Selected Psychological Aspects of Helping Professionals

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Abstract:
Professional helping is connected with a variety of positive and negative effects. Research studies focus on several consequences of helping work which can be experienced by helping professionals most often – compassion satisfaction (Stamm, 1999; Stamm, 2010), compassion fatigue (Figley, 1995; Figley, 2002; Stamm, 2010), burnout (Figley, 1995; Figley, 2002; Maslach, Jackson, & Leiter, 1996; Stamm, 2010), and perceived stress (Cohen, Kamarck, & Mermelstein, 1983; Tilley & Chambers, 2003). Compassion satisfaction is defined as a pleasure resulting from the ability to help and is connected with the positive feelings about work and colleagues (Stamm, 2010). Perceived stress is described as experienced levels of stress or as a degree to which situations in life are assessed as stressful (Cohen, Kamarck, & Mermelstein, 1983). Compassion fatigue (secondary traumatic stress) describes a vicarious traumatization of the helper resulting from his/her indirect exposure to traumatic experiences by helping his/her clients or patients who were traumatized directly (Figley, 1995; Figley, 2002). Compassion fatigue also includes burnout symptoms as a result of frustration, powerlessness and inability to achieve work goals (Figley, 2002). However, Maslach, Jackson and Leiter (1996) view burnout as a multidimensional syndrome consisting of emotional exhaustion, depersonalization, and reduced personal accomplishment. Negative effects of helping are connected with higher levels of depression (Volpe et al., 2014), anxiety (Hegney et al., 2014), dissatisfaction with workload, or with non-supportive work environment (Ray et al., 2013; Stamm, 2010). Research studies suggest that it is possible to increase the level of compassion satisfaction and decrease the level of compassion fatigue (secondary traumatic stress and burnout) among helping professionals by performing self-care activities (Alkema, Linton, & Davies, 2008; Bloomquist et al., 2015; Killian, 2008; Lawson & Myers, 2011). Self-care is defined as a set of intentional steps related to the care for physical, mental, and emotional health (Moore, 1995). Self-care strategies help to improve physical health, emotional well-being, and interpersonal functioning of helping professionals (Cox & Steiner, 2013). Relevant self-care strategies are for example supervision, debriefing, spending time with family and friends, exercise, spirituality, sense of humour, maintaining balance between professional and personal life, or reflecting on positive experiences (Killian, 2008; Lawson & Myers, 2011). However, there is limited knowledge about compassion satisfaction, burnout, secondary traumatic stress and its correlates among helping professionals in Slovakia.

Present research study was therefore focused on the analysis of compassion satisfaction, secondary traumatic stress, burnout, emotional well-being, and self-care among helping professionals in Slovakia. The first aim of the study was to examine the prevalence of selected, positive and negative, aspects of professional helping (compassion satisfaction, burnout, secondary traumatic stress, emotional well-being and performed self-care) among the Slovak helping professionals. The second aim of the study was to examine the predictive utility of emotional well-being and self-care activities in explaining the level of compassion satisfaction, burnout and secondary traumatic stress among helping professionals in Slovakia.

The research sample was purposive and consisted of 240 helping professionals (psychologists, social workers and health professionals) working in institutions providing social care for orphans in East Slovakia. More women (90 %) than men participated (10 %), with regard to the proportion of both genders among helping professionals working in the institutions providing social care for orphans in Slovakia. The age of participants ranged from 20 to 61 years (M = 40.11; SD = 11.41). The length of their work experience ranged from 1 to 42 years (M = 11.22;
The participants completed the Slovak adaptation of the professional quality of life scale (Köverová, 2016; the original English version Stamm, 2010), the emotional habitual subjective well-being scales (Džuka & Dalbert, 2002) and the performed self-care questionnaire (Lovaš, 2014). They reported the frequency of experiencing positive and negative effects of helping (compassion satisfaction, burnout, and secondary traumatic stress; 1 = never, 5 = always), the frequency of experiencing positive and negative emotions at work (pleasure, happiness, joy, energy, fear, sadness, anger, guilt, shame, pain; 1 = almost never, 5 = almost always), and the frequency of performing self-care activities (physical self-care, health sustaining activities, and psychological self-care; 1 = never, 5 = always). Internal consistency estimates (Cronbach alpha) for the used measures were adequate (.649 - .847).

The results indicated the higher incidence of positive than negative aspects of helping among helping professionals who experienced higher levels of compassion satisfaction, higher levels of positive emotions; and lower levels of negative emotions, burnout and secondary traumatic stress. The results also suggested that the helping professionals performed more physical than psychological self-care activities. Linear regression analyses indicated that performed self-care and emotional well-being were significant predictors of compassion satisfaction, burnout and secondary traumatic stress. A higher level of compassion satisfaction was best explained by the higher frequency of positive emotions experienced at work (β = .379; p < .01). The level of compassion satisfaction was also predicted by performed self-care, specifically by psychological self-care activities (β = .231; p = .01) and health sustaining activities (β = .202; p = .023). The level of burnout was explained by the frequency of positive and negative emotions experienced at work (β = -.255; p = .005; β = .334; p < .01, respectively). The level of secondary traumatic stress was only predicted by the frequency of negative emotions experienced at work (β = .361; p < .01). Self-care activities did not explain the frequency of experiencing the negative consequences of helping (i.e. burnout and secondary traumatic stress). Nevertheless, the results indicated that among self-care activities performed by helping professionals, the psychological self-care could be relevant in explaining the level of burnout (β = -.163; p = .072) and secondary traumatic stress (β = .163; p = .096), according to the p-value.

The results indicated the importance of emotional well-being and performed self-care activities in explaining the levels of compassion satisfaction, burnout and secondary traumatic stress experienced by Slovak helping professionals working in institutions providing social care for orphans. The findings of the research provide a deeper insight into the positive and negative effects of the professional helping and will be used as a research background in the subsequent preparation of the intervention programmes aimed at promoting compassion satisfaction and eliminating burnout and secondary traumatic stress among helping professionals in Slovakia.

**Keywords:**

**1. Introduction**

Helping professionals face a variety of positive and negative consequences resulting from their work. The positive effects of helping are called compassion satisfaction; the negative are called compassion fatigue (Figley, 1995; 2002; Stamm, 2010). Stamm (2010) views compassion satisfaction and compassion fatigue as components of a more general concept called professional quality of life, which refers to the positive and negative feelings of a helper towards their work.

Compassion satisfaction refers to the pleasure resulting from the ability to help, and also to the positive feelings about work and colleagues (Stamm, 2010). Compassion satisfaction is connected not only to helping work, but also to various aspects of the helper's work life. Ray et al. (2013) provide evidence that compassion satisfaction is positively correlated with six areas of work life among mental health care professionals: workload (job demands placed on an employee), control (autonomy of the employee at work), rewards (financial, social and internal), community (quality of relationships in the workplace), fairness (openness and respect in the workplace), and values (congruence between the organization's and the employee's values). Tremblay and Messervey (2011) found that higher levels of compassion satisfaction predicted lower levels of job strain (i.e. the level of psychological distress measured as a frequency of depressive and anxious feelings) among military chaplains. Killian (2008) identified social support as the most important predictor of compassion satisfaction among therapists. Compassion satisfaction was also predicted by working a smaller number of hours...
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per week with traumatized clients, and by greater sense of control over work (Killian, 2008). Higher levels of compassion satisfaction were connected to higher levels of mindfulness and emotional separation among clinical social workers (Thomas & Otis, 2010). This means that a helper's ability to focus on the present and to emotionally differentiate between themselves and their clients or patients is positively associated with compassion satisfaction. Lawson and Myers (2011) found that higher compassion satisfaction was connected with higher wellness among counsellors. Higher levels of compassion satisfaction are also related to low levels of depression among nurses (Hegney et al., 2014). Compassion satisfaction correlated positively with optimism, self-esteem, and a positive state of mind; and negatively with anxiety and depression among social workers and counsellors (Köverová, 2016).

Compassion fatigue refers to the negative consequences of helping. Figley (2002, 3) states that “compassion fatigue is a more user-friendly term for secondary traumatic stress disorder”. Compassion fatigue is a more general term that is viewed as a cost of helping (Figley, 1995; 2002) and has been also described as vicarious traumatisation, secondary traumatic stress, secondary victimization (Figley, 2002). Compassion fatigue (secondary traumatic stress) is a result of helper’s indirect exposure to trauma through helping and from their higher emotional connection with their clients/patients who experienced the trauma directly (Figley, 1995; Figley, 2002; Stamm, 1999; Stamm, 2010). This aspect of secondary traumatic stress distinguishes this concept from the traditional perception of stress defined as a degree to which situations in one's (work) life are appraised as stressful (Cohen, Kamarck, & Mermelstein, 1983).

According to Coetzee and Klopper (2010), compassion fatigue is developed gradually and is preceded by compassion stress (middle state) and compassion discomfort (early state). Figley (2002) states that extremely high levels of secondary traumatic stress experienced by helpers lead to the development of secondary traumatic stress disorder. Its symptoms do not differ from the symptoms of primary posttraumatic stress disorder (developed among direct victims of traumatic events), and include re-experiencing the traumatic event, persistent arousal (irritability and difficulties with concentration), sleep difficulties, intrusive images, anxiety, or avoiding behaviour (Figley, 1995; Stamm, 2010). Higher levels of secondary traumatic stress are related to higher levels of helper's emotional engagement with traumatic experiences of their clients/patients (Figley, 2002). Secondary traumatic stress was negatively correlated with optimism, and positively correlated with depression, anxiety, and a negative state of mind among helping professionals (Köverová, 2016). Thomas and Otis (2010) provide evidence that high levels of compassion fatigue among clinical social workers are connected to low levels of emotional separation. Killian (2008) found that compassion fatigue among therapists was predicted by work drain, therapist’s sense of powerlessness, therapist’s trauma history, and lack of emotional awareness. Secondary traumatic stress experienced by nurses is negatively correlated with compassion satisfaction (Lauvrud, Nonstad, & Palmstierna, 2009), and positively correlated with depression and anxiety (Hegney et al., 2014). Ray et al. (2013) demonstrated that compassion fatigue was negatively correlated with selected areas of work life (workload, control, rewards, community and fairness) among mental health care professionals.

However, the concept of secondary traumatic stress disorder was insufficient to explain a whole variety of compassion fatigue symptoms (Figley, 2002). Therefore, counter-transference and burnout were distinguished to capture those symptoms (Figley, 1995; 2002). Counter-transference is defined as “the unconscious attunement to and absorption of victim’s stresses and traumas” (Figley, 2002, 19). This process is facilitated by empathy of the helper (Figley, 2002). Burnout is viewed as “a result of frustration, powerlessness, and inability to achieve work goals” (Figley, 2002, 19). Burnout is developed gradually (Figley, 1995; Stamm, 1999).
and its symptoms are manifested in cognitive, emotional, behavioural, spiritual, relational, and work performance domains (Figley, 2002). For instance, burnout is associated with preoccupation with trauma, apathy, lowered concentration and self-esteem (cognitive symptoms); fear, guilt, anxiety, depression (emotional symptoms); irritability, withdrawal, impatience, sleep difficulties (behavioural symptoms); loss of faith and purpose (spiritual symptoms); isolation, loneliness, conflicts with others (relational symptoms); and with lower work motivation, lower achievement, conflicts with co-workers, or absenteeism (work performance symptoms) (Figley, 2002).

Most of these symptoms of burnout are also referred to in the model of burnout developed by Maslach, Jackson and Leiter (1996), who distinguish three aspects of burnout. Maslach, Jackson and Leiter (1996, 192) define burnout as "a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity". According to Maslach, Jackson and Leiter (1996), burnout is associated with depletion of emotional resources, loss of energy, fatigue (emotional exhaustion); negative, cynical attitudes and feelings about clients, loss of idealism, irritability (depersonalization); and with negative evaluation of oneself with regard to work, reduced productivity or capability, withdrawal, or an inability to cope (reduced personal accomplishment). Tilley and Chambers (2003) report that higher levels of emotional exhaustion among mental health nurses were associated with patient care, work environment and lack of support, and low levels of personal accomplishment were associated with dissatisfaction with the organization.

Research on compassion fatigue and burnout provide evidence that burnout is associated with a higher incidence of these symptoms among helping professionals. Hegney et al. (2014) found a positive correlation between burnout and anxiety among nurses. Volpe et al. (2014) report that higher level of burnout is associated with higher scores for depression among mental health professionals. According to Thomas and Otis (2010), burnout is negatively correlated with emotional separation and mindfulness. Burnout was also found to be associated with low levels of optimism and self-esteem, a less positive and more negative state of mind, and higher levels of depression and anxiety among helpers (Köverová, 2016). Helping professionals are at risk of burnout when their emotional involvement is high, but when their social support or job satisfaction (feelings of personal work accomplishments) are inadequate (Adams, Boscario, & Figley, 2006). A higher level of burnout is associated with feelings of exhaustion and frustration, dissatisfaction with workload, or with non-supportive work environment (Stamm, 2010).

Studies provide evidence that burnout can develop not only among helping professionals with longer work experience, but also among early career mental health professionals (Volpe et al., 2014), and even among students of helping professions (Michalec, Diefenbeck, & Mahoney, 2013). Volpe et al. (2014) found lower levels of personal accomplishment and higher levels of emotional exhaustion among early career psychiatrists, and higher levels of depersonalization among early career non-medical mental health professionals. Nursing students showed moderate levels of emotional exhaustion, and average levels of burnout as part of compassion fatigue (Michalec, Diefenbeck, & Mahoney, 2013).

Burnout is also related to stress (Köverová, 2016; Volpe, 2014) and is a result of an exposure to various stressors and negative life events (Tilley & Chambers, 2003; Adams, Boscario, & Figley, 2006). Adams, Boscario and Figley (2006) found that a higher number of negative life events predicted higher levels of distress among social workers. The review by Tilley and Chambers (2003) identified the following sources of stress reported by mental health workers (mental health nurses, psychiatrists, clinical psychologists, mental health social workers and occupational therapists): client related issues, caring for the emotional needs of patients, professional self-doubt, poor supervision, administration and organizational concerns, changes
within the health service, management issues, time management, heavy workload, overwork, financial and resource issues, interpersonal and home/work conflicts, role conflicts, personal stresses, lack of reward or lack of resources. It is therefore clear that traumatic experiences of clients/patients (within secondary traumatic stress) are not the only possible stressors in helping professions.

Research studies also suggest that it is possible to increase the level of compassion satisfaction and decrease the level of compassion fatigue (secondary traumatic stress and burnout) among helping professionals by performing self-care activities (Alkema, Linton, & Davies, 2008; Bloomquist et al., 2015; Killian, 2008; Lawson & Myers, 2011). Killian (2008) found that self-care strategies used by therapists included supervision, debriefing, spending time with friends and family, exercise, and spirituality. Lawson and Myers (2011) identified the following personal and professional activities that were most helpful for counsellors: spending time with partner/family, maintaining a sense of humour, maintaining balance between professional and personal lives, maintaining self-awareness, reflecting on positive experiences, engaging in quiet leisure activities, trying to maintain objectivity about clients, and maintaining professional identity. Bloomquist et al. (2015) found that social workers reported higher levels of compassion satisfaction when they practiced more professional (e.g. setting limits with clients, taking breaks, talking to colleagues, getting regular supervision) and emotional self-care (e.g. expressing positive and negative emotions, spending time with family and friends, hobbies).

Practicing more professional, emotional and spiritual (e.g. praying, practicing yoga or meditations) self-care, decreased the level of burnout among social workers (Bloomquist et al., 2015). Psychological self-care activities (e.g. practicing mindfulness, taking time for reflection, participation in one’s own therapy, setting goals, saying no to extra activities) predicted higher levels of burnout and secondary traumatic stress, which may reflect the tendency of helping professionals with already higher levels of compassion fatigue to engage in activities that should help them decrease those negative consequences of helping (Bloomquist et al., 2015).

Performed self-care is therefore an important factor influencing the quality of professional helping. This construct is defined as a set of intentional steps related to the care for physical, mental, and emotional health (Moore, 1995). Self-care is a challenge for every individual and it can be particularly important for the professionals who daily help others. Self-care strategies help to improve physical health, emotional well-being, and interpersonal functioning of the helping professionals (Cox & Steiner, 2013), and contribute to higher satisfaction with their personal and professional life. In a global context, self-care among helping professionals is considered to be an important pre-condition for their ability to help others more effectively, because it is associated with higher levels of work performance, job satisfaction and self-efficacy, and prevents helping professionals from developing a variety of possible negative effects of professional helping, e.g. work stress, burnout, secondary traumatic stress, depression, or compassion fatigue. On the contrary, lack of self-care can be associated with the gradual development of those negative psychological consequences of helping.

There is limited knowledge about compassion satisfaction, compassion fatigue and its correlates in Slovak settings. Therefore, the aims of the present research were to identify the prevalence of selected psychological aspects of professional helping (compassion satisfaction, compassion fatigue, well-being, and performed self-care) among helping professionals in Slovakia and to identify the most important predictors of compassion satisfaction, and the two domains of compassion fatigue (secondary traumatic stress and burnout).
2. Method

Participants and procedure

Two hundred and forty helping professionals (psychologists, social workers and health professionals) participated in the research. More women (90%) than men (10%) participated. The ratio of men and women in the research sample reflects the proportion of both genders among helping professionals in Slovakia. The age of participants ranged from 20 to 61 (M = 40.11; SD = 11.41). The years of experience in the helping professions ranged from 1 year to 42 years (M = 11.22; SD = 10.55). The research sample was purposive. All respondents worked in institutions providing social care for orphans and for seniors in East Slovakia.

All participants completed the professional quality of life scale, the emotional habitual subjective well-being scales and the performed self-care questionnaire. They reported the frequency of experiencing positive and negative effects resulting from helping, the frequency of experiencing positive and negative emotions at work, and the frequency of performing self-care activities.

Measures

Professional quality of life scale (Stamm, 2010; Slovak adaptation Köverová, 2016)

The professional quality of life scale (Stamm, 2010; Slovak adaptation Köverová, 2016) consists of 30 items measuring the level of compassion satisfaction (10 items; e.g. "I get satisfaction from being able to help people."), burnout (10 items; e.g. "I feel worn out because of my work as a helper."), and secondary traumatic stress (10 items; e.g. "I feel as though I am experiencing the trauma of someone I have helped."). The items are answered using a 5-point scale (1 = never; 5 = always). High scores indicate high levels of positive (compassion satisfaction) and negative (burnout, secondary traumatic stress) effects of helping. Stamm (2005) reports adequate estimates of internal consistency (Cronbach alpha) for all three scales (.87 for compassion satisfaction; .90 for burnout; .87 for secondary traumatic stress). Reliability estimates (Cronbach alpha) for compassion satisfaction, burnout, and secondary traumatic stress in Slovak adaptation of the professional quality of life scale were .806, .556, and .754, respectively (Köverová, 2016).

Emotional habitual subjective well-being scales (SEHP, Džuka & Dalbert, 2002)

Emotional habitual subjective well-being scales (Džuka & Dalbert, 2002) were used to measure the emotional component of well-being, i.e. the frequency of experiencing positive and negative emotions. The instrument consists of two separate scales. The first scale (scale of positive state of mind) measures the frequency of experiencing four positive emotions or physical states (pleasure, happiness, joy, energy). The second scale (scale of negative state of mind) measures the frequency of experiencing six negative emotions or physical states (fear, sadness, anger, guilt, shame, pain). A 6-point scale is used to answer all 10 items (1 = almost never; 6 = almost always). Džuka and Dalbert (2002) report adequate values of internal consistency estimates (Cronbach alpha) for the scale of positive state of mind (.77), and for the scale of negative state of mind (.74).
Performed self-care questionnaire (VSS, Lovaš, 2015)

Performed self-care questionnaire (Lovaš, 2015) was used to measure the frequency of engaging in self-care activities, i.e. activities in the area of self-care that an individual performs intentionally and of his/her own accord. Present research was therefore based on the concept of self-care as a comprehensive implementation of these activities (Moore, 1995). Performed self-care questionnaire consists of 21 items focusing on the following three areas of self-care: physical well-being (factor 1, e.g. “I do exercise because of condition.”), activities performed in the situation of health problems (factor 2, e.g. “I avoid situations with risk of disease.”), and positive frame of mind (factor 3, psychological aspect, e.g. “I suppress bad mood.”). The items of the questionnaire are answered by a 5-point scale (1 = never; 5 = always). Higher scores indicate higher levels of self-care activities in each of the three factors.

Statistical analyses

The data were analyzed using SPSS statistics 20 software. Linear regression analysis (enter method) was used to test if well-being and performed self-care significantly predicted compassion satisfaction, secondary traumatic stress and burnout. Linear regression analyses were run separately for compassion satisfaction, burnout and secondary traumatic stress. The predictor variables were the three domains of performed self-care (physical self-care, health sustaining activities, and psychological self-care) and the two domains of well-being (the positive and the negative state of mind).

3. Results

The results of descriptive statistics are presented in Table 1. The mean prevalence of the positive aspects of helping (compassion satisfaction and positive state of mind) was higher than the mean prevalence of the negative aspects of helping (burnout, secondary traumatic stress, and negative state of mind). Mean scale scores were moderate for compassion satisfaction (M = 3.71; SD = .588) and for the positive state of mind (M = 3.62; SD = .814), moderate to low for burnout (M = 2.49; SD = .466) and secondary traumatic stress (M = 2.31; SD = .54), and low for the negative state of mind (M = 2.28; SD = .57).

Mean scale scores on performed self-care questionnaire were moderate for all three areas of self-care activities (M = 3.96; SD = .567 for the health sustaining activities; M = 3.78; SD = .572 for the psychological self-care activities; and M = 3.4; SD = .702 for the physical self-care activities). The comparison of the three mean scale scores indicated that the most used self-care activities among helping professionals were the health sustaining activities, whereas the least used were the physical self-care activities.
Table 1: Means, standard deviations and internal consistency (α) of used measures (n = 240).

<table>
<thead>
<tr>
<th>Measure subscales</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>Scale range</th>
<th>α</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion satisfaction</td>
<td>3.71</td>
<td>.588</td>
<td>1</td>
<td>4.9</td>
<td>1-5</td>
<td>.847</td>
</tr>
<tr>
<td>Burnout</td>
<td>2.49</td>
<td>.466</td>
<td>1.1</td>
<td>3.7</td>
<td>1-5</td>
<td>.649</td>
</tr>
<tr>
<td>Secondary traumatic stress</td>
<td>2.31</td>
<td>.540</td>
<td>1.2</td>
<td>3.7</td>
<td>1-5</td>
<td>.796</td>
</tr>
<tr>
<td>Positive state of mind</td>
<td>3.62</td>
<td>.814</td>
<td>1.25</td>
<td>5.75</td>
<td>1-6</td>
<td>.768</td>
</tr>
<tr>
<td>Negative state of mind</td>
<td>2.28</td>
<td>.570</td>
<td>1</td>
<td>4.17</td>
<td>1-6</td>
<td>.705</td>
</tr>
<tr>
<td>Self-care (physical)</td>
<td>3.4</td>
<td>.702</td>
<td>1.38</td>
<td>5</td>
<td>1-5</td>
<td>.758</td>
</tr>
<tr>
<td>Self-care (health)</td>
<td>3.96</td>
<td>.567</td>
<td>2.57</td>
<td>5</td>
<td>1-5</td>
<td>.677</td>
</tr>
<tr>
<td>Self-care (psychological)</td>
<td>3.78</td>
<td>.572</td>
<td>2.33</td>
<td>5</td>
<td>1-5</td>
<td>.667</td>
</tr>
</tbody>
</table>

The results of the linear regression analysis for compassion satisfaction are presented in Table 2. The five tested predictor variables (positive state of mind, negative state of mind, physical self-care, psychological self-care and health sustaining activities) explained approximately one third of the variance of the compassion satisfaction ($R^2 = .323$). A higher level of compassion satisfaction was best explained by the higher frequency of positive emotions experienced at work ($β = .379$; $p < .01$). Significant positive predictors of the compassion satisfaction were also two domains of self-care: psychological self-care ($β = .231$; $p = .01$) and health sustaining activities ($β = .202$; $p = .023$).

Table 2: Results of linear regression analysis for compassion satisfaction.

<table>
<thead>
<tr>
<th>Predictor variables</th>
<th>$R^2$</th>
<th>$B$</th>
<th>$β$</th>
<th>$t$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive state of mind</td>
<td>.323</td>
<td>.287</td>
<td>.379</td>
<td>4.374</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Negative state of mind</td>
<td>-.108</td>
<td>-.089</td>
<td>-.111</td>
<td>-1.111</td>
<td>.269</td>
</tr>
<tr>
<td>Self-care (physical)</td>
<td>-.142</td>
<td>-.156</td>
<td>-1.724</td>
<td>.087</td>
<td></td>
</tr>
<tr>
<td>Self-care (health)</td>
<td>.228</td>
<td>.202</td>
<td>2.297</td>
<td>.023</td>
<td></td>
</tr>
<tr>
<td>Self-care (psychological)</td>
<td>.259</td>
<td>.231</td>
<td>2.636</td>
<td>.010</td>
<td></td>
</tr>
</tbody>
</table>

Table 3 presents the results of the linear regression analysis for burnout. The five predictor variables explained almost one third of its variance ($R^2 = .289$). The level of burnout was predicted by the frequency of experiencing negative and positive emotions at work, respectively. A higher level of burnout was explained by the higher frequency of negative emotions experienced in relation to helping ($β = .334$; $p < .01$), and by the lower frequency of positive emotions resulting from helping ($β = -.255$; $p = .005$). None of the self-care activities was significant predictor of burnout ($p < .05$). Nevertheless, the psychological self-care seemed to be the most relevant predictor of burnout, according to the $p$-value (.072). This finding suggested that a higher level of psychological self-care performed by helping professionals could explain their low level of burnout ($β = -.163$; $p = .072$).
Table 3: Results of linear regression analysis for burnout.

<table>
<thead>
<tr>
<th>Predictor variables</th>
<th>R²</th>
<th>B</th>
<th>β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive state of mind</td>
<td>0.289</td>
<td>-0.159</td>
<td>-0.255</td>
<td>-2.871</td>
<td>.005</td>
</tr>
<tr>
<td>Negative state of mind</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-care (physical)</td>
<td>.042</td>
<td>0.056</td>
<td>0.334</td>
<td>4.082</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Self-care (health)</td>
<td>-.064</td>
<td>-.069</td>
<td>-.064</td>
<td>-.769</td>
<td>.443</td>
</tr>
<tr>
<td>Self-care (psychological)</td>
<td>-.150</td>
<td>-.163</td>
<td>-.163</td>
<td>-1.818</td>
<td>.072</td>
</tr>
</tbody>
</table>

The results of the linear regression analysis for secondary traumatic stress are displayed in Table 4. In this case, the five predictor variables explained the smallest amount of variance of the criterion variable (R² = .169). The only significant predictor of secondary traumatic stress was the negative state of mind. A higher level of secondary traumatic stress was predicted by a higher frequency of experiencing negative emotions as a result of helping (β = .361; p < .01). Again, none of the self-care activities was significant predictor (p < .05) of secondary traumatic stress experienced by helping professionals. However, the results suggested that psychological self-care activities could be relevant in explaining the level of secondary traumatic stress among helping professionals (β = .144; p = .096). The positive relationship between psychological self-care and secondary traumatic stress could suggest that helping professionals, who experienced higher levels of secondary traumatic stress, were trying to decrease the level of secondary traumatic stress by increasing the frequency of psychological self-care activities.

Table 4: Results of linear regression analysis for secondary traumatic stress.

<table>
<thead>
<tr>
<th>Predictor variables</th>
<th>R²</th>
<th>B</th>
<th>β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive state of mind</td>
<td>0.169</td>
<td>-0.084</td>
<td>-0.141</td>
<td>-1.465</td>
<td>.146</td>
</tr>
<tr>
<td>Negative state of mind</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-care (physical)</td>
<td>0.346</td>
<td>0.361</td>
<td>0.361</td>
<td>4.081</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Self-care (health)</td>
<td>0.111</td>
<td>0.154</td>
<td>0.154</td>
<td>1.535</td>
<td>.128</td>
</tr>
<tr>
<td>Self-care (psychological)</td>
<td>0.053</td>
<td>0.059</td>
<td>0.059</td>
<td>0.610</td>
<td>.543</td>
</tr>
</tbody>
</table>

4. Discussion

The first aim of the current research was to examine the prevalence of selected psychological aspects of professional helping among helping professionals in Slovakia. It was found that the mean prevalence of the positive aspects of helping (compassion satisfaction) was higher than the mean prevalence of the negative aspects of helping (burnout, secondary traumatic stress). Helping professionals also experienced more positive than negative emotions at work. These findings are positive, though unexpected. General knowledge in this area refers to the predominance of compassion fatigue and burnout among helping professionals (Figley, 2002; Lee et al., 2010; Ray et al., 2013; Stamm, 2010). Our results can reflect the social desirability bias. It is possible that the helping professionals in our research sample wanted to create a positive impression of their work life. The dominance of the positive consequences of helping can also be related to the specifics of helping professions that were included in our research – psychologists, social workers and health professionals working in institutions providing social and health care do not have to be in the contact with highly traumatized clients and therefore do not have to experience the highest levels of burnout and secondary traumatic stress.

Further results of the research indicated that the most used self-care activities among helping professionals were the health sustaining activities and the psychological self-care activities,
respectively, and the least used were the physical self-care activities. This is consistent with the suggestion of Alkema, Linton and Davies (2008) that helping professionals should take part in psychological and spiritual self-care activities more than in physical self-care activities. Psychological self-care activities are important for maintaining and/or enhancing a good mental condition of the helping professionals, and thus improve their ability to help others professionally. Earlier research studies also brought evidence that helping professionals considered psychological, emotional, or spiritual self-care activities to be the most helpful for the effectiveness of their work (Bloomquist et al., 2015; Hricová & Vargová, 2014; Killian, 2008; Lawson & Myers, 2011).

The second aim of the study was to identify the most important predictors of compassion satisfaction, and the two domains of compassion fatigue - secondary traumatic stress and burnout. It is possible to conclude that the best predictor variables of compassion satisfaction and compassion fatigue were positive and negative emotions experienced at work, especially fear, anger, guilt, joy and enjoyment. The positive emotions (joy, enjoyment) experienced at work explained the higher level of compassion satisfaction and the lower level of burnout among helping professionals. The negative emotions (fear, anger, guilt) experienced at work explained higher levels of burnout and secondary traumatic stress in helping professionals. This is consistent with the previous research studies on the relationships between the three aspects of professional quality of life (compassion satisfaction, burnout, secondary traumatic stress), and the frequency of experiencing positive/negative emotions (Hegney et al., 2014; Köverová, 2016; Lawson & Myers, 2011; Linley & Joseph, 2008).

The present research also brought evidence that self-care was particularly important for enhancing compassion satisfaction, but insignificant for decreasing the level of burnout and secondary traumatic stress among helping professionals. Within performed self-care, its psychological aspect seemed to be the most important predictor of compassion satisfaction. Nevertheless, our results suggested that psychological self-care could be related to lower levels of burnout. More surprisingly, psychological self-care also seemed to be connected to higher levels of secondary traumatic stress. Although this finding was not significant, it could reflect that helping professionals, who experienced an increase in the level of secondary traumatic stress, tried to decrease it by engaging in psychological self care activities (i.e. positive thinking, suppressing negative thoughts). Therefore, psychological self care could be viewed as rather a consequence than a protective factor of secondary traumatic stress among helping professionals. Our findings are consistent with the results of the research study by Alkema, Linton and Davies (2008), who point out that self-care strategies, that are effective in promoting compassion satisfaction, may not prevent helping professionals from burnout and secondary traumatic stress. Tremblay and Messervey (2011) argue that compassion satisfaction can be intentionally developed by various interventions and can act as a protective factor of compassion fatigue. Huggard (2003) also concludes that the most important factor in effective management of secondary traumatic stress is to develop skills that enable an early recognition of, and insight into, the strong emotions experienced by helping professionals in their relationships with patients. Based on the literature, Whitfield and Kanter (2014) suggest several positive coping strategies aimed at the prevention of secondary trauma, e.g. self-care (exercise, social support, and spiritual connection), seeking peer support and trauma-specific supervision, learning about secondary trauma prevention and treatment, or assessing and managing workload. Our research provides empirical evidence that increasing emotional well-being and performing self-care activities are relevant strategies for promoting compassion satisfaction, and decreasing burnout among helping professionals.

An enhancement of the professional quality of life (i.e. increasing compassion satisfaction, and decreasing burnout and secondary traumatic stress) among helping professionals is an important and challenging issue. Compassion satisfaction positively affects various domains of work life.
(Ray et al., 2013; Stamm, 2010; Tremblay & Messervey, 2011), and is correlated with experiencing more positive and less negative emotions (Hegney, et al., 2014; Lawson & Myers, 2011). On the contrary, compassion fatigue (burnout and secondary traumatic stress) results in the variety of negative symptoms manifesting in cognitive, emotional, behavioural, spiritual, relational, or work area; affects personal and professional life of the helper, and can have negative impact on their clients or patients (Figley, 2002; Hegney et al., 2014; Ray et al., 2013). Higher levels of compassion satisfaction and lower levels of burnout can improve the quality of professional care, and subsequently increase the satisfaction of clients or patients (McHugh et al., 2011; Poghosyan et al., 2010). Therefore, attention should be given not only to the traumas of the clients, but also to the vicarious traumas of the caregivers, in order to prevent or treat burnout and secondary trauma effectively, and thus to enable helpers to continue providing professional support and treatment to traumatized clients (Whitfield & Kanter, 2014).

**Conclusion**

The results of our research highlight the importance of emotional well-being and self-care for explaining compassion satisfaction, burnout, and secondary traumatic stress among helping professionals. Although the research sample was non-representative, and the results are most relevant only for selected groups of helping professionals (psychologists, social workers, health professionals), it is possible to use these findings in order to improve helping practice. The results of the research provide a deeper insight into the positive and negative effects of helping among helping professionals in Slovakia, and will be used as a research background in the following preparation of the intervention programmes aimed at promoting compassion satisfaction, and eliminating burnout and secondary traumatic stress among helping professionals.

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References:


