Empathy and coping as predictors of professional quality of life in Australian Registered Migration Agents (RMAs)

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Threats to professional quality of life such as compassion fatigue constitute a risk for those working with trauma-exposed individuals. Research has investigated professional quality of life in first responders, mental health practitioners, and medical personnel, but the impact on Registered Migration Agents (RMAs) who work with trauma-exposed refugee clients has not been evaluated. This study examined the prevalence of secondary traumatic stress, burnout and compassion satisfaction in 188 RMAs, and the roles of empathy and coping strategies. More than one-third of the sample members were potentially at risk of compassion fatigue (under two-thirds indicated compassion satisfaction). Regression results suggested that compassion fatigue was significantly related both to lower empathy and to maladaptive coping; while adaptive coping and high empathy significantly predicted compassion satisfaction. Results indicate a potential occupational hazard for RMAs working with trauma clients; suggesting tailored interventions to reduce the risk of deleterious compassion fatigue on RMAs.

Keywords: burnout; compassion satisfaction; coping strategies; empathy; professional quality of life; registered migration agent; secondary traumatic stress.

During the first half of 2017, Australian registered migration agents (RMAs) managed 68% of the temporary protection visas and 19% of the permanent protection visas (Office of the Migration Agents Registration Authority, 2017) issued by the Australian Department of Immigration and Border Protection (DIBP). As the process of applying for protection necessarily involves disclosure of applicants' accounts of persecution, fear, trauma and violence (Smith-Khan, 2017), RMAs working on behalf of clients from initial enquiry through to acceptance or rejection of the visa by the DIBP are exposed to such accounts. These narratives have been shown to evoke emotional responses in the listener (Byrne, Lérias, & Sullivan, 2006). Whether these emotional responses impact upon

professional quality of life in RMAs is of interest. To our knowledge, investigation into the professional wellbeing of RMAs working with potentially traumatized clients (hereafter referred to as trauma clients) has not been conducted.

Research into other professionals working with trauma clients, including lawyers, social workers and counsellors, first responders, doctors, and nurses, suggests investigation is warranted (Brobst, 2014; Levin & Greisberg, 2003). Furthermore, it has been suggested that immigration law and working with refugees constitutes a high risk for secondary traumatic stress (STS; Barrington & Shakespeare-Finch, 2013).

Comparisons of the legal industry with other industries provide valuable insights,

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because RMAs may also practise as lawyers, and work performed by lawyers is very similar to that of RMAs. Comparisons point to substantially higher rates of depression, anxiety and substance abuse and lower overall well-being in lawyers (Kelk, Medlow, & Hickie, 2010; Seligman, Verkuil, & Kang, 2005). Examining outcomes of compassion satisfaction, STS and burnout provides a vehicle for appraising the professional quality of life of RMAs who work with trauma clients. Furthermore, protective factors were of interest with a view to mitigating potential risk factors that have been associated with more profound problems (Pearlman & Caringi, 2009; Salston & Figley, 2003).

Professional quality of life

Professional quality of life, or professional wellbeing, is defined as the feeling tone individuals experience in their working capacity as human service workers engaging closely with others (Stamm, 2010). The response of helpers to emotional material can be explained primarily by compassion fatigue and compassion satisfaction, namely, the negative and positive aspects of helping, respectively (Stamm, 2010).

Literature suggests risk factors such as maladaptive coping strategies may negatively impact professional quality of life (Skeffington, Rees, & Mazzucchelli, 2017). Other research suggests empathy (Wagaman, Geiger, Shockley, & Segal, 2015) and adaptive coping strategies (Jacobson, 2012) are protective factors that may mitigate these risks. The current study aimed to examine the professional quality of life of RMAs through the lens of these variables.

Secondary traumatic stress occurs when helpers experience more negative than positive appraisals from their work (Figley, 1995). Vicarious trauma, traumatic stress, traumatic strain, and secondary trauma are frequent synonyms. Symptoms resulting from direct contact with trauma clients include

hyperarousal, avoidance, intrusions, trust and intimacy difficulties, depression, changed cognitions about safety, and increased use of substances (Levin & Greisberg, 2003; McCann & Pearlman, 1990). If left unchecked, STS has the potential to escalate into PTSD (Pearlman & Caringi, 2009).

Burnout is characterised by exhaustion, decreased personal accomplishment, and depersonalization of clients (Adams, Boscarino, & Figley, 2006), presenting with symptoms such as reduced performance, depression, anxiety, increased addictions, and interpersonal difficulties (Maslach & Leiter, 2008). Burnout can be differentiated from STS as a general stress phenomenon and, further, as a process related to chronicity of work stressors, whereas STS may present transiently without necessarily leading to burnout (Figley, 1999; Maslach & Leiter, 2008).

Conversely, when helpers endorse positive feelings and altruistic satisfaction about working with trauma clients, compassion satisfaction is said to result (Figley, 2013; Stamm, 2010). Notably, compassion fatigue, which represents a composite of STS and burnout, and compassion satisfaction, are not considered mutually exclusive; helpers may concurrently evidence high levels of both (Stamm, 1999; 2002). It is proposed that whether helpers experience compassion satisfaction or compassion fatigue is in part contingent upon the quality of their empathic response (Ludick & Figley, 2016).

Lawyers and compassion fatigue

As mentioned, the legal industry provides valuable insights into the impact of working with trauma clients. Burnout in lawyers has been attributed to inadequate non-technical training in 'soft skills' of how to work closely with and communicate unfavourable news to distressed clients (James, 2008). The risk of secondary traumatization for lawyers was also first identified over 20 years ago (Pearlman & Saakvitne, 1995). Significantly higher levels

of vicarious trauma have been identified in criminal lawyers compared to non-criminal lawyers, evidenced by PTSD-like symptoms (Vrklevski & Franklin, 2008). Similarly, compared to mental health practitioners, Australian lawyers exposed to traumatic material at comparable levels showed significantly higher STS scores (Maguire & Byrne, 2017). Their results suggest that organizational factors may have more influence than personality factors on how helpers respond to clients' traumatic material. Further studies showing similar levels of compassion fatigue when comparing mental health care workers with medical practitioners (e.g., Zeidner, Hadar, Matthews, & Roberts, 2013) imply that some disciplines may pose a greater risk than others.

Finally, Baillot, Cowan, and Munro (2013) found evidence in case managers handling claims for asylum seekers of STS adversely affecting job performance, threatening their clients' chances of obtaining asylum. Furthermore, case managers used a range of putatively maladaptive coping strategies, such as denial of responsibility and detachment, in a bid to avoid the contagion of distressing client emotions. The relevance of coping strategies to RMA professional quality of life is discussed next.

Coping

Coping refers to the process of using cognitive, emotional and behavioural methods to execute a response to stimuli considered to exceed the threshold an individual is able to handle (Bober, Regehr, & Zhou, 2006; Endler & Parker, 1994). Coping strategies have typically been classified according to emotion-focused/problem-focused, or adaptive/maladaptive dichotomies. Coping strategies used by RMAs are of interest to assess whether STS and burnout might be mitigated by differences in situational coping responses. One of the very few studies evaluating coping strategies employed by lawyers reported that perceived stress and physical stress symptoms

were mediated via maladaptive coping strategies (Kobasa, 1982).

Adaptive coping strategies used by RMAs who exhibit high levels of compassion satisfaction are also of interest, to inform remediation efforts for those at risk of STS. Jacobson (2012) assessed coping strategies used by Employee Assistance Program (EAP) professionals. Results indicated that adaptive coping strategies were predictive of compassion satisfaction. It was therefore hypothesized that maladaptive coping strategies would be associated with increased STS and burnout, and adaptive coping strategies would be associated with increased compassion satisfaction. Empathy, another variable that might also influence RMA professional quality of life, is discussed next.

Empathy

A multidimensional process, empathy facilitates insight into another's emotional state in reference to oneself. It spans extremes of basic concern at another's distress, through to identification with their plight (Gerdes, 2011). It is considered a direct pathway to STS, on the basis that increases in empathy are proportionate to increases in the potential for personal distress (Ludick & Figley, 2016). Empathy comprises physiological components such as affective response and affective mentalizing, and cognitive components, including self–other awareness, perspective taking, and emotion regulation (Gerdes, Lietz, & Segal, 2011).

Affective response, considered a more basic empathic response, comprises an initial unconscious physiological response (Segal, Gerdes, Lietz, Wagaman, & Geiger, 2017). By contrast, emotion regulation is the capacity to balance subjective reactions to another's situation to prevent overwhelming emotional arousal from becoming distressed (Segal et al., 2017). Indeed, in addition to personal distress, compassion fatigue and burnout may be the consequence of an affective response without emotion regulation (Decety, Yang, & Cheng, 2010).

Another cognitive component, self–other awareness, is the ability to distinguish between feelings and experiences as belonging either to another person or to the self (Lamm, Bukowski, & Silani, 2016). RMAs in possession of high self–other awareness would evidence strong boundaries and not be at risk of personally absorbing the client’s situation outside their professional obligations to assist. Conversely, if RMAs exhibit an affective response, followed by low self–other awareness, emotional contagion from their client is likely (Hatfield, Rapson, & Le, 2011), since an ability to protect themselves from the transmission of aversive emotion is absent.

Higher empathy has been shown to predict less burnout in physicians (Lamothe, Boujut, Zenasni, & Sultan, 2014) and in mental health practitioners: an ability to connect intimately with clients while maintaining clear interpersonal boundaries has demonstrated protection from STS (Harrison & Westwood, 2009). Furthermore, emotion regulation, affective response, and self–other awareness specifically have been found to influence professional quality of life outcomes in other populations (Wagaman et al., 2015). Accordingly, it was hypothesized that high levels of empathy would be associated with increased compassion satisfaction, and low levels would be associated with STS and burnout.

Based upon the above research within comparable industries, the present study combined these variables, hypothesizing (1) that low levels of empathy and maladaptive coping strategies would be associated with aversive professional quality of life outcomes, such as burnout and STS in RMAs, and (2) that high levels of empathy and adaptive coping strategies would, conversely, be associated with compassion satisfaction.

Method

Participants

Of the 188 Australian RMAs who participated, 61.2% were female ($n = 115$) and 35.6% were

male ($n = 67$). 3.2% ($n = 6$) did not specify their gender. The gender split is not necessarily representative of the industry, which reports 47.9% females and 52.1% males (OMARA, 2017). Participants were primarily 38–47 years old (27.7%); in possession of a Grad Cert or Grad Dip in Migration Law (61.7%) as the highest qualification relevant to their job role, while a further 16% held a Bachelor of Laws; 53.2% were originally from Australia or New Zealand, 36.2% were self-employed on a part-time basis, and 33.0% had been working in the industry for 5–10 years. Regarding exposure to distressed clients, 17.2% of RMAs never worked with trauma clients, 35.0% rarely did, 19.4% sometimes did, 10.0% frequently did, and 18.3% did so very frequently.

Materials

Participants completed an online survey, which comprised questions regarding demographics, frequency of exposure to working with trauma clients, and three self-report questionnaires.

Demographic questionnaire

Information was sought regarding a range of demographic items (e.g., gender, age, and employment status).

Exposure

To ascertain the level of contact with trauma clients, RMAs responded on a 5-point Likert scale, from 1 (*never*) to 5 (*very frequently*), to: ‘How frequently do you work with trauma-exposed clients?’ and ‘How frequently do you feel affected by your work with trauma-exposed clients?’

The brief COPE

The Brief COPE (Carver, 1997) is a 28-item abridged version of the original 48-item Coping Orientation to Problems Experienced (COPE; Carver et al., 1989). Items are designed to measure 14 situational coping responses to recent stressors in relation to

RMA's work, rather than to yield an overall score of coping. The original 14-factor structure (Carver, 1997) has been replicated several times (Monzani et al., 2015; Muller & Spitz, 2003), and sound internal consistency of subscales and similar test-retest reliability established (Cooper, Katona, & Livingston, 2008). As the author does not recommend creating total scores or aggregates representing adaptive and maladaptive coping strategies (Carver et al., 1989), we conducted a second-order Exploratory Factor Analysis. Two factors comprising 10 items ($\alpha = .82$) and 11 items ($\alpha = .71$), which represented adaptive coping and maladaptive coping, respectively, were utilised in the current study.

The Empathy Assessment Index (EAI; Lietz et al., 2011)

The 22-item multidimensional EAI measures empathy from a cognitive neuroscience perspective (Segal et al., 2017). Items include 'I am good at understanding other people's emotions' and 'I can agree to disagree with other people'.

Adequate confirmatory factor analytic structure has been demonstrated across multiple samples (Inzunza, 2015; Lietz et al., 2011). Excellent internal consistency was established ($\alpha = .82$; Lietz et al., 2011), and results confirmed the expected 5-factor model with each of the factors demonstrating acceptable to excellent internal consistency ranging from $\alpha = .70$ to $\alpha = .84$. Internal consistency in the current study was slightly lower but still acceptable (Tabachnick & Fidell, 2013), ranging from $\alpha = .63$ to $\alpha = .75$.

The Professional Quality of Life (ProQOL; Stamm, 2010)

The ProQOL has been used extensively across many different professions to measure professional quality of life (see website: <http://www.proqol.org/Bibliography.html>). It subsumes three subscales of STS, burnout, and compassion satisfaction. Higher scores on the

subscales representing compassion fatigue indicate a higher risk for burnout and STS; higher scores on the compassion satisfaction subscale indicate higher satisfaction related to a RMA's ability to effectively assist clients. Reliability coefficients within our study were very good for the three subscales: STS ($\alpha = .86$), burnout ($\alpha = .84$), and compassion satisfaction ($\alpha = .90$).

Design & procedure

Our study involved a correlational, cross-sectional one-group survey design using a purposive sampling strategy to target current or previous Australian RMAs. Independent variables were empathy and coping strategies conceptualised as either adaptive or maladaptive. Professional quality of life outcomes measured by STS, burnout, and compassion satisfaction constituted dependent variables.

Data collection via an anonymous voluntary survey occurred over six months. The online survey was advertised on various social media sites and was administered using the PsychData online survey platform. Ethics approval was obtained from the Bond University Human Research Ethics Committee.

Results

An alpha level of .05 was used, and all data were analysed using IBM SPSS Statistics v. 24. Preliminary analysis confirmed no major violations of assumptions, and there were less than 5% missing data. Descriptive statistics based on the author's combination of cut scores (Stamm, 2010) indicated that 61.2% of the sample fell within ideal or normal-range categories, and 36.7% fell into at-risk/distressed categories. Notably, ProQOL scores were intended for screening rather than diagnostic purposes (Stamm, 2010). Therefore, these results do not definitively categorise RMAs as suffering STS or burnout but, rather, potentially as being at risk of such outcomes.

Hierarchical regressions were conducted to determine the contributions of empathy and

Table 1. Multiple regression analyses predicting burnout, compassion satisfaction, and STS.

	Model 1 Burnout B (β)	Model 2 Compassion satisfaction B (β)	Model 3 STS B (β)
<i>Step 1</i>			
Age	-1.5 (-0.25**)	1.32 (0.24**)	-1.47 (-0.25**)
Gender	-0.46 (-0.04)	0.30 (0.03)	-0.79 (-0.08)
Exposure	-0.04 (-0.01)	0.01 (0.00)	0.51 (0.09)
<i>Step 2</i>			
Age	-0.54 (-0.09)	1.44 (0.26***)	-0.47 (-0.08)
Gender	-0.45 (-0.04)	0.35 (0.04)	-0.78 (0.07)
Exposure	-0.31 (-0.06)	-0.10 (-0.02)	0.21 (0.04)
Maladaptive coping	0.76 (0.57***)	—	0.81 (0.61***)
Adaptive coping	—	0.25 (0.23**)	—
<i>Step 3</i>			
Age	0.04 (-0.06)	0.74 (0.14)	-0.09 (-0.02)
Gender	-0.39 (-0.04)	0.44 (0.05)	-0.55 (-0.05)
Exposure	-0.36 (-0.06)	0.18 (0.03)	0.16 (0.03)
Maladaptive coping	0.54 (0.40***)	—	0.67 (0.50***)
Adaptive coping	—	0.21 (0.19**)	—
Affective response	-0.13 (-0.07)	0.45 (0.25**)	0.37 (0.19**)
Affective mentalising	0.40 (0.15)	-0.13 (-0.05)	0.08 (0.03)
Self-other awareness	-0.70 (-0.27**)	0.76 (0.31**)	-0.58 (-0.22*)
Perspective taking	0.01 (0.00)	-0.37 (-0.18)	0.32 (0.15)
Emotion regulation	-0.67 (-0.30***)	0.54 (0.26**)	-0.56 (-0.25***)

Note. $N = 175$.

* $p < .05$; ** $p < .01$; *** $p < .001$.

coping to professional quality of life, after controlling for demographic factors and exposure frequency.

Hierarchical multiple regression:

Predicting burnout

Hypothesis 1, that maladaptive coping and low empathy would predict burnout, was supported. After controlling for the demographic variables, maladaptive coping accounted for 30% of the variance, $R^2_{\text{change}} = .30$, $F_{\text{change}}(1, 170) = 79.46$, $p < .001$. Empathy components of emotion regulation ($\beta = -.30$, $p < .001$) and self-other awareness ($\beta = -.27$, $p < .01$) were significantly negatively related to burnout. The total combination of independent variables accounted for 50.4% of the variance in

burnout. Table 1 displays unstandardised and standardized regression coefficients of all three models.

Hierarchical multiple regression:

Predicting STS

The second model assessing STS also aimed to address *Hypothesis 1*, assessing maladaptive coping and lowered empathy as predictors of STS. Maladaptive coping strategies demonstrated a significant positive association with STS, explaining substantial variance, $R^2_{\text{change}} = .33$, $F_{\text{change}}(1, 170) = 97.36$, $p < .001$, while subsequent inclusion of empathy explained further variance, $R^2_{\text{change}} = .12$, $F_{\text{change}}(5, 165) = 8.13$, $p < .001$. As per the burnout model, self-other awareness ($\beta = -.22$, $p = .018$) and

emotion regulation ($\beta = -.25, p < .001$) were significant predictors, in addition to affective response ($\beta = .19, p = .007$). Collectively, variables explained 53.1% of the variance in STS.

Hierarchical multiple regression: Predicting compassion satisfaction

Hypothesis 2, that high levels of empathy and adaptive coping would predict compassion satisfaction, was supported. After controlling for demographics, the addition of adaptive coping explained significant variance in compassion satisfaction, $R^2_{\text{change}} = .05, F_{\text{change}}(1, 170) = 9.87, p = .002$, as did the subsequent addition of empathy, $R^2_{\text{change}} = .19, F_{\text{change}}(5, 165) = 8.71, p < .001$. Self-other awareness ($\beta = .31, p = .007$), emotion regulation ($\beta = .26, p = .001$) and affective response ($\beta = .25, p = .004$) were once again significant positive predictors of compassion satisfaction. All independent variables together explained 29.7% of the variance in compassion satisfaction, $R^2 = .30$.

Discussion

It was hypothesized, first, that increased STS and burnout would be associated with maladaptive coping strategies and low empathy. Regression analyses fully supported this hypothesis, consistent with prior research. Maladaptive coping strategies were similarly found to predict secondary trauma symptomology in Australian emergency service workers (Skeffington et al., 2017), for whom the specific coping strategies of distraction, substance use, venting, and self-blame explained a significant amount of variance. Except for distraction, these were common to the suite of maladaptive coping strategies used by RMAs.

The result of decreased empathy predicting increased STS and burnout mirrored other studies of social workers (Wagaman et al., 2015). However, the addition of a significant positive relationship for STS with affective response in the current study suggests greater utilization of emotional empathy by RMAs

when confronted by secondary trauma. The *empathy paradox*, which suggests empathy's ability both to harm and to protect (Salston & Figley, 2003), may be evidenced by affective response positively predicting both compassion fatigue and compassion satisfaction in this sample.

In contrast to the model predicting compassion satisfaction, the models predicting STS and burnout found maladaptive coping to account for greater variance than empathy. This might suggest that RMAs who are low in empathy components of emotion regulation and self-other awareness may have difficulty generating a healthful empathic response when confronted with clients' traumata. In concert with the consequent use of maladaptive strategies, they may be more vulnerable to compassion fatigue. It is possible that empathy may offer greater protective value than that of coping strategies.

It was hypothesized, second, that compassion satisfaction would be associated with high empathy and adaptive coping strategies. Regression analysis results fully supported this hypothesis, with two aspects of empathy (self-other awareness and emotion regulation), and adaptive coping strategies contributing significantly to compassion satisfaction. In addition, a further component of empathy, affective response, was also implicated in predicting compassion satisfaction. Affective response, the ability to unconsciously mirror clients' emotional states, precipitates cognitive empathic processing of accounts of trauma (Segal et al., 2017). This result is in agreement with theoretical models that state that empathy constitutes a significant pathway to compassion satisfaction, and lack thereof, to STS (Ludick & Figley, 2016).

The results also support previous studies independently affirming the role of empathy in predicting compassion satisfaction. In social workers Wagaman et al. (2015) found that 20% of the variance in compassion satisfaction was explained by empathy (compared to 19% in the current study), with close replication of

self–other awareness, emotion regulation, and, notably, affective response.

Concurrence with prior studies where adaptive coping also predicted higher potential for compassion satisfaction (Jacobson, 2012) shows promise for recruiting adaptive coping skills as a protective factor against compassion fatigue. This contrasts with some authors who have suggested that because adaptive coping is not efficacious under all conditions (Lazarus & Folkman, 1984), it may not be the panacea to preventing compassion fatigue.

Limitations and future research

Limitations included the use of a cross-sectional design, preventing inferences about causality. Furthermore, although major migration agent industry bodies consented to recruitment of their members, membership is not compulsory, and participants constitute a self-selecting sample. The sample's representativeness of the population is also questionable on the basis of gender bias. This issue is potentially compounded because empirical evidence has shown that females typically report higher levels of secondary traumatization than do males (Kassam-Adams, 1999). Caution is therefore warranted in interpreting these results, as generalizability may be affected.

Having investigated the impact of empathy and coping strategies on professional quality of life, future research may consider the influence of potential moderators such as detachment, self-care, and social support. Providing training to RMAs at risk of compassion fatigue is only ameliorative to the extent that significant moderators of the exposure-distress relationship are also accounted for. The helper's personal trauma history is an established predictor of compassion fatigue in other professions (Figley & Figley, 2017; Kassam-Adams, 1999) that may also warrant investigation in RMAs.

Practical implications

Professional development training may address both STS and burnout, which have the potential to degrade the empathic engagement of RMAs with clients and therefore work performance, as a minimum. More pervasive problems may include absenteeism, attrition, and misconduct complaints, which can result in suspension or cancellation of RMA licenses (OMARA, 2017). Empathy training specifically may ameliorate distress, thereby reducing maladaptive coping strategies.

RMAs are not privy to structured clinical supervision and training afforded mental health practitioners. Therefore, the impetus for implementing measures to safeguard the mental health of these individuals by reducing the effects of and normalising responses to trauma work lies with industry bodies, employers and CPD providers. Other than professional development and training, such measures might also include formalised networks of peer sharing and/or consulting, for example, both online and in-person forums, to facilitate best practice knowledge transfer from more experienced RMAs.

Ethical standards

Declaration of conflicts of interest

Danielle Raynor has declared no conflicts of interest.

Richard Hicks has declared no conflicts of interest.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the Bond University Human Research Ethics Committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in the study.

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