey in a reply-paid envelope. Forty-one hard copy surveys were distributed and 21 were returned yielding a response rate of 51.2%. Response rates for studies on vicarious traumatisation of mental health workers tend to vary from 32 to 57% (Sabin-Farrell & Turpin, 2003), which indicates that the current study’s response rate is relatively good. Other organisations consented to emails being sent to their workers that contained a link for the online version of the survey. In an effort to increase the sample size, psychologists at the university and psychologists who listed sexual assault, sexual abuse and post-traumatic stress disorder as their area of work on the national register for psychologists were also emailed an invitation to participate and link to the online survey. Of the 260 psychologists who were emailed an invitation to participate in the study, 40 psychologists (15.4%) completed the online survey. There were no significant differences on key study variables for therapists who completed hard copies and those who completed the survey online.

The final sample of 61 therapists included 51 (83.6%) females and 10 (16.4%) males. The age of therapists ranged from 23 to 66, with a mean age of 42.39 (SD = 12.09). Fifty-three of the therapists were psychologists, five were counselors and three were social workers, and all of them have provided therapeutic services to survivors of sexual violence. Of the sample, 20 (32.8%) reported that the majority of their current work was with survivors of sexual violence and 38 (62.3%) reported that the majority of their current work involved contact with trauma survivors. Over two-thirds of the therapists were either self-employed or in permanent employment (n = 42, 68.9%), 11 (18.0%) had part-time, casual or temporary employment, and the remaining 8 (13.1%) worked on a volunteer basis.

Measures

Compassion satisfaction

The 10-item Compassion Satisfaction subscale of the 30-item Professional Quality of Life Scale by Stamm (2003) was used to measure compassion satisfaction in this study. This scale has been used in previous research to measure compassion satisfaction in a sample of mental health providers (Sprang, Clark, & Whitt-Woosley, 2007). Therapists were asked to rate each statement from 0 (never) to 5 (very often) for how frequently they experienced characteristics such as “I get satisfaction from being able to help people.” Observed Cronbach’s alpha for this subscale was .86.
Secondary traumatic stress

The 10-item Secondary Traumatic Stress subscale of the 30-item Professional Quality of Life Scale by Stamm (2003) was used to measure secondary traumatic stress. The Professional Quality of Life Scale has been used to measure compassion fatigue in a sample of telephone counselors (O’Sullivan & Whelan, 2011). In the present study, therapists were asked to rate on a scale from 0 (never) to 5 [very often] how frequently they experienced characteristics such as “As a result of my helping, I have intrusive, frightening thoughts.” Observed Cronbach’s alpha for the items of the Secondary Traumatic Stress subscale was initially poor (\( \alpha = .32 \)); however, improved to \( \alpha = .77 \) when item 7 (“I find it difficult to separate my personal life from my life as a helper”) was removed. Therapists are likely to see the ability to separate personal life from work life as a desirable quality and thus may have been reluctant to endorse item 7 if it were in fact true of them. Thus, the Secondary Traumatic Stress subscale used in analyses excluded item 7.

Adjustment

The 7-item Depression subscale and 7-item Anxiety subscale of the widely used 21-item Depression, Anxiety and Stress Scales (Lovibond & Lovibond, 1995) were used as indicators of adjustment. The Depression and Anxiety subscales represent a dimensional approach to distress rather than a categorical conceptualisation of disorder (Lovibond & Lovibond, 1995). Participants rated each statement, such as “I felt that I had nothing to look forward to,” from 0 (not at all) to 3 (very much/most of the time). The subscale scores for depression and anxiety were multiplied by 2 to be consistent with the full 42-item version of the Depression, Anxiety and Stress Scales. Internal consistency was found to be adequate for depression (Observed Cronbach’s alpha = .84) and anxiety (Observed Cronbach’s alpha = .87) in this sample.

Positive emotionality

The five positive items of the Bradburn Affect Balance Scale (Bradburn, 1969) were used to measure positive emotionality. For this study therapists were asked to rate how often they felt each of five positive items such as “particularly excited or interested in something” and “on top of the world” in the past few weeks on a scale from 1 (not at all) to 5 (very often). This scale has been used in previous research to measure positive emotionality in the context of trauma symptoms (e.g., Smith, Rasinski, & Toce, 2001). Internal consistency was good in the present study (Observed Cronbach’s alpha = .89).

Positive reframing

The 2-item positive reframing subscale of the Brief Cope (Carver, 1997) was used to measure positive reframing. Therapists were asked to rate each coping statement from 0 (I don’t do this at all) to 3 (I do this a lot) with regard to “how you cope with working with survivors of sexual violence.” The coping statements are “I try to see it in a different light, to make it seem more positive” and “I look for something good in
what is happening.” The positive reframing subscale of the Brief Cope is often used as a measure of meaning focused coping (e.g., Park, Edmondson, Fenster, & Blank, 2008), and due to its brevity this subscale was used in the current study to limit the burden placed on therapists participating in the study. Observed Cronbach’s alpha was .84.

**Procedure**

After obtaining ethics approval for the study from the university’s human research ethics committee, organisations and individual therapists were invited to participate in the study. Therapists either completed a hard copy of the survey or an electronic copy, which was hosted by a secure Internet-based survey site (Survey Methods). Therapists who completed the hard copy at work or home were provided with an explanatory statement about the study and a reply-paid envelope to return the survey. The therapists who completed the online version were emailed the link to the online explanatory statement and survey, which they could complete at work or at home.

**Results**

**Overview of analyses**

Preliminary analyses examined the zero-order relationships among study variables. Following preliminary analyses, two hierarchical multiple regressions were performed to test whether compassion satisfaction moderated the relationship between secondary traumatic stress and adjustment for the two indictors of adjustment (depression and anxiety). For the significant interaction identified, simple slopes were plotted and examined for relatively high and low levels of compassion satisfaction according to guidelines put forward by Aiken and West (1991). Following moderation analyses, mediation of the relationship between positive emotionality and compassion satisfaction by positive reframing was examined using bootstrapping, which is a non-parametric resampling procedure. Bootstrapping has been recommended as a new method for testing mediation, because it does not impose the assumption of normality of the sampling distribution (Preacher & Hayes, 2008). An alpha level of .05 was used for all analyses.

**Preliminary analyses**

Prior to conducting analyses, the data were checked for data entry errors. A missing value analysis using SPSS 19.0 found that there was less than 5% missing data. Missing values were imputed using mean substitution. Means and standard deviations for the key study variables are presented in Table 1. The mean scores for compassion satisfaction and secondary traumatic stress in this sample fall in the average range (Stamm, 2010). The mean scores for depression and anxiety were lower in this sample compared with normative data in Australia for depression ($M=6.34$, $SD=6.97$) and anxiety ($M=4.70$, $SD=4.91$), although the mean scores in the normative sample vary according to gender and age bracket (Lovibond & Lovibond, 1995). The majority of therapists in the sample scored in the “normal” range for
Table 1. Descriptive statistics and bivariate correlations.

<table>
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<tr>
<th></th>
<th>Range of scores</th>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>Minimum</td>
<td>Maximum</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1. Compassion satisfaction</td>
<td>39.59</td>
<td>4.58</td>
<td>30</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Secondary traumatic stress</td>
<td>25.27</td>
<td>3.04</td>
<td>19</td>
<td>32</td>
<td>-.10</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Depression</td>
<td>4.86</td>
<td>5.92</td>
<td>0</td>
<td>32</td>
<td>-.15</td>
<td>.38**</td>
<td></td>
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</tr>
<tr>
<td>4. Anxiety</td>
<td>2.93</td>
<td>6.02</td>
<td>0</td>
<td>32</td>
<td>-.18</td>
<td>.29*</td>
<td>.74***</td>
<td></td>
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<tr>
<td>5. Positive emotionality</td>
<td>19.29</td>
<td>3.06</td>
<td>9</td>
<td>25</td>
<td>.52***</td>
<td>-.28*</td>
<td>-.41**</td>
<td>-.37**</td>
<td></td>
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<tr>
<td>6. Positive reframing</td>
<td>4.12</td>
<td>1.64</td>
<td>0</td>
<td>6</td>
<td>.40**</td>
<td>.07</td>
<td>-.30*</td>
<td>-.23</td>
<td>.28*</td>
</tr>
</tbody>
</table>

*p < .05; **p < .01; ***p < .001.
depression (85.2%) and anxiety (88.5%) with the remaining therapists scoring between “mild” and “extremely severe” (Lovibond & Lovibond, 1995).

The examination of scatterplots indicated that the relationships between the key study variables are linear in this sample. Bivariate correlations among the study variables are displayed in Table 1. Compassion satisfaction was not related to secondary traumatic stress indicating that although these professional quality of life variables may co-occur they are independent of each other. Secondary traumatic stress was related to higher scores on depression and anxiety; however, compassion satisfaction was not related to depression or anxiety. Correlations also indicated that positive emotionality was related to higher scores on both the positive reframing and compassion satisfaction measures. As expected, positive reframing and compassion satisfaction were positively related.

**Moderation analyses**

To examine the moderating role of compassion satisfaction for the relationship between secondary traumatic stress and adjustment, two hierarchical multiple regression analyses were performed, each predicting a different indicator of adjustment (depression and anxiety). For both analyses, secondary traumatic stress and compassion satisfaction were mean centred and entered into the regression equation in a block at Step 1. The interaction term between secondary traumatic stress and compassion satisfaction, which was entered at Step 2, was created with the centred variables to guard against multicollinearity. The results for the regression analyses are summarised in Table 2. Secondary traumatic stress was a significant predictor of depression and anxiety, such that higher scores on secondary traumatic stress were related to higher scores on depression and anxiety. Compassion satisfaction was not a significant predictor of depression or anxiety. Although the interaction term added a significant increase in variance to the model for predicting both depression and anxiety, the interaction term was only a significant predictor of anxiety. Figure 1 shows the regression plot for anxiety where it can be seen that there

<table>
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<tr>
<th></th>
<th>Depression</th>
<th>Anxiety</th>
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<tr>
<td>ΔR²</td>
<td>β</td>
<td>ΔR²</td>
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<tr>
<td>Step 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary traumatic stress</td>
<td>.16**</td>
<td>.10*</td>
</tr>
<tr>
<td>Compassion satisfaction</td>
<td>.37**</td>
<td>.27*</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
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<tr>
<td>Secondary traumatic stress × compassion satisfaction</td>
<td>-.18</td>
<td>-.31*</td>
</tr>
</tbody>
</table>

Note: R², Adj. R² and F presented are for the full model. ΔR² for Steps 1 and 2 do not add to R² for anxiety due to rounding error. Beta weights presented for point of entry into the regression equation. *p < .05; **p < .01; ***p < .001.
was a significant positive slope for therapists with low levels of compassion satisfaction ($\beta = .59$, $p = .001$), but for therapists with high levels of compassion satisfaction, the slope did not differ significantly from zero ($\beta = -.02$, $p = .925$). This indicates that for therapists with low compassion satisfaction, anxiety was found to increase as secondary traumatic stress increased.

**Mediation analyses**

As recommended for small sample sizes (Hayes, 2009; Preacher & Hayes, 2004) we used non-parametric bootstrapping to test the simple mediation model of positive reframing as a mediator for the relationship between positive emotionality and compassion satisfaction. Mediation is established if the 95% bias corrected confidence intervals (CI) for the indirect effect do not include 0 (Preacher & Hayes, 2004). The results based on 5000 bootstrapped samples indicated that there was mediation (lower 95% CI = .01, upper 95% CI = .27), however, because the direct effect of positive emotionality on compassion satisfaction was significantly different from zero, positive reframing only partially mediated the relationship between positive emotionality and compassion satisfaction. As can be seen in Figure 2, the path between positive emotionality and compassion satisfaction is smaller but still significant once positive reframing is entered into the regression equation. Therefore, therapists who have high levels of positive emotionality are likely to have greater compassion satisfaction, and this in part is due to positive reframing, whereby therapists who score high on positive emotionality are likely to use positive reframing more, and through high levels of positive reframing, more likely to indicate higher levels of compassion satisfaction.

![Figure 1. Compassion satisfaction moderated the relationship of secondary traumatic stress and anxiety. Depicted are slopes for 1 standard deviation above and 1 standard deviation below the mean for compassion satisfaction.](image-url)
Discussion

The present study not only examined the potential protective role of compassion satisfaction for therapists who work with sexual violence survivors but also tested a possible pathway to enhance compassion satisfaction by applying the broaden-and-build theory of positive emotions (Fredrickson, 2004). In this sample of therapists, secondary traumatic stress was related to greater depression and anxiety and support was found for the buffering role of compassion satisfaction on the negative effects of secondary traumatic stress on anxiety. Specifically, therapists with relatively high levels of compassion satisfaction were protected from the negative effects of secondary traumatic stress on anxiety. However, therapists’ level of compassion satisfaction was found to have no significant bearing on the relationship between secondary traumatic stress and greater depression. Preliminary research has found that the other positive effect of trauma work, post-traumatic growth, had a stress buffering effect on both anxiety and depression for trauma therapists (Samios et al., 2012). Perhaps, post-traumatic growth rather than simply identifying ways in which trauma work can be satisfying for the therapist is necessary to buffer the negative effects of secondary traumatic stress on depression. This suggests that post-traumatic growth and compassion satisfaction are indeed distinct personal resources that have differential effects on the secondary traumatic stress experienced by trauma therapists. Although compassion satisfaction and post-traumatic growth have been found to be unrelated (Birck, 2001), their interactive or multiplicative effect on depression and a range of adjustment indicators over and above their additive effect may be a fruitful avenue for future research.

In terms of the process in which compassion satisfaction is fostered in trauma therapists, we examined whether positive emotions may broaden a therapist’s attentional focus as conceptualised by positive reframing and build compassion satisfaction as a personal resource for therapists. The results provide support for a direct pathway between positive emotionality and compassion satisfaction in

Figure 2. Positive reframing as a partial mediator for the relationship between positive emotionality and compassion satisfaction.

![Figure 2](image-url)
addition to an indirect pathway, whereby positive emotionality works through positive reframing to “cause” greater compassion satisfaction. This preliminary finding indicates that the broaden-and-build theory of positive emotions may provide an adequate theoretical basis for examining compassion satisfaction in trauma therapists. With the increasing evidence that positive emotions can broaden an individual’s attention and thinking in both personal and interpersonal (e.g., their sense of ‘oneness’ with close others: Waugh & Fredrickson, 2006) domains and result in a wide range of resources including positive relations with others (Fredrickson et al., 2008), future research should examine the effect of positive emotionality not only on the wellbeing of the therapist but also on the therapeutic relationship and outcomes for the client.

This is, to our knowledge, the first study to examine the stress-buffering effect of compassion satisfaction in a sample of therapists who work with survivors of sexual violence and to also examine compassion satisfaction within a broaden-and-build framework. Although this study has provided greater insight into compassion satisfaction in trauma therapists, which has attracted much lesser research attention than post-traumatic growth, the present study has a number of limitations. In addition to the relatively small sample size and lower response rate for online surveys, the cross-sectional design limits inferences regarding the direction of the relationships between both secondary traumatic stress and compassion satisfaction with adjustment outcomes. Of course, the examination of mediation is also limited by the cross-sectional design of the study. To test mediation, which implies a causal pathway, where possible data for all measures should be collected from therapists over three points in time (Hoyle & Robinson, 2003). Collecting data from trauma therapists who are likely to have elevated levels of compassion fatigue and burnout presents a range of challenges for researchers. In particular, it is likely that therapists with better adjustment will be more willing and able to participate in research (Sabin-Farrell & Turpin, 2003), and that this effect will be amplified over time as the therapists with poorer adjustment are less likely to participate in the final phases of a longitudinal study. The findings of the current study indicate the importance of examining the positive side of trauma work, and thus provide a starting point for future research that addresses the challenges of collecting data from therapists over time in order to further our understanding of therapist wellbeing and professional quality of life.

Notwithstanding the limitations outlined above, this study has several methodological strengths, including the examination of both depression and anxiety as adjustment outcomes, examining a positive effect of trauma work to aid in restoring balance in psychological research so that both negative and positive aspects of human functioning are studied (Linley et al. 2006), and the conceptualisation of compassion satisfaction within an established theoretical framework (the broaden-and-build theory of positive emotions). Indeed, examining correlates of compassion satisfaction from a theoretical perspective has extended the literature on the correlates of compassion satisfaction beyond work-context correlates, such as specialised training in trauma work (Sprang et al., 2007), work experience (Craig & Sprang, 2010), and environmental safety (Hatcher & Noakes, 2010). These and other work-context variables (e.g., job role) are, of course, also important to examine and may be controlled for in future research, where the sample size permits the
analysis of more complex models that may also control for demographic factors, such as age.

Although further research is necessary, the present study’s findings indicate that compassion satisfaction is likely to be helpful in ameliorating the effects of secondary traumatic stress on anxiety in therapists who work with sexual violence survivors. As such, therapists should be aware of not only the secondary traumatic stress symptoms they may be experiencing but also their level of compassion satisfaction. Therapists could benefit from completing the self-report subscales of the Professional Quality of Life Scale (Stamm, 2003) in conjunction with other self-care strategies, such as those put forward by Pearlman (1999). Future research could examine the effectiveness of a loving kindness meditation intervention (Fredrickson et al., 2008) for trauma therapists, where therapists train their attention towards warm and tender feelings (Garland et al., 2010). It is possible that strategies designed to enhance positive emotions, positive reframing, and compassion satisfaction may be beneficial if incorporated into the supervision of trainee therapists. Most likely this would require a supervisor–supervisee relationship that has a sense of mutual respect (Gazzola & Theriault, 2007) where the supervisor is responsible for providing an environment of safety and support (Larsen & Stamm, 2008).

Note
1. This study analyses data from a larger data set from which some of the data have been published by the same authors in the British Journal of Guidance and Counselling (refer to Samios, Rodzik, & Abel, 2012).

References


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