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SENSE OF COHERENCE AND COPING AS PREDICTORS OF COMPASSION SATISFACTION AND FATIGUE IN PSYCHOLOGY TRAINEE THERAPISTS

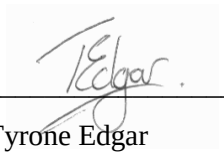
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A research project submitted in partial fulfilment of the requirements for the degree of M.A. Clinical Psychology in the faculty of Humanities, University of the Witwatersrand, Johannesburg, 21 December 2011.

I declare that this research project is my own, unaided work. It has not been submitted before for any other degree or examination at this or any other university.



Tyrone Edgar

12 December, 2011

Abstract

The aim of this research was to longitudinally and quantitatively investigate sense of coherence (SOC) and coping strategies as predictors of compassion satisfaction (CS) and compassion fatigue (CF) as measured by secondary traumatic stress (STS) and burnout (BT) during the first six months of training in a professional psychology training programme. Trainee therapists', "dramatically shift" their "focus of functioning over time" to adorn the personality and self of the therapist (Rønnestad & Skovholt, 2003, p. 28). This adaptive process may initially unravel over six months as trainees balance client and workload stressors (Hill, Sullivan, Knox & Schlosser, 2007; Tryssenaar & Perkins, 2001). However, research on the developmental processes behind the negative (CF) and positive (CS) avenues of therapeutic stressors is lacking in the trainee therapists' population, especially quantitatively (Schwing, LaFollette, Steinfeldt & Wong, 2010; Thériault, Gazzola & Richardson, 2009). This research aimed to explore these issues in relation to professional development through SOC and coping as predictors of CS and CF over a six month training period. Variables were investigated quantitatively through the Professional Quality of Life Scale (ProQOL) (Stamm, 2010) the Brief COPE (BCOPE) (Carver, 1997) and the 29-item self-report Orientation to Life Questionnaire (OLQ) (Antonovsky, 1987). As such, the primary focus of this research was on how SOC and coping strategies were utilised by trainee therapists as process variables in predicting the positive (CS) and negative (CF) avenues of therapeutic work over a six month period of psychotherapy training. Findings suggested that, at the beginning of training, sense of coherence was directly associated with the core outcome variables (CS and CF (as measured by STS and BT). When trainee therapists started seeing clients two months later, the effect of SOC was mediated by coping. At the end of training, only coping was directly associated with outcome variables as the effect of SOC on CS and CF disappeared. These implications are further discussed in the research.

Keywords: Trainee therapists, Sense of Coherence, Coping Strategies, Compassion Satisfaction and Compassion Fatigue

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I would sincerely like to thank my Lord and Saviour Jesus Christ for giving me the favour and grace to complete this research project. His Word describes the meaning behind this study:

"And let us not loose heart and grow weary and faint in acting nobly and doing right, for in due time and at the appointed season we shall reap, if we do not loosen and relax our courage and faint" – Galatians 6:9 (Amp).

I would also like to acknowledge and thank my parents for their support, encouragement and unfailing love throughout this research project and year. Lastly, I would like to thank Dr. Esther Price for her invaluable contribution, wisdom and patient effort in this research project; it is because of supervisors like Dr. Price that trainee therapists can reach their potential.

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Chapter 1

1. Introduction

The initial stages of psychological training involve a process of integration that provides the foundation and motivation for becoming a psychotherapist (Hill, Sullivan, Knox & Schlosser, 2007; Skovholt & Rønnestad, 2003). This foundation appears to initially unfold over a semester (six months) as trainees shift functioning from an internal to external to internal focus (Hill et al., 2007; Rønnestad & Skovholt, 2003). To effectively negotiate these shifts, trainees need the ability to "experience, understand, regulate and express emotions at a level that facilitates the counselling/therapy process" (Skovholt & Rønnestad, 2003, p. 48). Along with this capacity, they require continuous reflection for optimal learning and professional growth (Rønnestad & Skovholt, 2003). This reflective, expressive and regulatory aptitude appears to be captured by an individual's sense of coherence (SOC) (Antonovsky, 1987). The SOC concept appears to encapsulate the comprehensibility, meaningfulness and manageability a psychotherapist requires for optimal functioning. Previous literature suggests that experienced therapists use SOC to manage professional stressors and foster job satisfaction (Fourie, Rothmann & Van de Vijver, 2007; Linley, Joseph & Loumidis, 2005).

Additionally, trainee therapists "need to be aware of their negative and positive reactions to clients" if they are to develop optimally as professionals (Hill et al., 2007, p. 22). The negative avenues of training can be conceptualised as compassion fatigue (CF) (Figley, 1995). There are two parts to CF; secondary traumatic stress (STS) captures the anxiety aspects of CF and burnout (BT) encapsulates the overwhelming nature of CF (Stamm, 2010). Trainee therapists may experience CF without the necessary inclusion of traumatic stimuli. Indeed, the simple "ambiguity of professional work" is a "major catalyst" for "novice stress" which can involve "acute performance anxiety" (Skovholt & Rønnestad, 2003, p. 45). Attempting to address and normalise this stress may arrest boundary issues, impairment and incompetence in trainee therapists (Hill et al., 2007; Tryssenaar & Perkins, 2001). This could help trainees develop progressively in their profession without getting caught in a "negative and stagnant" process termed "negative development" (Rønnestad & Skovholt, 2003, p. 38).

In contrast, the positive avenues of therapeutic work can be conceptualised as compassion satisfaction (CS) (Stamm, 2002). Trainee therapists with increasing levels of CS may feel satisfied, invigorated and content when helping others (Stamm, 2002). Fostering CS in trainee therapists may

help preserve and increase "professional productivity and sustained motivation" (Stamm, 2002, p. 107). Even further, CS is considered a "protective factor" against CF (Collins & Long, 2003; Sprang, Clark & Whitt-Woosley, 2007). Accordingly, CS is a positive avenue of professional development which can protect trainees against the stagnant and deteriorating aspects of negative development (Cicognani, Pietrantoni, Palestini & Prati, 2009; Collins & Long, 2003; Sprang, Clark & Whitt-Woosley, 2007). Therefore, aiding trainee therapists to sustain a functional level of CS may help predict the negative avenues of therapeutic work and provide trainee therapists with prolonged satisfaction in their careers.

Furthermore, upon encountering the negative avenues of therapeutic work, trainee therapists "naturally attempt to process this intense data" (Rønnestad & Skovholt, 2003, p. 48). This process may involve utilising SOC as it has been associated with "fewer negative changes and more positive changes" (Linley et al., 2005, p. 185). Counsellors with higher levels of SOC have been found to experience less burnout, more work engagement and greater role satisfaction (Fourie et al., 2007; Ortlepp & Friedman, 2002). Accordingly, SOC is thought to directly and indirectly affect CF and CS levels (Fourie et al., 2007). More specifically, SOC may be a flexible selective resource for choosing coping behaviour that is judged to be appropriate in relation to specific stimuli (Boss & Mulligan, 2003). This suggests that SOC may be mediated by coping in predicting CF and/ or CS as outcomes in trainee therapists. Applying and exploring this observation to the trainees' shifts in functioning across a six month period of training, may shed light on the negative and positive avenues of professional development.

Presumably, as training responsibilities increase to include both client stressors and training workloads, SOC becomes somewhat "shattered" or strained (Janoff-Bulman, 2002 p. 90). This process becomes a catalyst for an "internal construction work" in which SOC is "altered" along with a "shedding of values, beliefs and methods that do not fit the personality and the self of therapist" are "shed" (Pearlman & Saakvitne 1995, p. 152; Skovholt & Rønnestad, 2003, p. 50). Perhaps, while trainee therapists grapple with the stress of therapeutic work, this process becomes a catalyst for development (Pearlman & Saakvitne 1995). In the face of therapy/client stressors, trainee therapists may differentially adopt coping styles as a function of whether or not their baseline SOC was higher or lower, and these coping patterns may mediate the relation between SOC and the fatigue of therapeutic work (CF), as well as SOC and the satisfaction of helping others (CS). After six months, these adaptive shifts may be integrated into the trainees SOC considering that "adaptive strategies" have been found "flowing through both professional and personal lives" after roughly the "4th to 6th" month of therapeutic experience (Tryssenaar & Perkins, 2001, p. 24).

This research proposes an empirically derived framework based on how SOC and coping may directly and indirectly predict the positive (CS) and negative (CF) avenues of psychotherapeutic training over a six month period. The framework suggests that a fundamental "mini-cycle" may unfold over a six month training period in which "exploration about self and about the relationship between self and environment, contribute to the construction of the self"- in this this case the practitioner self (Savickas, Nota & Rossier et al., 2009, p. 7). After this initial mini-cycle is laid, then perhaps further explorative and developmental activities may be erected which can enhance the psychotherapist (Super, Savickas & Super, 1996). Previous research has suggested that a deeper understanding of therapeutic development may be obtained when conceptualising around stress management and the therapeutic relationship (Lebow, 2005; Rønnestad & Skovholt, 2003; Shapiro, Brown & Biegel, 2007). Perhaps, investigating these suggestions may shed light on a beginning mini-cycle of therapeutic development.

To achieve the above aim, this research quantitatively investigated the direct and indirect effects of trainee therapists' SOC in relation to CF and CS with coping as a potential mediator of this relation after two, four and six months of training. There also appear to be inconsistencies in the literature related to whether or not SOC directly or indirectly impacts on CF and CS. A secondary aim of this research, therefore, was to explore these relations in a quantitative longitudinal design focusing on the impact SOC changes had on CF and CS, both directly and indirectly, across six months of training.

Chapter 2

2. Literature Review

2.1. Professional Development

The literature conceptualizes professional development as a "self-other differentiation process where the counsellor or therapist gradually increases in ability to differentiate client and practitioner responsibilities and to relate in functional ways" (Skovholt & Rønnestad, 2003, p. 48). Considering this definition, previous literature has observed that functional and adaptive shifts can occur as early as four to six months into training (Hill, Sullivan, Knox & Schlosser, 2007; Tryssenaar & Perkins, 2001). As Hill et al., (2007, p. 15) noted, in the "space of one semester trainees became much less anxious, gained in confidence in their therapeutic abilities and became more comfortable in their therapeutic role." Tryssenaar and Perkins (2001) suggest this adaptation process may be predictable. The initial six months of training could, therefore, be a critical and predictable time in which training therapists learn to function in adaptive ways and develop as professionals.

More research, however, is required to understand the predictors of effective movement in professional development (Fouad, 2003). It has been recommended that future studies focus on the helper-client relationship regarding the process behind therapist development (Rønnestad & Skovholt, 2003). This is because direct clinical practice through therapy, has been rated the most important influence on therapist growth (Orlinsky, Botermans & Rønnestad, 2001). Other research has suggested researching novice counselors' anxiety around the therapeutic relationship in training (Schwing, LaFollette, Steinfeldt & Wong, 2010). It was observed that normalising such worries was important for effective facilitation of counselor development (Schwing et al., 2010). Perhaps by focusing on trainee anxieties around the helper-client relationship within the initial six months of training, critical predictors of effective professional development can be further conceptualised.

2.2. Trainee Therapists

The term trainee therapist was used throughout this research to refer to a beginner student, counsellor or psychotherapist who is currently undergoing professional development through their respective Master in Psychology training course. This research focused on trainee therapists in the South African context, specifically trainees at the University of the Witwatersrand (WITS). The sample consisted of students in Clinical psychology, Educational psychology, as well as in Community-based counselling at WITS. The WITS (2011) programme has a broadly psychodynamic orientation and offers community-based practice across all three of the modules mentioned in addition to opportunities to take on clients on a longer-term basis. Some components of the course are offered as part of an integrated programme designed to foster interdisciplinary contact and to encourage multiple avenues of input (WITS, 2011). However, in all three programmes, close supervision, mentoring and attention is paid to clinical and multicultural sensitivity. Nevertheless, each of the psychology and community-based counselling degrees has a specific focus related to a particular therapeutic field of study.

To elaborate, the educational psychologists receive training focused on the psychological and scholastic assessment of children who are experiencing emotional and/or academic problems or barriers with learning and development (WITS, 2011). Working with these children includes play therapy, parent education and/or counselling. These trainees also work with teachers, parents, caregivers and communities. Concerning the clinical psychology programme, focus is on trainees learning to provide assessment, diagnosis and psychotherapy to a range of people suffering from various psychological disorders (WITS, 2011). The clinical trainees are assigned to two semester long placements at community clinics, one dealing primarily with traumatic stress cases and the other with a range of community health problems. Furthermore, the community-based counselling students are trained in psychological assessment, therapeutic skills, diagnostic capabilities and community psychology (WITS, 2011). These skills are aimed at understanding, diagnosing and providing

interventions for personal, interpersonal and social problems in living. The community-based trainees are involved in providing services to a number of community contexts within the South African environment.

Additionally, WITS structures the Masters' programmes in accordance with the Health Professions Council of South Africa (HPCSA). All the programmes mentioned, are two-year, full-time degrees that involve theoretical, practical and research elements. In the first year (M1), students register as 'student psychologists' with the HSPCA. This registration allows trainees' visits to hospitals or agencies for training purposes. As discussed, during M1, the students complete a theoretical and practical programme centred at WITS. The students are also required to complete a research report in a suitable psychological area during M1. The second year of Masters (M2) comprises of a full-time internship of twelve months duration at a training hospital or other centre approved by the HPCSA. At the end of M2, the students are eligible for registration in their respective categories with the HPCSA with subsequent community service being obligatory for certain categories. As noted, however, this research will focus primarily on the first six months training. Therefore, only the first half of the trainee therapists' M1 year was focused on in this research.

2.3. Sense of Coherence and Optimal Professional Development

To professionally develop, trainee therapists require the ability to "experience, understand, regulate, and express emotions at a level that facilitates the counselling/therapy process" (Skovholt & Rønnestad, 2003, p. 48). This involves the ability to continually reflect upon professional experiences in general and difficulties and challenges in particular (Rønnestad & Skovholt, 2003). The reflection process is considered a "continuous and focused search for a more comprehensive and nuanced in-depth understanding of oneself and others and of the processes and the phenomena that the practitioner meets in his or her work" (Rønnestad & Skovholt, 2003, p. 29). In other words, in order to develop professionally, trainees need to continually search for more comprehension, meaning and manageability in relation to their respective practitioner challenges and responsibilities. Arguably, the trainee therapists need to search for a sense of coherence (SOC) (Antonovsky, 1987). The SOC concept is defined as:

> "A global orientation that expresses the extent to which one has a pervasive, enduring, though dynamic feeling of confidence that (1) the stimuli, deriving from one's internal and external environments in the course of living are structured, predictable and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges worthy of investment and engagement" (Antonovsky, 1987, p. 19).

According to Antonovsky (1987, p. 75), SOC is "understood as a global orientation or disposition leading to a certain attitude towards the environment." Those with strong SOC have an enduring attitude or feeling of confidence that they can manage, comprehend and put meaning to internal and external environments as predictable, and that there is a high probability that things will develop as well as can be expected (Fourie, Rothmann & Van de Vijver, 2007).

In the training context, trainee therapists with higher SOC may be able to manage, comprehend and put meaning to their internal and external therapeutic environment as predictable and that there is a high probability that things will develop well. These trainees may also be able to identify the necessary resources required to meet the demands of therapeutic practice and feel such demands are worthy of their investment and engagement. Accordingly, increasing levels of SOC are possibly indicative of a trainee's ability to acquire the comprehensive and nuanced in-depth understanding of oneself and environment that allows for effective movement through therapeutic training (Rønnestad & Skovholt, 2003). More specifically, SOC is broken down into three clear components, namely meaningfulness, comprehensibility and manageability. These components are highly related to one another and can be discussed in terms of relative importance in relation to the trainee therapists (Antonovsky, 1987; Rice, 2000).

Firstly, meaningfulness is defined as the extent to which one feels that life is making sense on an emotional and not just a cognitive level (Antonovsky, 1987; Fourie et al., 2007). It is viewed as the drive component of SOC, implying that when a person is confronted with stressful stimuli they will be capable of motivating themselves to make sense of it (Antonovsky, 1987; Rice, 2000). Arguably, the meaningfulness subscale allows trainee therapists to make sense of therapeutic challenges. It is the aptitude that seems to permit trainees to facilitate professional development (Skovholt & Rønnestad, 2003) - not just on a cognitive level but also on an emotional level. Therefore, trainee therapists, who are able to utilise their meaningfulness, may be able to make emotional sense of their challenges which in turn may foster professional development.

Secondly, comprehensibility refers to the extent to which one perceives stimuli from the internal and external environment as information that is logical rather than irrational (Antonovsky, 1987; Rice, 2000). This process generates clarity allowing for a person to find meaningfulness and to comprehend ways of managing situations (Rice, 2000). As such, in the process of fostering meaningfulness and manageability, the comprehensibility subscale allows for the "ambiguity of professional work" to become more clear (Skovholt & Rønnestad, 2003, p. 45). Producing clarity is a primary objective of adequate reflection. As noted, reflection is the search for comprehensibility and understanding of oneself in relation to practitioner challenges (Rønnestad & Skovholt, 2003). Trainee therapists, therefore, reflect more by fostering applicable levels of comprehensibility. This implies they are

searching to perceive practitioner stimuli from the internal and external therapeutic environment as information that is logical rather than irrational. The development of the comprehensibility subscale, therefore, appears to be important in professional reflective qualities.

Thirdly, manageability is equated with the "extent to which one perceives that resources are at one's disposal and are adequate to meet the demands posed by the stimuli bombarding one" (Antonovsky, 1987, p. 17). A person's manageability is important because if a situation is perceived as unmanageable then they are less likely to find meaning or strive to comprehend the predicament (Antonovsky, 1987). Trainee therapists need a number of strategies to help them manage their anxieties, especially around intense internal reactions to clients (Hill et al., 2007). Fostering manageability in trainee therapists, therefore, may allow them to better perceive which external resources are suited and necessary to meet therapeutic demands. In turn, professionally adapted manageability may help them ameliorate the "anxiety, concerns about self-efficacy, and hot buttons" associated with professional development (Boss & Mulligan, 2003; Hill et al., 2007, p. 21).

2.4. Negative Avenues of Professional Development

Trainee therapists not only require an internal sense of coherence to effectively develop as professionals, they also need to be "aware of their negative and positive reactions to clients, their fears and urges" (Hill et al., 2007, p. 22). There is an increasing appreciation in occupational health psychology that both positive and negative health aspects should be considered to gain a comprehensive view of the status of workers (Fourie et al., 2007). Perhaps this notion should also be applied to trainee therapist development. As Rønnestad and Skovholt, (2003) suggest, if a more comprehensive conceptualization of trainee development is to be conceptualized then the negative avenues of professional development need to be considered. This may be because normalising negative avenues arrests boundary problems, incompetence, impairment and disillusionment which can all hinder optimal development (Hill et al., 2007; Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 2003).

The negative avenues of psychotherapy can be considered in terms of compassion fatigue (CF) (Figley, 1995). The CF reaction is characterised by the "negative aspects of providing care to those who have experienced extreme or traumatic stressors" (Stamm, 2010, p. 21). The CF reaction particularly involves the following:

> "A state of tension and preoccupation with the cumulative trauma of clients as manifested in one or more of the following ways: re-experiencing of traumatic events, avoidance/numbing of reminders of traumatic events, persistent arousal and is combined with the added effects of cumulative stress or burnout" (Figley, 2002a, p. 11).

Those that experience CF have episodes of sadness and depression, sleeplessness, and general anxiety (Cerney, 1995). In some instances, they may suffer from a "psychic overload; losing their objectivity and their ability to be helpful" (Conrad & Kellar-Guenther, 2006). Accordingly, the negative responses found in CF include feelings of being afraid and overwhelmed (Stamm, 2010). As such, Stamm (2010) measures, scores and conceptualises CF separately. In particular, secondary traumatic stress (STS) (Stamm, 1995) captures the fearful aspects of CF, while burnout (BT) (Maslach, 1982) comprises the overwhelming aspects of CF.

Concerning the STS component of CF, such a reaction involves "being preoccupied with thoughts of people one has helped" (Stamm, 2010, p. 21). It includes an experience or reaction of tension and distress that is directly related to the demands of living with and/or empathetically caring for someone who displays the symptoms of PTSD (Figley, 2002a). Many other descriptions have been used to describe the STS reaction. These include vicarious traumatization (McCann & Pearlman, 1989), co-victimization (Hartsough, 1985), traumatic countertransference (Herman, 1992) and contact victimization (Figley, 1995). Caregivers that experience STS generally report feeling "trapped, overwhelmed, and infected by others' trauma" (Stamm, 2010, p. 21). This can induce feelings of distress, sleep deprivation, avoidance, and an inability to separate one's person life from one's life as a helper (Figley, 2002a; Stamm, 2010). In other words, those who care for others can experience a secondary reaction and suffer themselves (Figley, 2002a; Lebow, 2005).

The BT component is a part of CF that is characterised by feelings of unhappiness, disconnectedness, and insensitivity to the work environment (Stamm, 2010, p. 21). It usually involves a state of physical, emotional and mental exhaustion caused by a "depletion of an ability to cope with one's everyday environment" (Gentry, Baranowsky & Dunning, 1997, p. 124). The BT concept also includes feeling overwhelmed, overloaded, uncontrolled and generally involves interpersonal problems in the workplace (Maslach & Leiter, 1997). Those that experience BT have been known to feel "out-of-touch with the person he or she wants to be, while having no sustaining beliefs" (Stamm, 2010, p. 21). Factors producing BT in the counsellors-therapist population have included, level of exposure to trauma, general workload, history of personal trauma, inadequate training and a lack of interpersonal resources (Deighton, Gurris & Traue, 2007). In contrast to the more sudden and acute STS aspects of CF, BT is a gradual and cumulative wearing down process (Figley, 1995).

2.4.1. Compassion Fatigue and Professional Development

The CF concept is framed within a constructivist self-development theory, which is a developmental and interpersonal theory explaining the impact on an individual's psychological development, adaptation and identity (Pearlman & Saakvitne 1995). It is understood that therapists

who experience CF type symptomatology, are "marked by profound changes in core aspects of their therapist self or psychological foundation" (Pearlman & Saakvitne 1995, p. 152). The changes and shifts brought about by CF type symptomatology are described below:

> "Alterations include shifts in the therapist's identity and world view; in the ability to manage strong feelings, to maintain a positive sense of self and connect with others; and in spirituality or sense of meaning, expectation, awareness, and connection; as well as in basic needs for and schemata about safety, esteem, trust, and dependency, control, and intimacy." (Pearlman & Saakvitne 1995, p. 152).

Accordingly, as experienced therapists grapple with CF symptomatology their identity as therapists' shift, alter and change. Therapists try and "integrate the trauma material and these profound personal changes" into their therapeutic identities (Pearlman & Saakvitne 1995, p. 152). Perhaps, they undergo changes in their professional sense of meaningfulness, manageability, and comprehensibility (SOC).

Indeed, fundamental assumptions of the therapeutic self are ingrained in the experienced therapist and this equips them with a sense of confidence and trust to complete their work (Janoff-Bulman, 2002). According to Janoff-Bulman (2002 p. 18), the SOC concepts adequately described this outlook, namely a "sense of general optimism" that "things will work out well". However, "core assumptions" found in sense of coherence can become "shattered" by traumatic experience (Janoff-Bulman, 2002 p. 90). In the case of the therapeutic work, perhaps SOC becomes shattered by CF. Rebuilding these "shattered assumptions involves somehow integrating the old and the new" (Janoff-Bulman, 2002 p. 90). Accordingly, an integrative process may unfold in which the newly marked self of the therapist, brought about by CF experiences, becomes combined and integrated with the old less stout therapist self. This leads to more professionally robust meaningfulness, comprehensibility and manageability – a more professionally strong SOC. Indeed, there is a "close and reciprocal relationship" between how therapists handle therapeutic challenges and positive professional growth (Orlinsky et al., 2001; Rønnestad & Skovholt, 2003, p. 40). As such, therapists appear to experience some level of "stress–related growth," namely a "thriving as a result of coping with stress" (Park, 1998, p 267). In other words, as therapists learn to integrate the provoking, SOC shattering aspects of therapeutic work, they seem to grow as professionals.

In much the same way, when trainee therapists encounter CF stress, their SOC may become shattered and then reorganised at a professional level. Professional development theory has recommended future studies should focus on the helper-client relationship (Rønnestad & Skovholt, 2003). The reason for this focus is perhaps because such a relationship can produce CF type stress

capable of producing necessary alternations in the self of the therapists. Indeed, the "unknown ambiguity of professional work" can be a "major catalyst for intense stress" in the novice therapist (Skovholt & Rønnestad, 2003, p. 45). In other words, with increasing therapeutic demands, stress and anxiety can abound in the trainee therapist but this becomes meaningful contact for growth (Rønnestad & Skovholt, 2003, p. 33). It is particularly meaningful because it shatters assumptions unsuited for professional work which then leads to momentary lapses in SOC but later to a more professionally integrated sense of self.

2.4.2. Compassion Fatigue in Trainee Therapists

A difference, however, between experienced therapists and trainee therapists, is that the trainees do not necessarily need traumatic material to experience CF and so grow as professionals. Traumatic exposure may heighten trainee therapists' stress levels, but the "anxiety and fear of the unknown are like a one-two punch that seriously heightens the stress levels" of the beginner therapists (Skovholt & Rønnestad, 2003, p. 47). Interacting with client's intense data can be particularly distressing for the trainees (Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 2003; Tryssenaar & Perkins, 2001). They can become susceptible to an "inability to stop thinking about the client's problems or one's own reactions to them" (Skovholt & Rønnestad, 2003, p. 49). It seems that simply the unknown and ambiguous elements of client interaction are enough to increase the stress levels of trainee therapists to the extent that CF symptomatology is manifested (Tryssenaar & Perkins, 2001).

Indeed, trainee therapists become "very preoccupied with the emotional pain of clients and experience off-duty penetration of their own emotional boundaries" (Skovholt & Rønnestad, 2003, p. 49). Trainees' personal lives have been found to become "invaded with incessant worry and ruminations about counselling exchanges" (Thériault, Gazzola & Richardson, 2009, p. 112). This preoccupation does not appear solely related to traumatic emotional pain. Instead, the combination of the unknown, with the new experience of dealing with another's emotional pain, seems enough to transcend trainee therapists' emotional boundaries. Indeed, trainees are susceptible to "continually feel the disturbing emotions produced in the session" (Skovholt & Rønnestad, 2003, p. 49). This seems indicative of the way in which STS symptomatology can "infect" experienced therapists (Figley, 2002a; Stamm, 2010, p. 21). Indeed, when initially encountering client material, trainees become "flooded with impressions, images, feelings, ideas, worries and hopes" (Rønnestad & Skovholt, 2003, p. 49). Essentially, they became infected by the emotional experience of helping another without the inclusion of traumatic exposure.

Additionally, CF symptomatology is evident when a person has impairment in social, occupational or other areas of functioning due to helping others (Figley, 2002a). Related to nature of training

experiences, trainee therapists had issues around social and personal boundary regulation (Fouad, 2003; Hill et al., 2007; Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 2003; Thériault et al., 2009). As one trainee therapist stated, the "pain stayed with me residually when returning home" (Skovholt & Rønnestad, 2003, p. 49). Trainees, therefore, seem to find it difficult to regulate the emotional pain of helping others without it impacting on other more social areas of their lives. CF symptomatology also involves a "restricted ability to know the client" (Figley, 2002a, p. 4; Stamm, 2010). Trainee therapists often lost their ability to attend to clients and had no notion of how to act or behave (Fouad, 2003; Skovholt & Rønnestad, 2003). One novice stated, "I was so scared, I barely heard what the client was saying" (Rønnestad & Skovholt, 2003). They also display persistent avoidance of client stimuli and occasionally used terms such as "withdrawal, pull-back, dread, shut-down and reject" to express their desire to avoid getting to know clients further (Thériault et al., 2009, p. 111).

Furthermore, while exposed to STS stressors, trainee therapists can become "sick to their stomachs from exhaustion" (Tryssenaar & Perkins, 2001, p. 23). They experience BT as a result of the pace and stress of training (Shapiro, Brown & Biegel, 2007; Tryssenaar & Perkins, 2001). Indeed, with increasing STS, burnout can intensify and elevate levels of "depersonalisation, emotional exhaustion and low personal accomplishment" (Shapiro et al., 2007, p. 110).The trainees may find it particularly difficult to balance workloads, time manage and complete the required training coursework (Tryssenaar & Perkins, 2001). As one trainee suggested, "I now know what everyone was talking about when they mentioned new grad burnout" (Tryssenaar & Perkins, 2001, p. 23). As such, trainee therapists may also experience the overwhelming intensity of BT that characterises part of CF symptomatology.

Furthermore, trainees manifested both irritability and difficulty in concentrating due to their training experiences (Skovholt & Rønnestad, 2003; Tryssenaar & Perkins, 2001). One novice expressed her irritability over the intensity of training by stating, "I have cried every night when I arrive home…this cannot go on" (Tryssenaar & Perkins, 2001, p. 23). This is indicative of the significant shifts in interests and irritability usually noted in BT (Maslach, 1982; Wolfe, 1981). As such, feeling overwhelmed and overworked are regularly observed in the trainee therapist population and seem indicative of BT symptomatology (Fouad, 2003; Hill et al., 2007; Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 2003; Thériault et al., 2009). Collectively, therefore, trainee therapists appear to manifest CF as they encounter clients and training workloads and this does not seem to require the necessary inclusion of traumatic material.

The important consideration is, however, whether or not trainee therapists can manage, find meaning and comprehend this stress. As discussed, the successful negotiation of CF stress may result

in shifts and integrations capable of producing a robust practitioner identity (Pearlman & Saakvitne 1995; Rønnestad & Skovholt, 2003). Alternatively, the failure to adequately process such stress may result in a "stagnant and deteriorating process" termed "negative development" (Rønnestad & Skovholt, 2003 p. 38). Negative development produces limited application of therapeutic methods, a restricted client range and restricts professional roles (Rønnestad & Skovholt, 2003). Focusing, therefore, on how trainees attended to CF stress, could be important in the effective facilitation of trainee therapist development (Schwing et al., 2010). It could help to stop negative avenues of professional development such as incompetence, impairment and disillusionment which in turn may prevent negative development (Rønnestad & Skovholt, 2003).

2.5. Positive Avenues of Professional Development

Addressing the positive avenues of therapeutic work may be as important for optimal professional development as monitoring negative aspects such as CF. This may be because positive aspects drawn from helping others may help maintain levels of "professional productivity and sustained motivation" (Stamm, 2002, p. 107). The positive avenues of therapeutic work can be captured in terms of compassion satisfaction (CS) (Stamm, 2002). The CS term denotes a level of satisfaction that helping professionals find in their jobs and the degree to which they feel successful in their work (Conrad & Kellar-Guenther, 2006; Stamm, 2002). It is characterized by those who feel invigorated and successful (Stamm, 2010). Generally higher levels of CS are indicative of someone who can keep up with work protocols and is happy in their job, especially since they feel they can make a difference (Stamm, 2010).

2.5.1. Compassion Satisfaction and Professional Development

It has been found that counselor-therapist CS is a protective factor against CF (Collins & Long, 2003; Sprang, Clark & Whitt-Woosley, 2007). Conrad and Keller-Guenther (2003) found that those with higher levels of compassion satisfaction had lower levels of CF and BT. In other words, CS is a positive aspect of professional development that can protect trainees against negative development (Cicognani et al., 2009; Collins & Long, 2003; Sprang et al., 2007). Investigating the predictors of CS could lead to a more complete understanding of trainee therapist professional development. In particular, it could help predict how trainees rebuff stressors such as CF and BT into satisfying therapeutic challenges capable of producing professional efficiency and sustained enthusiasm.

2.5.2. Compassion Satisfaction in Trainee Therapists

There does not appear to be any CS research in the area of therapist development despite its recent introduction into a variety of therapeutic fields (Conrad & Kellar-Guenther, 2006; Sprang, et al., 2007; Stamm, 2002). This is surprising as CS "plays a vital role in the equation of human services" and it sustains motivation and productivity as previously noted (Stamm, 2002, p. 107). Furthermore, while sources of stress in therapeutic fields are well studied, stress management studies are lacking in the trainee therapist population despite its influence on trainee development (Lebow, 2005; Pearlman & Saakvitne, 1995; Shapiro et al., 2007). Research, however, that looks at these issues in the trainee therapist population could help students and/or supervisors "identify and put into place practices and policies that enhance the probability of satisfaction and reduce compassion fatigue" (Stamm, 2002, p. 114).

2.6. Sense of Coherence, Compassion Fatigue and Compassion Satisfaction

As trainee therapists "encounter challenges and emotional or cognitive overload, they naturally attempt to process this intense data" (Rønnestad & Skovholt, 2003, p. 48). Perhaps, trainee therapists utilise their SOC to process such information. Indeed, SOC has been found to influence the "negative and positive changes" in therapists (Linley et al., 2005, p. 185). Specifically, strong SOC has been associated with less burnout and more work engagement (Fourie et al., 2007). Counsellors with strong SOC also experience more role satisfaction and work-wellness (Fourie et al., 2007; Ortlepp & Friedman, 2002). Collectively this implies SOC may have an inverse relation with CF and a positive relation with CS in trainee therapists. In addition, Fourie et al., (2007, p. 43) suggests SOC has "a strong influence on both burnout and engagement and that this effect is both direct and indirect." In other words, SOC may not only help trainees comprehend, find meaning and manage emotions at a level that facilities development, but it might also directly and indirectly provide trainees with the necessary awareness of the negative and positive avenues of therapeutic work. This direct and indirect relation may be important in understanding effective movement through training.

2.7. Sense of Coherence and Coping

Previous literature has suggested that SOC moderates therapeutic challenges (Linley et al., 2005). This implies that SOC may be a "stress-buffer or stress-exacerbator" concerning trainee therapists CF and CS (Haine, Ayers, Sandler, Wolchik & Weyer, 2003 p. 622). Perhaps this alludes to the SOC concept as an "individually based coping resource," implying SOC has "successful coping resources" that can directly adapt to training situations well and thus moderate the negative and positive avenues of therapeutic work (Geyer, 1997, p. 1772). Trainee therapists, however, have not yet "organised the complex conceptual material" or internalised the "thinking patterns" needed to perform optimally as

professionals (Skovholt & Rønnestad, 2003, p. 46). Arguably the trainee therapists SOC has not as yet adapted in such a way that it can buffer or moderate CF and CS levels in a professionally proficient manner.

Perhaps, before SOC can function as an individually based coping resource to buffer therapeutic stressors, appropriate strategies need to be integrated into trainee therapists' manageability, comprehensibility and meaningfulness. It seems that SOC may undergo an adaption process in which it selects and incorporates coping behaviour that is amenable to specific stimuli (Boss & Mulligan, 2003). Research findings suggest the existence of pathways that connect SOC with perceived social support and cognitive appraisal, as well as self-efficiency and self-statements (McSherry & Holm, 1994). As such, SOC may be indirectly selecting or connecting to coping strategies. As trainee therapists shift functioning over six months of training, they may select adaptive coping mechanisms to indirectly predict CF and CS levels. Towards the end of these six months, SOC may again return to professionally based coping resources where coping becomes more integrated and directly predicts therapeutic stressors. Indeed, from roughly the "4th to 6th month" of practice experience, "adaptive strategies" have been found "flowing through both professional and personal lives" (Tryssenaar & Perkins, 2001, p. 24).

If coping strategies are initially selected by SOC, then coping may be a mediator between SOC and CF and SOC and CS. A mediating variable is an intervening or process variable (Baron & Kenny, 1986). Coping may intervene between SOC and CF and/or CS. This proposes that under the strain of training stressors, SOC may select a coping strategy capable of processing, intervening or mediating the fatigue (CF) or satisfaction (CS) of therapeutic work. This mediation process may impact on the trainees' manageability, comprehensibility and meaningfulness, thus indicating coping as a plausible mechanism through which CF or CS may affect SOC (Haine et al., 2003). In particular, trainees with higher SOC are more likely to select adaptive coping strategies which may result in more positive outcomes in terms of CF and CS. However, those with lower SOC will be more likely to select poorer coping strategies leading to more detrimental levels CF and CS outcomes. Furthermore, in times of extreme stress and disequilibrium, shattered SOC may result in choice of particularly maladaptive coping which is likely to be predictive of far poorer CF and CS outcomes.

2.7.1. Coping Strategies

Coping, therefore, can be defined as a "constantly changing cognitive and behavioural effort to manage internal and/or external demands that are appraised as taxing or exceeding the resources of a person" (Lazarus & Folkman, 1984, p. 141). There are three coping strategies identified in the literature namely emotion-focused, avoidance-oriented and problem-focused coping strategies (Endler

& Parker, 1990; Lazarus & Folkman, 1984). Emotion-focused coping involves coping behaviours aimed at managing emotions or regulating emotional distress (Lazarus & Folkman, 1984). Acceptance, emotional support, humour, positive reframing and religion make up the emotion-focused coping strategy (Carver, 1997; Cooper, Katona & Livingston, 2008). Employing this type of coping has been associated with lower psychological distress in some samples, although seeking social support for emotional reasons has been found inversely associated with psychological well-being (Brown, Mulhern & Joseph, 2002; Clohessy & Ehlers, 1999). One inhibitor of the use of coping resources has to do with the level of threat (Anderson, 2000). The greater the threat, the more primitive are efforts at emotion-focused coping, and, therefore the less likely that effective coping will occur (Anderson, 2000). Additionally higher levels of emotion adversely affect cognitive functioning and one's capacity for information processing (Lazarus & Folkman, 1984). Accordingly, while emotion-focused coping may regulate emotional distress, it may or may not be useful in managing the emotionally intense data associated with CF symptomatology.

Contrary to emotion-focused coping where the focal point is on some aspect of affect-regulation in a stressful situation, a person utilising avoidance-oriented coping generates distance, directs attention away from or avoids stressful encounters (Green, Choi & Kane, 2010). Indeed, the aim of avoidance-orientated coping is to divert or distract one from a stressful interaction (Green et al., 2010). Coping strategies that characterise avoidance-orientated coping involve behavioural disengagement, denial, self-distraction, self-blame, substance use and venting (Cooper et al., 2008). These coping strategies are generally considered maladaptive as they have an inverse relation with mental well-being (Cicognani et al., 2009; Green, et al., 2010). Indeed, the use of cognitive and behavioural avoidance generally predicts greater psychological distress amongst caregivers (Clohessy & Ehers, 1999; Chang, Lai, Lee, Connor, Davidson & Jeffries, 2003). As such, trainee therapists who utilise avoidance-orientated coping strategies may experience higher levels of CF symptomatology and lower levels of CS.

Finally, problem-focused strategies refer to those cognitive efforts utilised to regulate stressful encounters (Lazarus & Folkman, 1984). It is considered a goal-orientated coping strategy which involves active coping, instrumental support and planning (Cooper et al., 2008; Green et al., 2010). The use of these strategies can be considered adaptive as it predicts higher levels of psychological wellness in caregivers (Cicognani et al., 2009; Green et al., 2010). This coping strategy contributes to positive emotional outcomes partly due to the individual having a "sense of control" (Green et al., 2010, p. 735). Problem-focused coping has also been found to be positively correlated with sense of coherence (Pallant & Lae, 2002).

2.8. Developmental Framework

Based on the above literature, this research will propose an empirically derived, developmental framework for understanding the direct and indirect relations between SOC and coping in relation to CF and CS across the first six months of psychotherapeutic training. A framework will be provided because qualitative research has largely described broad observations of "dramatic" shifts in trainee "functioning," rather than particular longitudinal markers for therapist development (Hill et al., 2007; Rønnestad and Skovholt, 2003, p. 28). Indeed, while adaptive changes have been qualitatively observed over a "semester" or from "roughly the 4th to the 6th month" of training experience, no quantitative effort to measure how "predictable" these changes are has been explored in the developing trainee population (Hill et al., 2007, p. 11; Tryssenaar & Perkins, 2001, p. 6). Additionally, previous literature has encouraged exploring "coping strategies or personality traits, which promote compassion satisfaction and prevent compassion fatigue" as it preserves well-being and mental functioning in the caregiver population (Collins & Long, 2003; Fourie et al., 2007; Ortlepp & Friedman, 2002). Unpacking how trainees adapt and enhance CS and CF seems "vital in equation of human services" or necessary for professional functioning (Stamm, 2002, p. 114). The framework, therefore, will also include how SOC and coping may adapt both directly and indirectly to predict high CS and low CF.

The framework is not suggesting the entire spectrum of professional development is achieved after six months of training. Instead, it is arguing that foundational relations may develop after six months of training between SOC and coping in relation to the positive (compassion satisfaction) and negative (compassion fatigue) avenues of therapeutic work. The framework is conceptualised as the first of a series of "mini-cycles" through which "exploration about self and about the relationship between self and environment, contribute to the construction of the self"- in this this case the practitioner self (Savickas, Nota, Rossier et al., 2009, p. 7). After this initial mini-cycle is laid, then perhaps further explorative and developmental activities, especially related to CF and CS, may be built upon which can enhance the psychotherapist (Super, Savickas & Super, 1996). The following, therefore, is a framework of how trainee therapists' in the face of therapeutic training may differentially adopt coping styles as a function of their baseline SOC, and how these coping patterns may mediate the relation between SOC and the fatigue of therapeutic work (CF), as well as SOC and the satisfaction of helping others (CS).

2.9. Conventionally Focused Sense of Coherence and Emotion-Focused Coping

Initially, the trainee therapists' SOC may be "guided by a conventional way" of helping others (Rønnestad & Skovholt, 2003, p. 28). This implies trainee manageability, meaningfulness and

comprehensibility are not "guided by professional culture" or directed by the "concepts and principles of helping" (Rønnestad & Skovholt, 2003, p. 24). In this regard, SOC may select coping strategies that are, perhaps, less professionally applicable. Indeed, trainee therapists, with a conventional way of functioning, are known to provide strong emotional support, sympathy and give advice (Brems, 2001; Rønnestad & Skovholt, 2003). These strategies are generally contrary to skilled professional ways of functioning (Brems, 2001). They also seem indicative of emotion-focused coping where the aim is to manage emotions or regulate emotional distress through coping strategies such as positive reframing and emotional support (Carver, 1997; Cooper et al., 2008; Lazarus & Folkman, 1984). This way of functioning, however, may have contributed to the trainee therapists' CS – specifically their feeling of satisfaction and success when helping others. As Brems (2001, p. 10) observed, in those entering a career in mental health "one important motivator that commonly emerges" is "the original desire to help". Accordingly, emotion-focused coping strategies may be the foundational coping strategy SOC selects to mediate satisfaction when helping others.

The maintenance of CS at this early time may be a primary concern. Perhaps, this is because this emotional base of satisfaction "contributes to helping being experienced as authentic and natural" (Rønnestad & Skovholt, 2003, p. 28). The ability of SOC, therefore, to continue fostering emotion-focused satisfaction appears to set the stage for a later, more professional way of functioning. As such, SOC may continue to function as a selective resource that continues to select emotion-focused coping strategies to mediate CS levels. This may be the best time in which to select such an emotionally involved way of functioning as SOC is not at risk of the emotional and overwhelming penetration of CF exposure. Indeed, the trainee therapists have not as yet been assigned their first clients and may avoid the "primitive levels of hatred and misery" associated with helping people (McWilliams, 1994, p. 12; Skovholt & Rønnestad, 2003). In other words, SOC is not vulnerable to any negative impact from STS symptomatology. Even further the gradual wearing down process that brings about BT, may not as yet have had time to develop since the trainees have just begun their training. As such, trainees at this beginning time may not have encountered the overwhelming nature of BT capable inversely impacting on SOC levels (Fourie et al., 2007). In this context, trainees with stronger SOC may utilise emotion-focused coping which in turn predicts higher CS, specifically greater motivation and belief to tackle the training stressors that lie ahead.

2.10. Externally Focused Sense of Coherence and Problem-Focused Coping

As therapeutic responsibilities increase, SOC may be required to adjust to client material and training workloads. Indeed, the trainees' responsibilities may increase to include client exposure from roughly after the second month of training (WITS, 2011). As previously described, along with an increase in stress, SOC may become somewhat shattered, or at least strained. Indeed, "the map gleaned from one's personal life" - (conventionally SOC) - "is not adequate for the specific

challenge" of therapeutic work (Skovholt & Rønnestad 2003, p. 51). In this context, trainees have been found to "suppress characteristic ways of functioning" and undergo an external drive "towards the theoretical bodies of knowledge and professional-based conceptions of methods and techniques" (Rønnestad & Skovholt, 2003, p. 29). This process becomes a "catalyst" for a "vigorous internal construction work" in which SOC "sheds values, beliefs and methods that do not fit the personality and the self of the therapist" (Hill et al., 2007; Skovholt & Rønnestad, 2003, p. 50). Essentially, SOC is not adequate for the challenges of therapeutic responsibility and becomes shattered or suppressed. In turn, SOC undergoes a process in which new and more adaptive coping strategies are sought out to mediate CF and CS.

A process begins in which SOC searches for a "sense of control" over "mushrooming professional duties" (Green et al., 2010, p. 735; Tryssenaar & Perkins, 2001, p. 6). A strategy that provides such a control is problem-focused coping (Green et al., 2010). In particular, problem-focused coping involves instrumental support which is about "getting help and advice from other people about what to do" (Cooper et al., 2008, p. 839). In a therapeutic context supervision is considered "instrumental support as it provides guidance and assistance to get the job done" (Ming-sum, 2005, p. 86). Professionally developing students rely on the guidance of the supervisor to grow as therapists (Skovholt & Rønnestad, 2003). Indeed, second to direct client exposure, supervision was rated the next most facilitative influence on trainee therapist learning (Orlinsky et al., 2001). It seems that supervision is facilitative in the trainees' "identification of interpersonal styles that would fit both for their clients and for themselves" (Collins & Long, 2003; Schwing et al., 2010, p. 7). In addition to this, perhaps supervision also facilitates the process by which SOC functions as a resource in the selection of coping styles. Therefore, SOC may begin to seek out problem-focused strategies such as supervision, to mediate CF and CS levels.

Additionally, problem-focused coping includes planning (Cooper et al., 2008). Planning as a coping strategy involves "trying to come up with a strategy about what to do/thinking hard about what steps to take" (Cooper et al., 2008, p. 839). Over the course of training, the trainees appear to plan more around therapeutic responsibilities. They particularly prepare for logistics but also plan leisure activities (Collins & Long, 2003; Hill et al., 2007). This involves reading, going to movies, and the use of alternative therapies such as massage therapy, reflexology or aromatherapy (Collins & Long, 2003). These strategies are considered positive and have been found to decrease CF symptomatology, as they provide the trainee with a balance between work, play and rest (Collins & Long, 2003; Pearlman, 1995). In turn, these planned activities are thought to preserve a sense of personal identity (Trippany, White-Kress & Wilcoxon, 2004). Perhaps, while supervision helps SOC to adequately select and facilitate helpful coping strategies, planning may be selected by SOC to preserve its sense of cohesive balance.

Furthermore, problem-focused coping includes active coping (Cooper et al., 2008). This strategy involves "concentrating efforts on doing something about the situation being faced/taking action to try and make it better" (Cooper et al., 2008, p. 839). Arguably, supervision and planning could be considered active coping strategies as they are both active steps in trying to circumvent training stressors to ameliorate their effects (Carver, Weintraub & Scheier, 1989). Indeed, supervision has been found to calm anxiety levels and rebuff burnout in training populations (Hill et. al., 2007; Ming-sum, 2005; Rønnestad & Skovholt, 2003). Active participation in activities planned for recuperation also decreases stressors as previously noted (Collins & Long, 2003; Pearlman, 1995). Active involvement in "must-read expertise" is also known to diminish anxiety levels (Rønnestad & Skovholt, 2003, p. 33). In this way, it seems that SOC may select active coping involvement in supervision, planned activates, and must-read theory is an active coping strategy aimed at ameliorating the shattering nature of CF stressors while promoting CS and SOC stability.

2.11. Externally Focused Sense of Coherence and Avoidance-Orientated Coping

Furthermore, when combined with the somewhat intrusive nature of client interaction, the adjustments to SOC may leave the trainee therapist vulnerable, fragile and unbalanced (Rønnestad & Skovholt, 2003). Their SOC depletes (shatters) along with feeling and so trainees may feel they do not have the "personal characteristics, resourcefulness and ability to bridge the felt chasm between theory and practice" (Skovholt & Rønnestad, 2003, p. 12). In response, trainees may avoid this stressful context. Indeed, those with depleted SOC are also thought to be less "approach-orientated as they lack the confidence to cope with stress" (McSherry & Holm, 1994, p. 8). Indeed, Skovholt and Rønnestad (2003, p. 49) have observed that when trainees found professional challenges overwhelming, they became susceptible to an "inappropriate defensive maneuver" which involved the inability to "stay or enter the experiential world of the client". This process may allude to how SOC under CF pressure, selects an avoidant strategy to divert away from overwhelming challenges seemingly toxic to its manageability, comprehensibility and meaningfulness.

Indeed, by attending to client stressors, trainees run the risk of "insufficient closure," namely the "inability to stop processing intense data from the counselling or therapy room" (Skovholt & Rønnestad, 2003, p. 49). This seems indicative of CF symptomatology, especially since it invites a "maladaptive" and "counter-therapeutic" process producing cognitive, emotional and relation deficits (Skovholt & Rønnestad, 2003, p. 49). Attending to the training environment, therefore, may increase the shattering nature of CF stress and lead to deficits in key areas of functioning. In particular, since CF symptomatology is inversely related to SOC (Fourie et al., 2007), this scenario may deplete SOC functioning. This would leave the trainees without the SOC capable of selecting resources appropriate to meeting the demands of therapeutic practice (Antonovsky, 1987). It may also decrease their feeling

that such interaction is worthy of their investment and engagement (Antonovsky, 1987), which suggests trainee CS levels may deplete when SOC depletes. As noted, those with greater levels of CF have lower levels of CS in a caregiver population (Conrad & Kellar-Guenther, 2006).

As such, SOC may select avoidance-oriented coping strategies to generate distance from therapeutic challenges in order to avoid processes that can produce deficits in manageability, comprehensibility and meaningfulness. In this manner, the trainees may be able to preserve a functional level of SOC and CS, while they retreat from the deteriorating effects of CF. Indeed, as a "coping resource, disengagement lowers or prevents compassion stress" (Figley, 2002b, p. 1438). This disengagement, however, refers to a "recognition on the part of the psychotherapist for the importance of self-care and to carry out a deliberate program of self-care" (Figley, 2002b, p. 1438). In other words, avoidance-orientated coping may create a space in which trainee therapists can recuperate. Perhaps, this involves avoidance-orientated coping strategies such as venting which may allow the trainee to "say things to let unpleasant feelings escape/expressing negative feelings" (Cooper et al., 2008, p. 839). This strategy may be reminiscent of supervision or seeking support from colleagues when feeling overwhelmed.

Nevertheless, Figley's (2002b) notion of disengagement is different to the behavioural disengagement strategy found in avoidance-orientated coping. Indeed, behavioural disengagement involves, "giving up trying to deal with it/the attempt to cope" (Cooper et al., 2008, p. 839). Giving up the attempt to manage difficult client interaction seems counter-developmental. As previously noted, learning to deal with therapeutic challenges has a "close and reciprocal relationship" with positive professional growth (Orlinsky et al., 2001; Rønnestad & Skovholt, 2003, p. 40). Added to this, the self-blame strategy found in avoidance-orientated coping may also be maladaptive for SOC. Previous research has found that self-blame predicts less effective self-care in psychotherapists (Norcross, 2000). It is understood that such a strategy may "reduce problem solving" and "paralyse adaptive resources" (Norcross, 2000, p. 714). Trainees, perhaps, who are involved in such a coping strategy may have a paralysed SOC; incapable of selecting adaptive resources to mediate therapeutic challenges.

Even further, substance abuse is another avoidance-orientated coping strategy that may be detrimental to SOC. This strategy involves "using alcohol to or other drugs to make oneself feel better/to help oneself get through it" (Cooper et al., 2008, p. 839). According to Figley (2002b), substance abuse is a behavioural symptom of BT. As such, if trainee therapists abuse substances, the higher probability they will manifest behavioural deficits found in BT. Since BT has an inverse relation with SOC (Fourie, 2007), substance abuse may indirectly lower manageability, comprehensibility and meaningfulness levels in the trainees. Collectively, therefore, avoidance-

orientated coping strategies, if used to self-blame and abuse substances, rather than create space for recuperation, may be maladaptive and detrimental to SOC. Accordingly, the extent to which the SOC can appropriately, "distance" itself from the "on-going misery of client interaction between sessions," is the extent to which adequate manageability, meaningfulness and comprehensibility can be used to "deliver appropriate services" (Figley, 2002b, p. 1438). Avoidance-orientated coping, therefore, may mediate the relation between SOC and CF as well as SOC and CS while trainees are searching for better ways to deal with the stressors of training.

Collectively, levels of SOC in trainees may predict either problem-focused coping strategies or avoidance-orientated coping to mediate the relation between SOC and trainee outcomes. This may shed light on which "coping strategies or personality traits promote compassion satisfaction and prevent compassion fatigue" while helping to "protect and maintain mental health and well-being" (Hill et. al, 2007, p. 9). It seems that selecting avoidance-orientated coping may be maladaptive as it may result in an "inappropriate defensive maneuver" which contributes to emotional, cognitive and relation deficits (Skovholt & Rønnestad 2003, p. 49). Presumably avoidance-orientated coping depletes SOC. If applied appropriately, however, such a coping strategy may allow space for the trainees to engage in problem-focused coping strategies such as supervision. This may help SOC become better reorganised in such a way that it can become professionally robust. Accordingly, promoting problem-focused coping while monitoring avoidance-orientated coping, may be important if SOC is to become effective in spite of being in a state of flux under the strain of training.

2.12. Professionally Adapted Sense of Coherence

After more professional experience and responsibility, SOC may shift again towards a "renewed internal focus" (Rønnestad & Skovholt, 2003, p. 29). Perhaps this occurs between the 4th and 6th month of training as "adaptive strategies" are found "flowing through both professional and personal lives" (Tryssenaar & Perkins, 2001, p. 24). What this shift may involve is an integration of the more adaptive coping strategies into the trainees' SOC adequate for therapeutic work. It may lead to a more professionally integrated "therapeutic self or psychological foundation" that is capable of finding meaning, comprehensibility and manageability in the face of therapeutic stressors (Pearlman & Saakvitne 1995, p. 152). As described, the "unknown ambiguity of professional work" can be a "major catalyst for novice stress" (Skovholt & Rønnestad, 2003, p. 45). This stress, however, is "meaningful contact for growth" and a "powerful source of learning and development" (Rønnestad & Skovholt, 2003, p. 33). After the initial months of grappling with this stressful but meaningful material, SOC sorts and then selects useful "resistance resources" which allows SOC to become "more appropriate and adapted to situations" (Antonovsky, 1987, p. 146; Geyer, 1997, p. 1772).

These resistance resources may involve strategies utilised through problem-focused coping, such as supervision.

For example, Casement (1985, p. 24) argues the supervisor becomes "transitionally internalised" in beginner therapists. Noted earlier, supervision is considered a type of instrumental support and a problem-focused coping strategy. Essentially, SOC internalises the adaptive qualities of supervision or problem-focused coping. It, perhaps, internalises the "sense of control" afforded by these problem-focused coping strategies (Green et al., 2010, p. 735). Casement (1985, p. 24) also suggests supervisory support becomes "autonomous and separate from the supervisor." In other words, supervision or problem-focused coping strategies are no longer separate mediating coping resources that need to be periodically selected by SOC. Instead, the trainees have learned that such a resource is resistant to therapeutic stressors and have incorporated such coping resources into their ways of making meaning, managing and comprehending therapeutic work. As a result, they become like the "resilient practitioner," who has the "capacity to absorb and process input from clients" (Skovholt & Rønnestad, 2003, p. 50). They become self-reliant and SOC returns to an "individually based coping source" that is more professionally robust and autonomous (Geyer, 1997, p. 1772).

In other words, an "increasing higher-order integration of the professional self and personal self" unfolds as resistance coping strategies become integrated into trainee SOC (Rønnestad & Skovholt, 2003, p. 28; Tryssenaar & Perkins, 2001). In this regard, SOC and adaptive coping may become one and the same. This internalization process instills some new confidence in the trainees Tryssenaar & Perkins, 2001). It perhaps instills an enduring attitude or feeling of confidence that they can manage, comprehend and put meaning to internal and external environments as predictable, and that there is a high probability that things will develop as well as can be expected (Antonovsky, 1987; Fourie et al., 2007). Indeed, after a semester of training, trainee therapists feel "less anxious about seeing clients," begin to "feel pride and relief for having survived the initial sessions," and then "gradually come to feel more comfortable" with therapeutic challenges (Hill et al., 2007, p. 13).

2.13. Conclusion

In conclusion, trainee therapists appear to develop professionally as they engage with training experiences over a six month period. Trainee sense of coherence (SOC) seems to play a central role in the successful navigation of therapeutic training stressors. It may be student manageability, meaningfulness, and comprehensibility (SOC components) selects appropriate ways of coping with such challenges. However, based on the level of SOC, trainees may select different coping strategies across a six month period until incorporating a predominantly problem-focused coping strategy

presumably into their SOC. In this way they appear to undergo an initial shifting and integration process over a six month period that may generate the first of a fundamental cycle of professional development. Understanding, therefore, the fluctuations of this process in relation to compassion fatigue (CF) and compassion satisfaction (CS) may enhance the avenues of professional development and well-being. As such, this research will conduct a preliminary inquiry into predictors of CF and CS during the first six months of a professional psychology training programme with a secondary aim of exploring whether or not SOC is directly or indirectly associated with CF and/ or CS at various points during the first six months of training.

2.14. Hypothesis

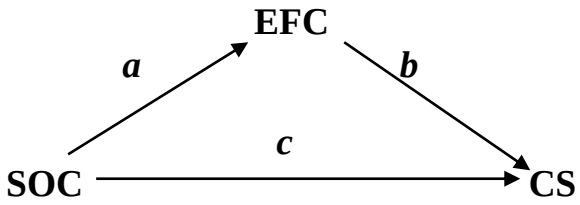
In order to achieve the study's aims, the following hypotheses were tested at the various points in time during the training. Training periods were defined as Time 1 (the beginning of training before seeing clients), Time 2 (2 months after training; at the point at which trainee therapists begin to see clients) and Time 3 (6 months after starting professional training). The hypotheses have been divided up as a function of the point in time during which the hypotheses were tested.

Emotion-focused coping (EFC) as a mediator of sense of coherence (SOC) and compassion satisfaction (CS) at Time 1:

Hypothesis 1: The effect of sense of coherence (SOC) on compassion satisfaction (CS) will be mediated by emotion-focused coping (EFC), suggesting that SOC will have an indirect effect on CS. This implies that EFC will mediate the relation between SOC and CS at Time 1. In order to establish this mediation model, four steps are required (Baron & Kenny, 1986). These steps are presented below as hypotheses that were tested in order to establish whether or not the proposed mediation was present in the data:

Step 1: ***Hypothesis 1A*****: As illustrated in Figure 1 below,** SOC will be associated with CS at Time 1 (Path *c*). Specifically, higher levels of SOC will be predictive of higher reported levels of CS, at Time 1.

Figure 1a: Emotion-focused Coping (EFC) as a mediator of Sense of Coherence (SOC) and Compassion Satisfaction (CS) at Time 1 (N = 32)



Step 2: Hypothesis 1B: SOC will be predict EFC at Time 1 (Path *a*).

Step 3: Hypothesis 1C: EFC will predict CS (Path *b*), at Time 1.

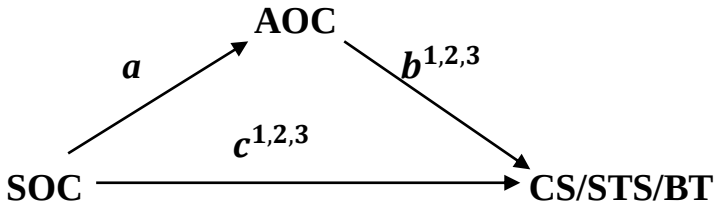
Step 4: Hypothesis 1D*:* To establish that EFC completely mediates the relation between SOC and CS, the effect of SOC on CS controlling for EFC (Path *c*) should be zero at Time 1.

Avoidance-orientated coping (AOC) as a mediator of sense of coherence and each of compassion satisfaction (CS) and compassion fatigue (STS & BT) at Time 2:

Hypothesis 2: The effect of SOC on each of CS, STS and BT will be mediated by AOC. This implies that AOC will mediate the relation between SOC and each of CS, STS and BT at Time 2. Once again, the Baron and Kenny (1986) steps are presented below as hypotheses that were tested in order to establish whether or not the proposed mediation was present in the data:

Step 1: ***Hypothesis 2A:*** SOC will predict each of CS, STS and BT at Time 2 (Path $c^{1,2,3}$). Specifically, lower levels of SOC will predict higher levels STS, higher levels of BT and lower levels of CS.

Figure 2: Avoidance-orientated coping (AOC) as a mediator of sense of coherence (SOC) and compassion fatigue (STS & BT) at Time 2 (N = 30)



NOTE: b^1 is AOC predicting CS; b^2 is AOC predicting STS; b^3 is AOC predicting BT. c^1 is SOC predicting CS; c^2 is SOC predicting STS; c^3 is SOC predicting BT.

Step 2: Hypothesis 2B: SOC will predict AOC at Time 2 (Path *a*). Specifically, lower levels of SOC will predict higher levels of AOC.

Step 3: Hypothesis 2C: AOC predict each of CS, STS and BT (Path $b^{1,2,3}$) controlling for SOC at Time 2. Specifically, higher levels of AOC will be predictive of lower reported levels of CS, higher STS levels and higher BT levels.

Step 4: Hypothesis 2D: AOC completely mediates the relation between SOC and each of CS, STS and BT controlling for AOC (Path $c^{1,2,3}$) should be zero (Baron & Kenny, 1986).

Problem focused coping (PFC) at Time 3:

Hypothesis 3: SOC will be associated with problem-focused coping but not with CS or CF. Instead problem-focused coping will be directly associated with CF (STS & BT) and CS.

Lastly, as stressed throughout the paper, it is important to mention that the aim of this study was not to report on longitudinal change patterns of trainee therapists. The aim was to rather report shifts at different time points that have theoretically been identified as critical to their development as trainee therapists. A developmental perspective with the longitudinal data will be reported on elsewhere and is beyond the scope of the present study.

Chapter 3

Methods

3.1. Research Design

The research was conducted quantitatively and followed a panel longitudinal design. This implied measuring variables of interest at different points across a 6 month training period in a sample of trainee therapists at the University of the Witwatersrand (WITS). In particular, a 6 month time line was divided into three respective time periods in consideration of trainee therapists' shifts and adaptive strategies noted in the literature. Time 1 was comprised of the first 2 months of training. Time 2 occurred from the 2nd to the 4th month of training as the trainee therapists started seeing their first clients. Time 3 occurred from roughly the 4th to the 6th month of training. Trainee therapists, therefore, were approached to participate in the study three times over the 6 month period.

During each time period, sense of coherence (SOC) and coping strategies were investigated in relation to compassion fatigue (CF) and compassion satisfaction (CS) on an interval basis. A significant advantage of this design was that panel data was particularly useful in answering questions about the dynamics of change. This was valuable in relation to the current study as the main purpose of the research was to evaluate shifts in SOC as predictors of CF and CS in student therapists as they encountered training challenges over 6 months of training. The quantitative data was gathered from a non-probability sample of clinical, counselling and educational psychology master students at WITS University through the administration of self-report questionnaires.

3.2. Sample and Sampling

The target population for the research study were students involved in a professional psychotherapy training programme. Accordingly, a sample of psychology (educational and clinical) and community-based counselling Masters students from WITS university were approached to participate in the research. Students in clinical and educational psychology, as well as the community-based counselling programmes completed the questionnaire across all three time periods. This sample was representative of the target population as these trainees were registered with Health Professions Council of South Africa (HPCSA, 2011) as student psychologists in a professional psychology training programme. The students encountered clients in a therapeutic setting from at least 2 months after starting their training. Collectively, for at least 6 months the students in this sample encountered a number of therapeutic responsibilities and training workloads with particular focus on clinical and multicultural aspects of the South African context (WITS, 2011).

A non-probability convenience strategy was used to gather the sample on the three separate occasions over the 6 month period. At Time 1, a sample size of 32 trainee therapists was gathered. The average age of the trainees at Time 1 was 25.50 (*SD* = 4.07) and they had encountered 0.12 (*SD* = 0.33) clients in a psychotherapeutic context. A sample size of 30 trainee therapist was obtained at Time 2. At this time the trainees were on average 25.77 (SD = 4.21) years of age and had encountered an average of 4.06 (SD = 3.79) clients in a psychotherapeutic context. At Time 3, a sample size of 21 trainee therapists was obtained. The trainees at Time 3 had on encountered on average 5.95 (SD = 4.45) clients in a psychotherapeutic context and the trainees were on average 26.23 (SD = 4.30) years of age. Gender was not included in the study as there were significantly more female trainees than male trainees. As such, gender was not requested in the research in order to protect the anonymity of the few males in each of the programmes.

3.3. Measures

The data was gathered through the use of a series of questionnaires. Demographic information such as age was requested on the demographic questionnaire (Appendix B). Additionally, participants were asked how many clients they had encountered at different points in their training. The demographic questionnaire also asked participants for an identifying number (PID). The PID number was necessary in order to accurately compare the participant's progress over the 6 month period of investigation. The PID number consisted of the last three digits of the participant's student number in order to ensure anonymity.

In addition, the demographic questionnaire asked participants to highlight any previous traumatic stress they may have encountered as well as the length of time they had been in their own full time

psychotherapy. The previous traumatic stress question was asked in order to control for the impact that previous trauma may have had on the trainee therapists SOC levels and coping strategies. However, due to the fact that some people included secondary and vicarious traumas while others only included direct traumas, the validity of this question was questionable and it was excluded from further analyses. Furthermore, the trainee therapists were asked about personal psychotherapy in order to explore the differential effects of length of psychotherapy on trainee SOC levels at baseline. The remaining questionnaires that were used in the research were the abbreviated Orientation to Life Questionnaire (OLQ) (Antonovsky, 1987), the Brief COPE scale (BCOPE) (Carver, 1997) and the Professional Quality of Life scale (ProQOL) (Stamm, 2010). These measures are discussed below:

3.3.1. The Professional Quality of Life Scale (ProQOL) (Appendix C)

The Professional Quality of Life Scale (ProQOL) (Stamm, 2010) is the 5th version of the original Compassion Satisfaction and Fatigue Test (CSF) (Figley & Stamm, 1996). The ProQOL incorporates two aspects, the positive (compassion satisfaction) and the negative (compassion fatigue) (Stamm, 2010). The CF part is divided into two parts. The first part concerns burnout (BT) items and the second part involves secondary traumatic stress (STS) items. According to Stamm (2010, p. 14) the CF "scales both measure negative affect but are clearly different; the BT scale does not address fear while the STS scale does". Collectively, the ProQOL has 30 statements that apply to having direct contact with helping people in their lives. Participants are asked to rate their reactions to these statements from 1 to 5 (1 =Never, 2=Rarely, 3 = Sometimes, 4= Often, 5 = Very often). Statements such as "I feel connected to others" and "My work makes me feel satisfied" are found in the scale. According to Stamm (2010) there is good construct validity with over 200 published papers and it is stable across time. The instrument has also displayed very good internal consistency with Cronbach's alpha's that range from .75 to .88 on respective scales (Stamm, 2010). Despite not reporting test-retest reliability, Stamm (2010, p. 25) suggests the ProQOL is "stable across time, which means that the scores across time reflect changes in the person and not the measure itself".

The ProQOL gives permission to replace the words helper or helps with words that are more suitable to the target population (Stamm, 2010). Accordingly, words such as counsellor or counsel have been utilised in this study instead of helper or help. In addition, similarly to the Udipi, Veach, Kao, LeRoy, (2007) study, ProQOL terms such as traumatic, trauma or frightening experience have been replaced with the terms distress, stress and stressful experiences. These changes have all been made in order to increase the face validity of the instrument in relation to the trainee therapist sample.

On both the STS and BT subscales, a score of 22 or less represents low levels of STS and BT, between 23 and 41 signifies average levels of STS and BT, while 42 or more indicates high STS and

BT levels (Stamm, 2010). Specifically concerning the STS subscale, approximately 25% of people score below 43 and about 25% score above 57 (Stamm, 2010). In relation to BT, about 25% of people score 57 and about 25% of people score below 43 (Stamm, 2010). Collectively, higher scores on both the STS and BT subscales indicate greater CF difficulties. Regarding the CS scale, a score of 22 or less indicates low levels of compassion satisfaction, between 23 and 41 signifies average compassion levels, while a score of 42 or more represents high levels of compassion (Stamm, 2010). According to Stamm (2010), 25% of people score 57 and about 25% of people score below 43 cornering the CS measure, with higher scores indicating greater work satisfaction. Scores of 50 on the CS Scale are comparable to scores of 50 on the STS or BT scales. The maximum raw score on the ProQOL is 50 and the total percentiles available are 100. Furthermore, while CF was used as a unitary phenomenon in the literature review, it has been conceptualized as a composite of STS and BT. However, because this has not be studied much in the trainee therapist population, this research will look at BT and STS separately and make reflections about each of STS and BT in terms of CF in the discussion.

3.3.4. The Brief COPE scale (Appendix D)

To evaluate the trainee therapists problem-focused, emotion-focused and avoidance-oriented coping strategies, the study administered the Brief COPE (BCOPE) (Carver, 1997). The Brief COPE can be used with three summary coping domains, namely problem-focused, emotion-focused and avoidance-oriented coping (Cooper, Katona & Livingston, 2008; Green, Choi & Kane, 2010). Problem-focused strategies include, active coping, instrumental support and planning (Cooper et al., 2008). Emotion-focused coping strategies involve acceptance, emotional support, humour, positive reframing and religion (Cooper et al., 2008; Carver, 1997). Avoidance-oriented coping strategies consists of behavioural disengagement, denial, self-distraction, self-blame, substance use and venting (Cooper et al., 2008; Carver, 1997; Green et al., 2010).

A higher score on the Brief COPE indicates a higher usage of a particular coping strategy (Atkinson et al., 2009). The scale measures an individual's overall coping on a 4-point scale (1- I haven't been doing this, to 4-I've been doing this a lot) (Carver, 1997). Participants respond to questions such as, "I've been taking action to try and make the situation better" and "I've been giving up the attempt to cope" (Carver, 1997). Internal consistency coefficients of all scales have usually been acceptable, although some alpha coefficients were between .50 and .60 (Carver, 1997). The Brief COPE in general exhibits strong convergent and discriminate validity in that they correlate in expectable but non-redundant patterns with theoretically related scales, including self-esteem, hardiness, Type A, trait anxiety and optimism (Carver, Scheier & Weintraub, 1989). The Brief COPE is also considered to have good test-retest reliability (Tuncay, Musabak & Gok et al., 2008). Additionally, in a similar manner to the study conducted by Udipi, Veach, Kao et al., (2008), Brief

COPE statements that use the word *it* were been replaced with the word *stress* in order to make the instrument more explicit to issues around stressful trainee therapist situations in this study.

3.3.5. The Orientation to Life Questionnaire (Appendix E)

Trainee sense of coherence (SOC) was measured using the 29-item self-report Orientation to Life Questionnaire (OLQ) (Antonovsky, 1987). The instrument is composed of 11 comprehensibility, 10 manageability and 8 meaningfulness items that make up the SOC concept as a whole (Rice, 2000). Participants are asked to rate themselves on a 7-point Likert scale ranging from 1-7. Statements and questions include, "when something happened, have you generally found that" and "do you have very mixed up feelings and ideas?". Normative data for the OLQ range from 132.4 (SD=22.0) to 160.4 (SD = 16.7) (Antonovsky, 1993; Rice, 2000; Runeson, Norback & Stattin, 2002). The OLQ has strong empirical support for internal consistency and validity predominantly in Western cultures (Rice, 2000). In the South African context the OLQ has been found to have very good internal consistency with Cronbach's alpha's of .92 in a sample of counsellors (Ortlepp & Friedman, 2002). Additionally, test-retest correlations show stability and range from 0.69 to 0.78 (Eriksson & Lindström, 2005)

3.4. Procedure

Permission was obtained from the Human Research Ethics Committee (HREC) of the University of the Witwatersrand (WITS) to approach the masters' students (Protocol Number: MCLIN/11/003 H – Appendix F). Once ethics clearance was granted the respective course co-ordinators from each master's programme were contacted and a request was made to contact the students in lectures over the next 6 months. As permission was granted, students were approached on 3 separate occasions. At Time 1, data collection occurred at the end of March 2011; at Time 2 data was collected at the end of May 2011 and at Time 3 data was gathered at the end of July 2011. On all occasions the students were approached in lectures with the permission from the course co-ordinator and the lecturer.

Additionally, at each occasion that the students are approached, they were handed a questionnaire and a participant information letter (Appendix A). The participant information letter informed respondents of the time it would take to complete the information, researcher contact details, support centre details and it informed the students of their participation rights in the study. Completing the questionnaire was considered as informed consent. Those that choose to participate in the research were asked to place their responses in a sealed collection box on completion. There was a collection box at the lecture or seminar venue and a collection box left in each of the respective master common rooms for drop off by the students. The collection boxes were collected after each contact and sealed for later analysis in a confidential setting. These measures were put in place to maximise

confidentiality and minimize experimental effects, as the researcher himself was a clinical psychology Masters student at WITS University.

3.5. Data Analytic Procedures

The statistical procedure began by evaluating the reliability of the scales being administered in the study. This involved gathering Cronbach Alpha reliability coefficients for the OLQ, brief COPE and ProQOL. Based on the analysis for parametric assumptions, a decision was made as to what procedures would be carried out in order to provide accurate results for each hypothesis. The variables under investigation were as follows: sense of coherence (SOC), problem-focused coping (PFC), emotion-focused coping (EFC), avoidance-orientated coping (AOC) compassion fatigue (CF), burnout (BT) and compassion satisfaction (CS).

In order to test for the proposed mediations, a series of regression analyses was conducted so to use the standardized regression coefficients to run a series of online Sobel Tests to test the various proposed mediations (Sobel, 1982). Notably, Baron and Kenny's (1986) four steps for mediation were considered when testing each mediation hypothesis. The first step required showing that the initial variable was correlated with the outcome. For example, this involved using CF (STS and BT) in a regression equation and SOC as a predictor (Baron & Kenny, 1986). This step showed if there was an effect that required mediation. The second step showed that the initial variable was correlated with the mediator (Baron & Kenny, 1986). This required, for example, using coping as a dependent variable and SOC as an independent variable. After establishing the initial two mediation steps, the third step was conducted to test whether the mediator affects the outcome variable (Baron & Kenny, 1986). In this research, for example, this involved using CF as the dependent variable in a regression equation and SOC and coping as predictors. In order to complete step four, coping had to completely mediate the SOC to CF relationship, the effect of SOC on CF controlling for coping had to be zero (Baron & Kenny, 1986). In order to test this mediation an online Sobel Test was run (Sobel, 1982).

Chapter 4

Results

4.1. Introduction

The following section presents an interpretation of the quantitative results that have been obtained regarding the research hypotheses outlined in the research study. This involves identifying the direct and indirect effects Sense of Coherence (SOC), problem-focused coping (PFC), emotion-focused

coping (EFC) and avoidance-orientated coping (AOC) have on trainee therapist Compassion fatigue (CF) and compassion satisfaction (CS). Notably, indicators of CF were operationalised by measuring the constructs of secondary traumatic stress (STS) and burnout (BT) (Stamm, 2010). Prior to the discussion of the hypothesis testing, descriptive statistics are presented, intercorrelations between key variables are discussed, Cronbach Coefficients Alpha's are noted and parametric assumptions tested and presented.

4.2. Descriptive Statistics

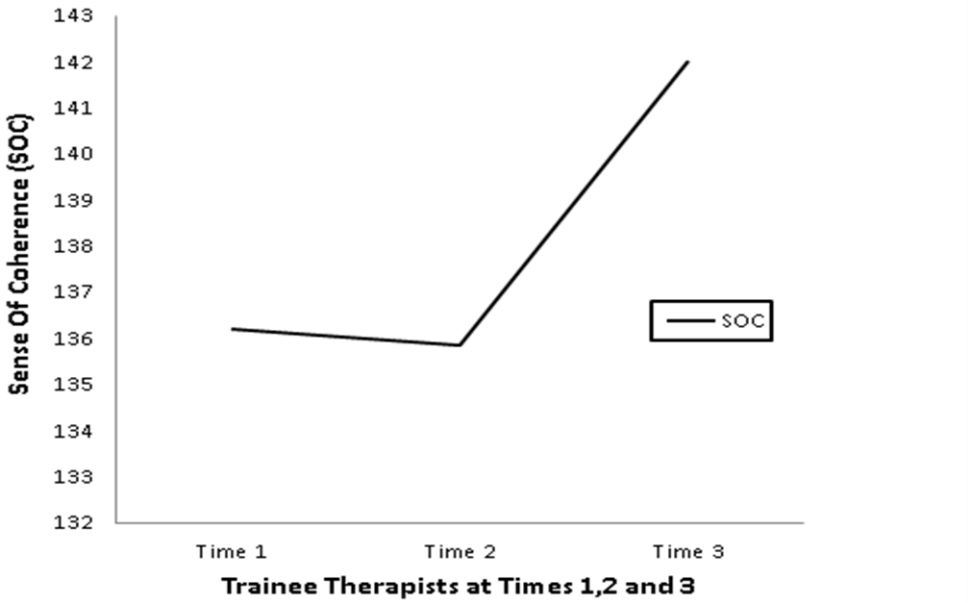
Table 1 below shows the means (*M)* and standard deviations (*SD*) of all key variables at each of the three time periods.

Table 1*: Means and standard deviations for key variables across all three Time Periods*

	Time 1 (*n* = 32)		**Time 2 (*n*= 30)**		**Time 3 (*n* = 21)**	
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*
Sense of Coherence	136.19	17.60	135.83	22.74	142.00	15.56
Compassion Satisfaction	41.80	12.79	49.13	6.49	51.48	5.77
Secondary Traumatic Stress	56.58	7.56	62.23	7.58	62.19	6.68
Burnout	51.81	6.78	52.97	7.22	50.90	5.60
Emotion-focused coping	28.81	4.11	27.20	3.82	26.86	4.55
Avoidance-orientated coping	22.59	4.48	23.90	4.96	23.05	4.38
Problem-focused coping	18.78	3.32	17.03	3.59	18.33	3.81

At Time 1, the trainees sense of coherence (SOC) observably decreased very slightly from an average of 136.19 (*SD* = 17.60), at Time 1, to an average of 135.83 (*SD* = 22.74) at Time 2. At Time 3, however, trainee SOC was at its highest with an average of 142 (SD = 15.56). These average scores all fall within the normative range of SOC in the general population (Antonovsky, 1993; Rice, 2000; Runeson, Norback & Stattin, 2002). Fluctuations in the trainee therapists SOC are illustrated in Figure 3 on the next page.

***Figure 3*:** Trainee Therapists Sense of Coherence over a 6 Month Training Period



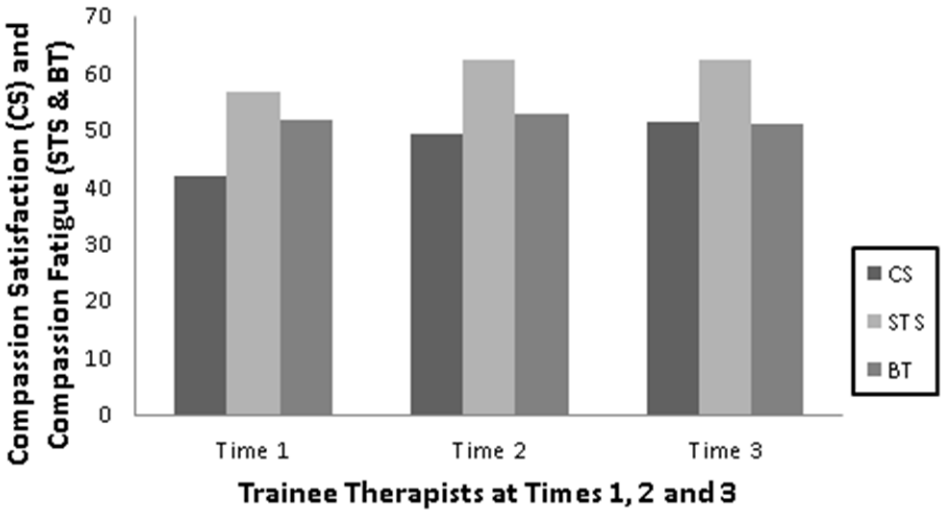
When considering the trainee therapists compassion satisfaction (CS) and compassion fatigue (CF), patterns were observable across the three time periods. These patterns, however, are merely observations and were not tested for significance as it goes beyond the scope of this research. Additionally, the trainee therapists CS and CF (STS & BT) scores were converted to T-scores in accordance with Stamm (2010). The scores, therefore, can be compered across all three time periods.

Concerning, compassion satisfaction (CS), at Time 1, trainee therapist CS was on average 41.80 (*SD* = 12.79). Scores of 43 or less are considered low (Stamm, 2010). As such, the trainees CS levels were low at Time 1. At Time 2, trainee CS increased to an average of 49.13 (*SD* = 6.49). Scores of around 50 are considered average (Stamm, 2010). Accordingly, the trainees CS levels at Time 2 were average. At Time 3, trainee CS was at its highest over the 6 month training period with an average 51.48 (*SD*= 5.77). As this average is again close to 50, the trainees CS at Time 3 was considered average or normal (Stamm, 2010).

When considering the secondary traumatic stress (STS) aspect of compassion fatigue (CF), trainee therapists STS levels, at Time 1, were on average 56.58 (*SD* = 7.56) but this average increased at Time 2 to 62.23 (*SD* = 7.58). While the trainees STS was at its highest at Time 2, trainee STS decreased slightly at Time 3 to an average of 62.19 (SD = 6.68). According to Stamm (2010), scores of 57 or more are high. As such, the trainee therapists were experiencing, on average, high levels of STS over the 6 months of training (Stamm, 2010). Concerning the burnout (BT) aspect of CF, trainee therapist BT was on average 51.81 (*SD* = 6.78) at Time 1 but scores increased to an average of 52.97 (SD = 7.22) at Time 2. At Time 3, however, BT scores decreased to an average of 52.97 (SD = 7.22). According to Stamm (2010), scores of around 50 are considered average. As such, across all three time periods, trainee BT fell within the average range for burnout.

It appears, therefore, that CS scores were lower than CF scores across the 6 month training period. The only exception to this finding was at Time 3 when the trainees CS was 51.48 (*SD* = 5.77) which was slightly higher than the trainees BT average of 50.90 (*SD* = 5.60). However, these differences are likely to be due to sample variation alone as no significance testing was done to test whether or not they are statistically different. Additionally, the trainee therapists BT scores were observably lower than their STS scores over the 6 month period. It must be reiterated, however, that these are merely observations and these patterns were not tested for significance. The patterns observed in trainee therapist CS and CF (STS & BT) over the 6 month training period, are illustrated in Figure 4 below. Figure 4 shows how BT and STS remained virtually stable across the three time periods, while CS started off at a lower rate and increased at Time 2, on average, resulting in stability in levels at Time 3.

Figure 4: Trainee Therapist Compassion Satisfaction (CS) and Compassion Fatigue (STS & BT) over a 6 month Training Period.



When considering trainee therapists' coping at Time 1, the average level of emotion-focused coping (EFC) strategies was 28.81 (SD = 4.11)the average level of avoidance-orientated coping (AOC) strategies was 22.59 (SD = 4.48) and the average level of problem-focused coping (PFC) was 18.78 (SD= 3.32). At Time 2, trainee EFC strategies remained at approximately the same level with an average of 27.20 (SD = 3.82), Additionally, at Time 2, AOC strategies stayed at approximately the same level as they did at Time 1 (*M*= 23.90; SD = 4.96). Problem focused coping strategies (PFC) also remained approximately the same with an average of 17.03 (SD = 3.59). At Time 3, the EFC was relatively lower at an average of 26.86 (SD = 4.55), AOC strategies averaged at 23.05 (SD = 4.38) while PFC strategies averaged at 18.33 (SD = 3.81). Many of these increases and decreases are extremely small and are simply as a function of sample error variation. The average levels of each coping style across time are depicted in Figure 5 below:

***Figure 5*:** Trainee therapists Coping Strategies over a 6 month Training period

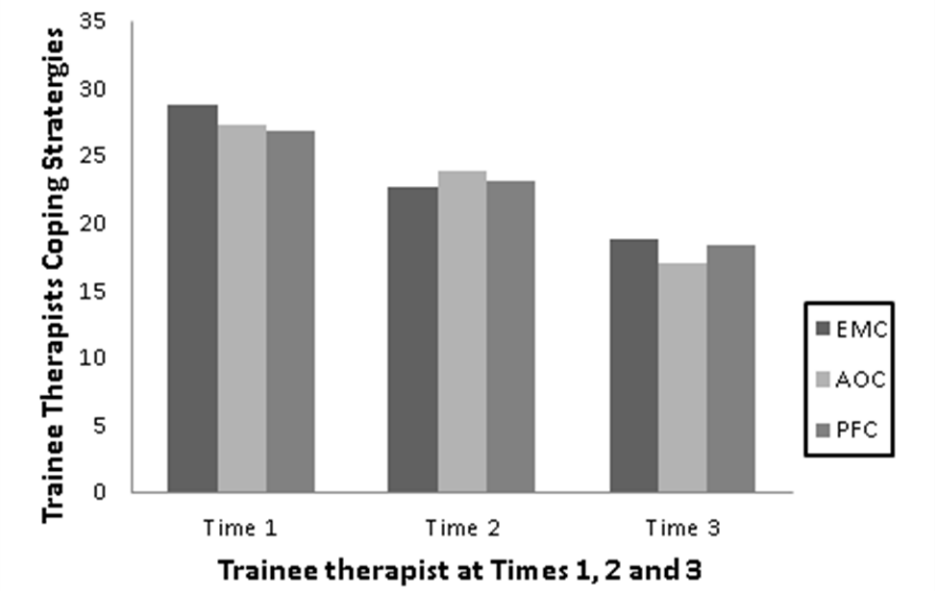


Table 2 below presents means (*M*) and standard deviations (*SD*) of other important variables in the research:

Table 2*: Means and standard deviations of clients seen and trainee age across all three Time Periods*

	Time 1 (*n* = 32)		**Time 2 (*n*= 30)**		**Time 3 (*n* = 21)**	
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*
Clients	0.13	0.34	4.07	3.79	5.95	4.46
Age	25.50	4.07	25.77	4.20	26.24	4.30

According to Table 2, a sample size of 32 trainee therapists was obtained at Time 1. The trainees mean age at Time 1 was 25.50 (SD= 4.07) and they had encountered on average of 0.13 (SD = 0.34) clients. At Time 2, the sample size decreased to 30 trainee therapists. The average age was 25.77 (SD = 4.20) and trainees, on average, had encountered 4.07 (SD = 3.79) clients. At Time 3, the sample size had decreased to 21 trainee therapists. On average, trainee therapists were 26.24 (SD = 4.30) years of age and had encountered approximately 5.95 (SD = 4.46) clients.

Furthermore, Table 3 presents a frequency count of trainees in therapy over the 6 months.

Table 3: Trainee Therapist in Therapy over a 6 months Training Period

	Time 1			**Time 2**			**Time 3**		
Time in Therapy	n	%	Cum%	n	%	Cum%	n	%	Cum%
Not in Therapy	1	3.13	1	0	0	0	0	0	0
0-3 Months	14	43.75	15	3	10.00	3	1	4.76	1
3-6 Months	3	9.38	18	8	26.67	11	4	19.05	5
6-12 Months	7	21.88	25	8	26.67	19	6	28.57	11
12-18 Months	3	9.38	28	4	13.33	23	2	9.52	13
18-24 Months	1	3.13	29	3	10.00	26	4	19.05	17
More than 24 Months	3	9.38	32	4	13.33	30	4	19.05	21
Total	32			30			21		

At Time 1, the largest proportion of trainees, 43.75%, had been in therapy for 0-3 months. In fact, all but one trainee therapist (97%) were reportedly attending personal psychotherapy. However, by Time 2, all trainee therapists were reportedly attending personal psychotherapy as required by the professional training programmes Additionally at Time 2, approximately 90% of the trainee therapists had been in personal psychotherapy for 3 or more months. At Time 3, approximately 76.19% of the trainee therapist had been in personal psychotherapy for at least 6 or more months.

4.3. Intercorrelations Between Variables

In order to ascertain all the relations between key variables, a series of Pearson's product-moment correlation analyses were conducted where all variables met the assumptions of Pearson's *r*. Pearson's *r* requires that all variables are continuous and measured on either a ratio or interval scale, the variables must be approximately normally distributed or must have a sample size of at least 30 to invoke the central limit theorem. All pairs of variables must be linearly related, outliers must be limited or removed, and lastly, there must be homoscedasticity of data (Huck, 2009). All these assumptions were met and Pearson's *r* was conducted. Considering the fact that some of these assumptions overlap with the parametric assumptions of regression and ANOVA (used in the main analyses), to avoid duplication, please refer to the "parametric assumptions" section in the main analysis. The correlations are calculated for each time period.

***Table 4**: Intercorrelation Matrix of Key Variables at Time 1(N =32)*

		1	2	3	4	5	6	7
1	Sense of Coherence	-						
2	Compassion Satisfaction	0.59**	-					
3	Secondary Traumatic Stress	0.09	0.63**	-				
4	Burnout	-0.37*	-0.14	0.46*	-			
5	Emotion-focused coping	0.07	0.10	0.10	-0.08	-		
6	Avoidance-orientated coping	-0.32	0.12	0.46**	0.45*	0.31	-	
7	Problem-focused coping	0.22	0.14	0.13	-0.04	0.60**	0.46**	-

Note: * $p < 0.05$; ** $p < 0.01$

Time 1:

A moderate correlation between SOC and CS ($r = 0.59$; $p < 0.01$) was found which implied that higher levels of SOC at Time 1, were related to higher levels of CS levels. When considering CF (STS & BT), there was a modest, negative correlation between SOC and BT ($r = -0.37$; $p = 0.03$), but no significant correlation between SOC and STS ($r = 0.09$; $p = 0.62$). As such, higher SOC was associated with lower BT but not associated at all with STS. Additionally, trainee STS was correlated moderately and positively with CS ($r = 0.63$; $p < 0.01$) which was unexpected, as it implies trainees with higher levels of STS, also experienced higher CS levels at Time 1. Concerning trainee therapist coping, AOC was moderately and positively correlated with STS ($r = 0.46$; $p < 0.01$) and BT ($r = 0.45$; $p = 0.01$). Trainees, therefore, utilising AOC strategies reported higher STS and BT levels. Additionally, PFC was positively associated with both EFC ($r = 0.60$; $p < 0.01$) and AOC ($r = 0.46$; $p < 0.01$). An increase, therefore, in PFC strategies was associated with increased EFC and AOC strategies in the trainee therapists.

Table 5*: Intercorrelation Matrix of Key Variables at Time 2 in Trainee Therapists (N =30)*

		1	2	3	4	5	6	7
1	Sense of Coherence	-						
2	Compassion Satisfaction	0.65**	-					
3	Secondary Traumatic Stress	-0.46*	-0.13	-				
4	Burnout	-0.77**	-0.70**	0.49**	-			
5	Emotion-focused coping	0.30	0.19	0.04	-0.25	-		
6	Avoidance-orientated coping	-0.68*	-0.42*	0.55**	0.66*	-0.15	-	
7	Problem-focused coping	0.46*	0.36*	-0.23	-0.39*	0.60**	-0.25	-

Note: * p < 0.05; ** p < 0.01

Time 2:

Trainee's with higher SOC had higher CS (r = 0.65; $p < 0.01$) which was expected at Time 2. Regarding CF, trainee therapist STS was moderately negatively correlated with SOC ($r = -0.46$; $p = 0.01$) suggesting that as levels of SOC increased, there was an associated decrease in reported levels of STS. Trainee BT had a moderate to high negative correlation with SOC (-0.77; $p < 0.01$), suggesting that as levels of SOC increased, the reported levels of burnout (BT) decreased. BT was also found associated with negatively on CS ($r = -0.70$; $p > 0.01$). In addition, there was a moderate, positive correlation between BT and STS ($r = 0.49$; $p < 0.01$) which implied that as BT levels increased, so did the levels of STS.

Considering coping strategies at Time 2, as expected AOC was negatively correlated with SOC ($r = -0.68$; $p < 0.01$) and CS ($r = -0.42$; $p = 0.02$), while positively correlated with STS ($r = 0.55$; $p < 0.01$) and BT ($r = 0.66$; $p < 0.01$). As such, an increase in AOC strategies at Time 2 was related to a decrease in the trainees' SOC and lower levels of reported CS as well as an increase in STS and BT levels. Additionally, there was a moderate, positive correlation between PFC and SOC ($r = 0.46$; $p = 0.01$), and PFC and CS ($r = 0.36$; $p = 0.01$), implying trainee therapists using PFC strategies at Time 2, had greater levels of SOC and CS respectively. It was also found that PFC was positively correlated with EFC strategies ($r = 0.60$; $p < 0.01$). This proposes that as levels of PFC strategies increased, so did the levels of EFC strategies, possibly suggesting that at Time 2, trainee therapists who used PFC were also more likely to use EFC strategies. Additionally, while PFC was not correlated with STS, it was significantly and negatively correlated with BT ($r = -0.39$; $p = 0.04$). As such, as the levels of PFC increased in this sample (at Time 2), the observed reported levels of BT decreased.

***Table 6**: Intercorrelation Matrix of Key Variables at Time 3 in Trainee Therapists (N =21)*

		1	2	3	4	5	6	7
1	Sense of Coherence	-						
2	Compassion Satisfaction	0.38	-					
3	Secondary Traumatic Stress	-2.23	0.06	-				
4	Burnout	-0.67**	-0.45*	0.34	-			
5	Emotion-focused coping	0.38	0.66**	0.26	-0.43*	-		
6	Avoidance-orientated coping	-0.28	0.08	0.60*	-0.48	0.25	-	
7	Problem-focused coping	0.26	0.48*	0.48*	-0.16	0.53*	0.40	-

Note: * $p < 0.05$; ** $p < 0.01$

Time 3:

In contrast to Times 1 and 2, CS was not correlated with overall SOC ($r = 0.38$; $p = 0.09$). There was also a weak to moderate correlation between CS and BT ($r = -0.45$; $p = 0.04$) implying greater CS was related to lower BT levels. In addition, both PFC ($r = 0.48$; $p = 0.03$) and EFC ($r = 0.66$; $p < 0.01$) strategies were moderately correlated to CS. It was expected that higher PFC would be associated with higher CS, but it was unexpected that EFC would also have a positive relation with CS during this time. Unexpectedly, when considering CF dimensions, BT was moderately correlated with SOC ($r = -0.67$; $p < 0.01$) suggesting that higher SOC was related to lower levels of BT at Time 3. Moreover, EFC ($r = -0.43$; $p = 0.05$) strategies had a weak to moderate correlation with BT, suggesting the more PFC and EFC strategies utilised, the lower the trainees BT was at Time 3. Furthermore, PFC ($r = 0.48$; $p = 0.03$) and AOC ($r = 0.60$; $p < 0.05$) were both positively associated with STS. Unexpectedly, therefore, trainee's, who employed either PFC or AOC strategies, experienced higher levels of STS. PFC was also moderately and positively correlated with EFC ($r = 0.53$; $p = 0.01$) implying those employing a high number of PFC strategies, would also exhibit more EFC strategies.

4.4.1. Summary of Intercorrelations

Considering the complicated nature of the discussed correlation analyses above, it is important to summarize the general trends of these correlations. In sum, at Time 1, SOC was associated with the dependent variables of CS and BT but not with STS. It was also found that as CS and BT increased so did STS. In terms of coping at Time 1, AOC was associated with both the dependent variable of STS and BT. As such, the more trainee therapists employed AOC strategies at Time 1, the greater their CF.

At Time 2, SOC was associated with all three dependent variables. As SOC decreased, CS levels would have decreased along with an increase in STS and BT levels in the trainee therapists. CS was inversely associated with BT, while BT and STS were positively correlated. Additionally, at Time 2, the coping strategies most associated with the dependent variables of CS, STS and BT were AOC and PFC. Specifically, as trainees employed more AOC strategies, there SOC and CS decreased while there STS and BT levels increased. In contrast, the use of more PFC strategies was associated with greater SOC, higher CS and less BT. PFC was, however, not associated with STS.

At Time 3, SOC was associated inversely with the BT but not with any of the other dependent variables. Additionally, CS was inversely associated with BT. Concerning coping, EFC was positively associated with CS and negatively associated with BT. AOC was positively associated with STS. In addition, PFC was associated positively with the dependent variables of CS and STS as well as with another coping variable, namely EFC.

4.5. Instrument Reliability

Cronbach Alpha Coefficients were used to evaluate the reliability of the instruments used in the research. This is a versatile technique that yields a correlation which expresses the reliability of the testing instruments. Cronbach Alphas were obtained for all the relevant scales and subscales of the instruments applied in the study. This involved gathering Cronbach Alpha Coefficients for the ProQOL, Brief COPE and the OLQ. The results are summarised in Table 7 on the next page:

***Table 7**: Reliability of Instruments Scales and Subscales at each of the Three Time Periods*

	Time 1	**Time 2**	**Time 3**
	Cronbach Coefficients Alpha	**Cronbach Coefficients Alpha**	**Cronbach Coefficients Alpha**
ProQOL	.87 (raw)	.69 (raw)	.72 (raw)
	.88 (standardised)	.67 (standardised)	.72 (standardised)
BCOPE	.80 (raw)	.70 (raw)	.83 (raw)
	.81 (standardised)	.71 (standardised)	.85 (standardised)
OLQ	.88 (raw)	.92 (raw)	.82 (raw)
	.87 (standardised)	.92 (standardised)	.83 (standardised)

At Time 1, the raw and standardised Cronbach Alpha Coefficients for ProQOL scale yielded overall scores of .87 and .88 respectively. These raw and standardised Cronbach Coefficients Alphas are good (George & Mallery, 2003). As such, the ProQOL shows good internal consistency reliability and measured the construct of CF (STS & BT) satisfactorily at Time 1. At Time 2, the ProQOL

Cronbach Alpha Coefficients decreased to .69 (raw) and .67 (standardised). Accordingly, the raw and standardised Cronbach Coefficients Alphas for the ProQOL was questionable at Time 2 (George & Mallery, 2003). At Time 3, however, the ProQOL had acceptable good internal consistency reliability yielding Cronbach Alpha Coefficients of .72 for both the raw and standardised coefficients. As such, the ProQOL adequately measured trainee therapists CS, STS and BT at Time 3.

Considering the Brief Cope, Cronbach Alpha Coefficients were obtained for the total scale. At Time 1, the total revealed Cronbach Alpha Coefficients of .80 (raw) and .87 (standardised). This suggests good internal consistency reliability (George & Mallery, 2003). The Brief Cope usually demonstrates acceptable internal consistency coefficients, with some alpha coefficients ranging between .50 and .60 (Carver, 1997). As such, the Brief COPE in this sample at Time 1 had reasonably good internal consistency reliability and successfully measured the students coping strategies. At Time 2, the Brief COPE yielded lower Cronbach Alpha Coefficients, specifically .70 (raw) and .71 (standardised). Despite this decrease, these Cronbach Alpha Coefficients still suggest the Brief COPE demonstrates good internal consistency reliability at Time 2. At Time 3, Cronbach Alpha Coefficients for the Brief Cope scale were at their highest across all three times yielding an overall score of .83 (raw) and .85 (standardised). These scores are good and suggest the Brief COPE adequately measured overall coping at Time 3.

Furthermore, Cronbach Alpha Coefficients were obtained for the OLQ in relation to the total SOC scale. At Time 1, the OLQ showed good internal consistency reliability yielding Cronbach Alpha Coefficients of .88 (raw) and .87 (standardised). Cronbach Alpha Coefficients ranged from .86 to .89 at Time 1. At Time 2, the OLQ Cronbach Alpha Coefficients increased to .92 for both the raw and standardised scores. This implies the scale has excellent internal consistency reliability at Time 2. Scores at this Time ranged from .91 to .92 at Time 2. This increase in internal consistency reliability is consistent with other OLQ scores found in the South African context. Indeed, the OLQ has been found to have excellent internal consistency with Cronbach's alpha's of .92 in a sample of counsellors (Ortlepp & Friedman, 2002). At Time 3, however, OLQ Cronbach Alpha Coefficients decreased to .82 (raw) and .83 (standardised). Scores ranged from .80 to .84. The internal consistency reliability, is still, however, good and the OLQ adequately measured SOC in the trainees.

4.6. Main Analyses

Before the main analyses could be conducted, the parametric assumptions of regression were tested and are reported on below.

4.6.1. Parametric Assumptions

In order to assess whether or not parametric tests were appropriate to analyse the data, parametric assumptions were explored at each of the three time periods. Considering that the majority of the main analyses are based on linear regression analyses, the assumptions of the regression procedure were tested.

First of all, linear regression assumes that the dependent variable and independent variables are linearly related (Howell, 2009). In this instance, each of STS, BT and CS must be linearly related with each of SOC and each of the three coping styles. This was tested by plotting residuals versus predicted values which demonstrated that the data points were symmetrically distributed along a diagonal line suggesting that this assumption was met. Secondly, linear regression assumes independence of observations. This assumption assumes that errors are not correlated as this would suggest systematic (and unmeasured) sources of variance. This was tested by looking at autocorrelations of the residuals which confirmed that the errors were independent. The third assumption of regression is homoscedasticity, which assumes equal (constant) variance of the errors. This assumption was met as evidenced by the plot that was created to test for linearity above.

Lastly, regression assumes normality (Howell, 2009). The assumption of normality was tested using the PROC UNIVARIATE procedure in SAS (Schlotzhauer, 2009). Skewness and kurtosis indices were examined in addition to Shapiro-Wilk's W statistic. Findings suggested that most variables were normally distributed. An additional consideration is that the sample size at Times 1 and 2 (n= 32 and n= 30 respectively) were sufficient to invoke the central limit theorem (CLT) (Howell, 2008). However, with a sample size of 21 at Time 3 (due to attrition), the central limit theorem could not be invoked. Accordingly, a Shapiro Wilk's W test was used to determine normality (Singh, 2007). The Shapiro-Wilk statistic indicated that each of the dependent variables, CS, STS and BT at Time 3, individually appear univariate normal. As noted in Table 8 on the next page, the W statistic for each of the dependent variables was not significant (> .05), failing to reject the null hypothesis that the data is normally distributed.

***Table 8**: Shapiro-Wilk Test for normal Distribution of Dependent Variables at Time 3*

Variables	W-value	Prob < W
Compassion Satisfaction	0.95	0.40
Secondary Traumatic Stress	0.97	0.78
Burnout	0.97	0.71

Note: W-value calculated with the Shapiro-Wilk statistic

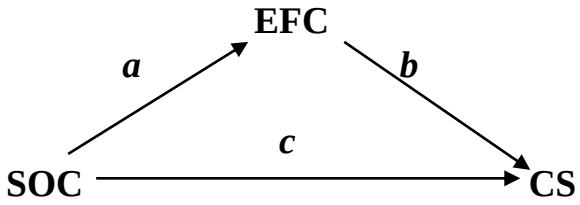
4.6.2. Hypothesis Testing

Emotion-focused coping (EFC) as a mediator of sense of coherence (SOC) and compassion satisfaction (CS) at Time 1:

Hypothesis 1: The effect of sense of coherence (SOC) on compassion satisfaction (CS) will be mediated by emotion-focused coping (EFC), suggesting that SOC will have an indirect effect on CS. This implies that EFC will mediate the relation between SOC and CS at Time 1. In order to establish this mediation model, four steps are required (Baron & Kenny, 1986). These steps are presented below as hypotheses that were tested in order to establish whether or not the proposed mediation was present in the data:

Step 1: ***Hypothesis 1A*****: As illustrated in Figure 1 below,** SOC will be associated with CS at Time 1 (Path *c*). Specifically, higher levels of SOC will be predictive of higher reported levels of CS, at Time 1.

Figure 1b: Emotion-focused Coping (EFC) as a mediator of Sense of Coherence (SOC) and Compassion Satisfaction (CS) at Time 1 (N = 32)



To test for Hypothesis 1A in Step 1, a simple regression analysis with SOC predicting CS for Path *c* alone was conducted. The effect of SOC on CS (Path *c*) was not significant $b =$, $t(31) = 0.$, $p = 0$. Accordingly, the null hypothesis for Hypothesis 1A was accepted as it could not be rejected. This suggests that SOC did not predict CS at Time 1 in this sample.

Step 2: Hypothesis 1B: SOC will be predict EFC at Time 1 (Path *a*).

To statistically analyse Hypothesis 1B in Step 2, a simple regression analysis was completed with SOC predicting EFC (Path *a*). The effect of SOC on EFC (Path *a*) was not significant $b = 0.02$, $t(31) = 0.36$, $p = 0.72$. Accordingly, the null hypothesis that SOC does not predict EFC at Time 1 was accepted as it was not possible to reject it.

Step 3: Hypothesis 1C: EFC will predict CS (Path *b*), at Time 1.

A simple regression analysis with EFC predicting CS (Path *b*) was conducted to test for Hypothesis 1C in Step 3. The regression equation was not significant $b = 0.32$, $t(30) = 0.56$, $p = 0.58$ suggesting that EFC was not associated with CS at Time 1.

Step 4: Hypothesis 1D*:* This step tested the hypothesis that EFC will mediate the relation between SOC and CS. To establish that EFC completely mediates the relation between SOC and CS, the effect of SOC on CS controlling for EFC (Path *c*) should be zero at Time 1 (Baron & Kenny, 1986). An alternative method for establishing this mediation is by using the standardized regression coefficients in an online Sobel calculator (Baron & Kenny, 1986).

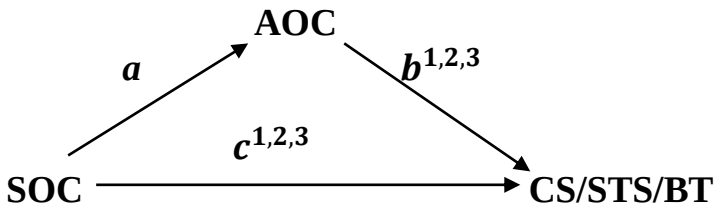
As the first three steps were not met, the statistical data was unlikely to support a mediation model. This assumption was supported, however after running the online Sobel test which revealed no mediation in the model, $z = 0.31$, $p = 0.38$. As such, contrary to the prediction of Hypothesis 1, EFC does not mediate the relation between SOC and CS at Time 1.

Avoidance-orientated coping (AOC) as a mediator of sense of coherence and each of compassion satisfaction (CS) and compassion fatigue (STS & BT) at Time 2:

Hypothesis 2: The effect of SOC on each of CS, STS and BT will be mediated by AOC. This implies that AOC will mediate the relation between SOC and each of CS, STS and BT at Time 2. The steps that were undertaken to test this mediation are detailed below along with the associated hypotheses that were tested:

Step 1: ***Hypothesis 2A:*** SOC will predict each of CS, STS and BT at Time 2 (Path $c^{1,2,3}$). Specifically, lower levels of SOC will predict higher levels STS, higher levels of BT and lower levels of CS.

Figure 2b: Avoidance-orientated coping (AOC) as a mediator of sense of coherence (SOC) and compassion fatigue (STS & BT) at Time 2 (N = 30)



NOTE: b^1 is AOC predicting CS; b^2 is AOC predicting STS; b^3 is AOC predicting BT. c^1 is SOC predicting CS; c^2 is SOC predicting STS; c^3 is SOC predicting BT.

To conduct Step 1, a series of simple regression analyses were run. In order to avoid excessive redundancy in reporting these findings, the three outcome variables (CS, STS and BT) were tested separately but are parsimoniously and collectively reported herein.

Concerning Path c^1, the regression equation testing whether or not SOC predicts CS was significant b = 0.19, t (29) = 4.50, p >0.01. Suggesting that as predicted, SOC does predicts CS at Time 2 in this sample. Considering Path c^2, the effect of SOC as a predictor of STS was also significant b = -0.15, t (29) = 0.-2.72, p = 0.01. This suggests that SOC is also a significant predictor of STS in this sample at Time 2. To analyse Path c^3 another simple regression was conducted. It was found that the effect of SOC as a predictor of BT was also significant b = -0.24, t (29) = -6.36, p <0.01, meeting the requirements of Step 1 of the mediation. As such, Path c^3 also passed Step 1, suggesting that SOC does predict BT at Time 2. Collectively, therefore, SOC does predict each of CS, STS and BT at Time 2.

Step 2: Hypothesis 2B: SOC will predict AOC at Time 2 (Path *a*).

Hypothesis 2B as outlined in Step 2 was tested via a simple regression analysis predicting AOC from SOC (Path *a*). The effect of SOC as a predictor of AOC was significant, (b = -0.15, t (29) = -4.91, p < 0.05), suggesting that SOC does predict AOC (Path *a*) at Time 2.

Step 3: Hypothesis 2C: AOC predict each of CS, STS and BT (Path $b^{1,2,3}$). Specifically, higher levels of AOC will be predictive of lower reported levels of CS, higher STS levels and higher BT levels.

To conduct Step 3, a series of single regression analyses were conducted. When considering Path b^1, the regression equation testing whether or not AOC predicts CS was significant (b = 0.-0.56, t (29) = -2.47, p = 0.02). Therefore, Path b^1 met the requirements for Step 3, as AOC was found to be a predictor of CS at Time 2. In terms of Path b^2, the regression equation testing whether or not AOC

predicts STS was also significant (b = 0.83, t (29) = 0.3.45, p < 0.05). This implies that at Time 2, as specified in Path b^2, AOC does predict STS. Lastly, the same hypothesis was tested for b^3 testing the effect of AOC as a predictor of BT. A significant regression equation (b = 0.96 t (29) = 4.66, p <0.01) suggests that AOC does predict BT at Time 2 in this sample. Collectively, therefore, AOC does predict each of CS, STS and BT at Time 2.

Step 4: Hypothesis 2D: The aim of this final step was to test whether or not AOC completely mediates the relation between SOC and each of CS, STS and BT by means of a Sobel test using standard errors and regression coefficients of Steps 2 and 3. Once again, an alternative method for establishing mediation is to use the standardized regression coefficients in an online Sobel calculator (Baron & Kenny, 1986).

As the first three steps were met for each mediation model, Step 4 was conducted on the online Sobel calculator. Concerning AOC mediating the relation between SOC and CS at Time 2, a significant mediation was found on both the one-tailed Sobel Test, (z =2 .2104, p = 0.01)and two-tailed Sobel Test, (z = 2.2104, p = 0.03). Regarding AOC as a mediator of the relation between AOC and STS at Time 2, the one-tailed Sobel Test was significant (z = -2.82, p <0.05) as well as the two-tailed Sobel test, (z = -2.82, p <0.05). Additionally, AOC as a mediator of the relation between AOC and BT at Time 2, was also found to be significant on both the one-tailed (z = -3.34, p <0.05) and two tailed (z = -3.34, p <0.05) Sobel tests. Accordingly, these findings suggestions that avoidance oriented coping at Time 2 (AOC) does mediate the relation between SOC and each of CS, STS and BT at Time 2 in this sample of trainee therapists.

Problem focused coping (PFC) at Time 3:

Hypothesis 3: SOC will be associated with problem-focused coping but not with CS or CF. Instead problem-focused coping will be directly associated with CF (STS & BT) and CS.

In order to test the above hypothesis, a series of Pearson's Product Moment Correlations were run (Table 6). According to the correlation matrix, SOC was not associated with PFC (r= 0.26, p= 0.25). PFC was associated positively with CS (r= 0.48, p= 0.03) and positively STS (r= 0.48, p= 0.03) (Notably, CS and STS had the same association with PFC). PFC, however, was not associated with BT (r = -0.16; p = 0.48). Instead, SOC was moderately correlated with BT (r= -0.67, p= < 0.01).

4.7. Additional Analysis

Sphericity checks whether or not the variance/ covariance matrix of the observed data follows a particular pattern (Lenong & Austin, 2006). Mauchly's test was used to test for sphericity and the test was highly significant suggesting that the observed matrix does not have approximately equal variances and equal covariances. Because of the violation of the assumption of sphericity, a multivariate approached was adopted for the repeated measures analysis of variance. Since the multivariate approach analyses the repeated measures data in the same manner as it would a regular MANOVA, the assumptions of MANOVA apply. Multivariate tests suggested a significant Time effect. This suggests that the CS, STS and BT scores across the three time periods have at least one mean vector pairing that resulted in a significant difference (Wilk's lambda = 0.489, $F_{(2,75)}$= 39.18, p <0.001). In addition, a significant Time X SOC interaction was observed across time at the multivariate level (wilk's lambda= 0.55, $F_{(2, 75)}$ = 30.13, p<0.001. These findings suggest that SOC was overall significantly related to each of CS, STS and BT across all time periods. In addition, SOC was found to interact with time to predict the three outcome variables suggesting that the effect of SOC was dependent on *when* the measurements were made during the first six months of training. Post hoc comparisons suggested that the greatest mean differences occurred between Time 2 and Time 3 in this sample of trainee therapists. Figures, 7, 8 and 9 illustrate SOC as related to CS, STS and BT across all three time periods:

Figure 6: Secondary Traumatic Stress as a function of Sense of Coherence in Trainee Therapists across Time.

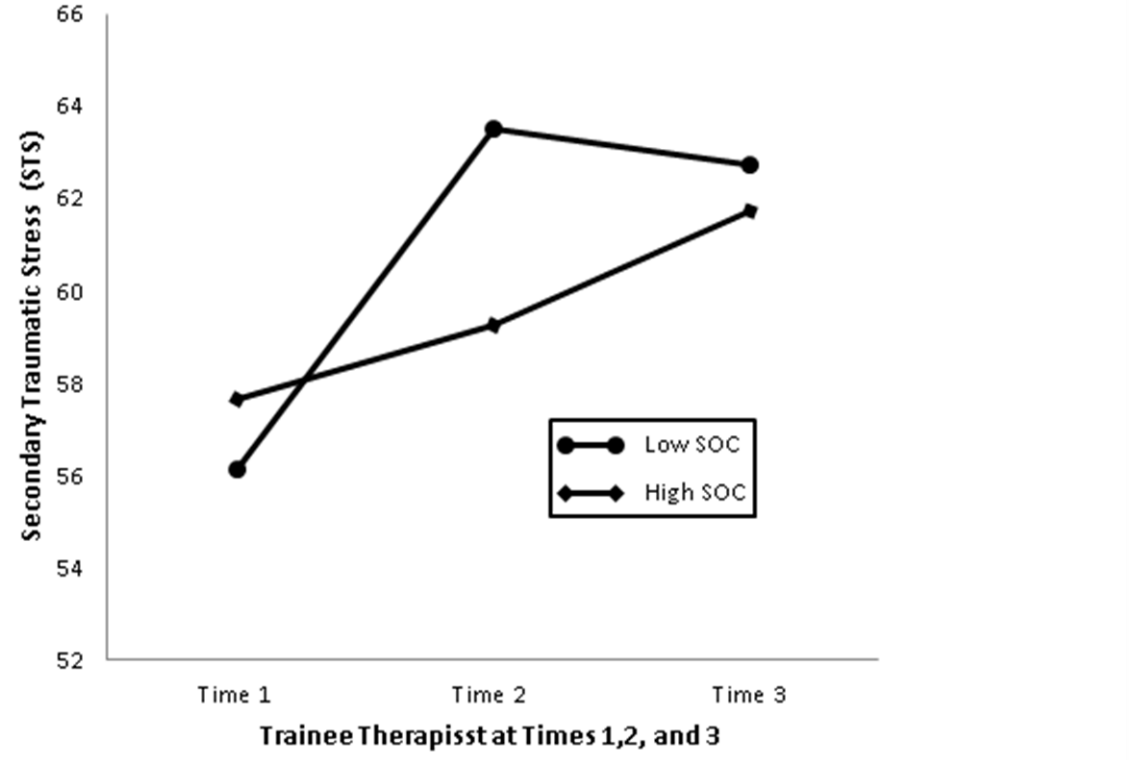


Figure 7: Compassion Satisfaction as a function of Sense of Coherence in Trainee Therapists across Time.

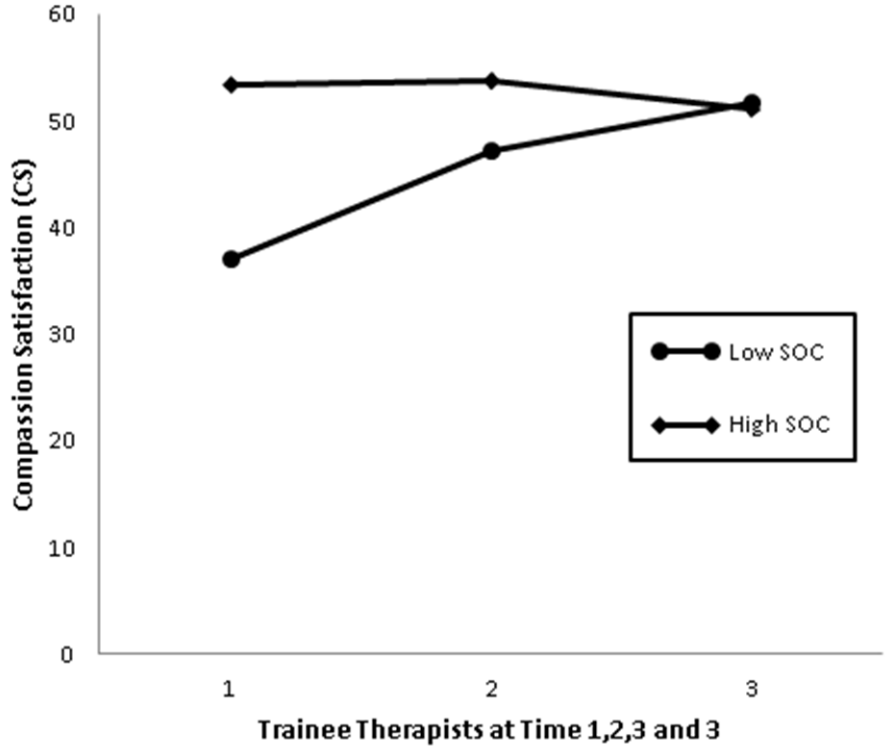
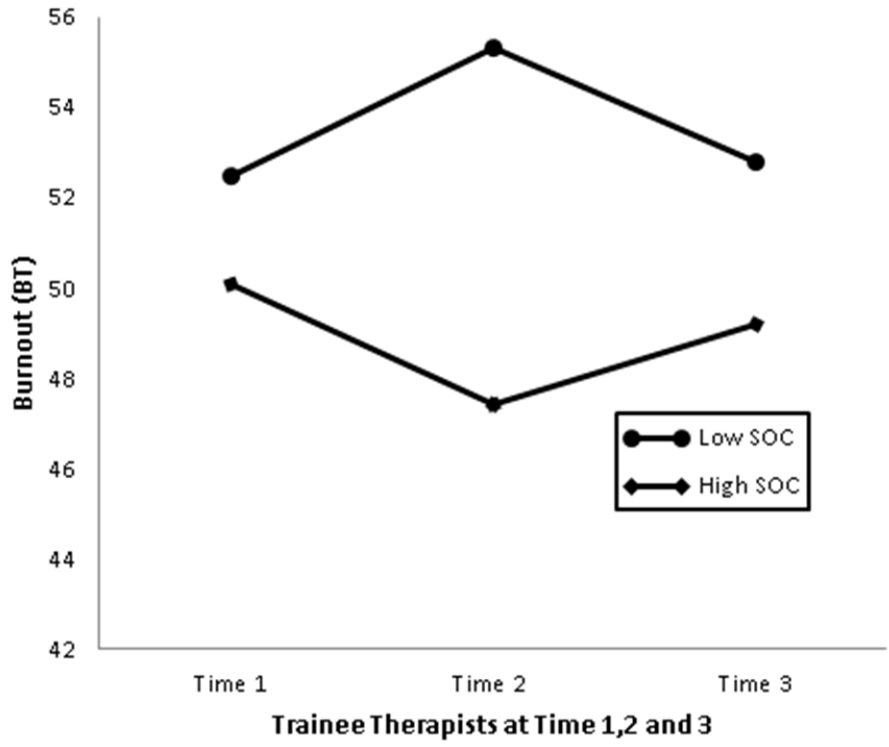


Figure 8: Burnout as a function of Sense of Coherence in Trainee Therapists across Time



5. Discussion

5.1. Discussion Introduction

This research aimed to investigate the positive (compassion satisfaction) and negative (compassion fatigue) outcomes in the developmental trajectory of trainee therapists during the first six months of their training. The aim was to specifically explore whether or not SOC is directly or indirectly associated with these outcomes, and whether or not it is mediated by coping. A secondary aim was to explore how SOC affected positive and negative outcomes in training therapists across a six month training period. The research particularly hypothesised around trainee therapists at the University of the Witwatersrand (WITS) as they negotiated three distinct time periods across the six month training period. At the beginning of training (Time 1), no coping mediation was found in the trainee therapists. Instead, sense of coherence directly predicted compassion satisfaction and burnout in the trainee therapists. From approximately the 2nd to 4th month of training (Time 2) trainee therapists' responsibility increased. In response, avoidance-orientated coping significantly mediated the relation between sense of coherence and compassion fatigue, as well as mediated sense of coherence and compassion satisfaction. As expected around the 6th month of training (Time 3), problem-focused coping directly predicted compassion satisfaction. Unexpectedly, however, problem-focused coping predicted secondary traumatic stress and sense of coherence predicted burnout after six months of training.

5.2. Time 1: Conventionally Focused Sense of Coherence

Time 1 represented the two month mark of psychotherapeutic training, just before the trainees encountered the all-important training catalyst of client exposure (Orlinsky, Botermans & Rønnestad, 2001). Accordingly, at the Time 1 the trainees had encountered, on average, 0.13 (SD = 0.34) clients. Trainee therapists were also thought to be operating from a conventional sense of coherence at this beginning time (Rønnestad & Skovholt, 2003). The trainees' sense of coherence was on average 136.19 (SD = 17.60). This average falls within the normal sense of coherence range in the general population which usually ranges between 132.4 (SD=22.0) and 160.4 (SD = 16.7) (Antonovsky, 1993; Rice, 2000; Runeson, Norback & Stattin, 2002). The mean age of this sample at Time 1 was 25.50 years (SD= 4.07) with a minimum age of 22 and a maximum of 39 years of age. Sense of coherence is hypothesised to become more stable by the end of the third decade of life, specifically around the age of 30 (Antonovsky, 1987, p. 118). This implies that the trainees, who were aged around 25 years, were still in a phase of trying to solidify a sense of manageability, meaningfulness and comprehensibility in their world.

In the context of Time 1, it was hypothesised that emotion-focused coping would mediate the relation between conventional sense of coherence and compassion satisfaction. This mediation hypothesis was not significant, suggesting that emotion focused coping did not medicate the relation between sense of coherence and compassion fatigue in this sample. This finding was contrary to the assumption that sense of coherence may be indirectly associated with compassion satisfaction and compassion fatigue (Fourie, Rothmann & Van de Vijver, 2007). Instead, it was found that sense of coherence directly predicted compassion satisfaction and the burnout component of compassion fatigue. This result supports literature that suggests sense of coherence has a direct relation with burnout, work-wellness and role-satisfaction (Fourie et al., 2007; Ortlepp & Friedman, 2002). Students, therefore, who came into the professional training programme with a more stable sense of coherence - a sense of their world as manageable, comprehensible and meaningful - were more likely to report compassion satisfaction or feelings of being a success at the start of their training.

Additionally, at Time 1, the trainees compassion satisfaction was on average 41.80 (*SD* = 12.97). According to Stamm (2010) scores of 43 or less are indicative of low compassion satisfaction. The trainee therapists, therefore, may have experienced difficulties "keeping up" or feeling that they could "make a difference" after two months of training (Stamm, 2010, p. 21). This finding supports research which argues trainees may feel inadequate at the beginning of their training journey (Skovholt & Rønnestad, 2003). Furthermore, the average burnout score in the caregiver population is 50 (SD = 10) (Stamm, 2010). The trainee therapists burnout averaged at 51.81 (*SD* = 6.78), suggesting they had moderate to average levels of burnout. The trainees may have felt somewhat overwhelmed and ineffective in their training environment after 2 months of training. The trainees also manifested high levels of secondary traumatic stress at Time 1. Indeed, their secondary traumatic stress was on average 56.58 (*SD* = 7.56), which Stamm (2010) indicates is fairly high. Combining, the trainees' high secondary traumatic stress with their moderate burnout, suggests the trainees felt "inadequate", "overwhelmed" and "stressed" at Time 1 (Stamm, 2010, p. 22). This finding supports the observation that burnout and secondary traumatic stress can act in tandem to heighten stress levels in trainees as they begin their training (Collins & Long, 2003).

It was surprising to find that trainee therapists had low compassion satisfaction, high secondary traumatic stress and moderate levels of burnout after the initial two months of training. Their enthusiasm for helping others was also expected to be propelling their motivation and satisfaction in their career choice (Brems, 2001). They had also encountered very little client exposure (*M* = 0.13, *SD* = 0.34), making it unlikely they would have experienced the contact required for secondary stress to develop. These findings, therefore, are somewhat inconsistent with literature suggesting secondary stress requires exposure to the cumulative trauma of clients before it manifests in caregivers (Figley, 2002a). Even further, such results are contrary to the notion that feelings and thoughts "flood" trainees

only after they encounter clients for the first time (Skovholt & Rønnestad, 2003, p. 49). It seems that the mere prospect of therapeutic exposure was enough to flood the trainees and produce secondary stress. This finding, however, is in line with the literature suggesting the ambiguity of professional work can produce "acute performance anxiety" in trainee therapists (Skovholt & Rønnestad, 2003, p. 1). Indeed, while seemingly unsure of practitioner challenges, the trainees appeared to become increasingly overwhelmed and anxious as early as two months into their training.

A reason, perhaps, as to why the trainee therapists may have demonstrated low compassion satisfaction and moderate to high compassion fatigue may have something to do with their sense of coherence levels at Time 1. As the literature suggests, conventional ways of being in the world are inadequate for therapeutic practice (Skovholt & Rønnestad, 2003). Indeed, despite sense of coherence being positively correlated with compassion satisfaction ($r = 0.59$; $p < 0.01$), it lacked the tenacity to elevate compassion satisfaction levels in the face of the ambiguity of professional work (Skovholt & Rønnestad, 2003).Similarly, sense of coherence had an inverse relation with burnout ($r = -0.37$; $p = 0.03$) but despite being in training for only two months, the trainees manifested moderate feelings of being overwhelmed. Added to the high secondary traumatic stress levels, it seems that trainees lack the "professional self-confidence" or sense of coherence to buffer feelings of anxiety and burnout at this beginning stage of training (Rønnestad & Skovholt 2003, p. 33). Accordingly, the trainees' sense of coherence (M =136.19; SD = 17.60) may indeed be conventional and unprofessional at this beginning stage of their training.

Furthermore, as secondary traumatic stress increased, so did compassion satisfaction at Time 1 ($r = 0.63$; $p < 0.01$). Trainees may have felt intrusively preoccupied with the ambiguity of therapeutic work while also feeling invigorated and satisfied. This seems in line with Stamm (2002, p. 113), who found that caregivers may experience compassion fatigue but also "feel positive benefits from it". This reaction to compassion fatigue is, however, guided by a "belief system" or "resilience" which helps them "feel like it's the right thing to do" (Stamm, 2002, p. 113). As such, perhaps, the equilibrium between compassion satisfaction and compassion fatigue is also balanced by the trainees' sense of coherence. As stated, however, the trainees' sense of coherence was correlated with low compassion satisfaction. This suggests the trainees' sense of coherence, at this time of training, may also have been unable to balance feelings of fatigue and feelings of satisfaction well enough to produce therapeutic gratification and drive. Accordingly, this finding again appears to support the assumption that the "map gleaned from one's personal life" (conventional sense of coherence) is "often not adequate for the specific challenge" of therapeutic work (Skovholt & Rønnestad, 2003, p. 7).

Added to the above findings, problem-focused coping was associated with both emotion focused coping ($r = 0.60$; $p < 0.01$) and avoidance-orientated coping ($r = 0.46$; $p < 0.01$). This suggests that as trainee therapists tried to cognitively regulate training through problem-focused coping, their attempts to emotionally regulate via emotion-focused coping and avoid stressful stimuli through avoidance-oriented coping collectively increased. A problem, however, was that avoidance-oriented coping increased secondary traumatic stress ($r = 0.46$; $p < 0.01$) and burnout (0.45; $p = 0.01$). This supports research suggesting avoidance coping is maladaptive as it has an inverse relation with mental well-being (Cicognani, Pietrantoni, Palestini et al., 2009; Green, Choi & Kane, 2010). In this respect, while trainee therapists attempted to utilise problem-focused coping strategies at Time 1, the manner in which their coping unfolded may have led to increased levels of compassion fatigue through avoidance-orientated coping. Accordingly, both the trainees' sense of coherence and coping strategies appeared out of sync with the demands of a therapeutic context at Time 1. However, individual conditions and changes over time influence sense of coherence and along with such changes come more successful coping strategies (Geyer, 1997; Nilsson, Holmgren, Stegmayr & Westman, 2003). Perhaps the trainees were yet to be "socialized into the professional culture" that allows for the trainees to adorn a more professional level of coherence along with more therapeutically equipped coping strategies to be adorned (Rønnestad & Skovholt, 2003, p. 28). These assumptions were explored further at Time 2 and 3 respectively.

5.3. Time 2: Externally Focused Sense of Coherence

Time 2 occurred after four months of training as the trainees' therapeutic responsibilities extended to include a combination of client exposure and workloads (WITS, 2011). Indeed by Time 2, the trainee therapists had encountered on average 4.07 (*SD*=3.79) clients in a psychotherapeutic setting, as opposed to encountering 0.13 (SD=0.34) clients at Time 1. Despite this increase in client exposure, trainee therapists' sense of coherence stayed practically the same at Time 2 with an average of 135.83 (SD = 22.74). This finding is somewhat contrary to the literature which suggests that the more stressful the situation for students the lower the sense of coherence, as previous models of making sense of the world are "shattered" (Janoff-Bulman, 2002 p. 90; Carmel & Bernstein, 1990). However, the finding supports research which has found that the higher the sense of coherence, the more stable and less likely it is to change over time (Nilsson et al., 2003).

In contrast to the stability of sense of coherence at Time 2, it was observed that compassion fatigue levels increased along with client exposure. This again is merely an observation and this relation was not statistically verified. Nevertheless, trainees' secondary traumatic stress increased to an average of 62.23 (SD = 7.58), which is high when compared to caregiver norms (Stamm, 2010). Therefore, it seems that after encountering clients, the trainees stress levels increased around the task of helping others (Bride, Robinson, Yegidis & Figley, 2003). This stress may "impair" the trainees' ability to

help those seeking services (Bride et al., 2003, p. 12). Secondary traumatic stress was inversely related with sense of coherence (r = -0.46; p = 0.01). As such, while the trainees' sense of coherence did not necessarily "shatter" (Janoff-Bulman, 2002 p. 90), it may have been somewhat impaired or immobile by the trainees' high secondary stress. This, perhaps, supports the research suggesting caregivers can become "infected" by the stress of helping others (Stamm, 2010, p. 21). It also supports literature suggesting apprehension and anxiety are observed as trainees encounter their first clients (Rønnestad & Skovholt, 2003, p. 9).

Additionally, the mean level of burnout at Time 2 increased slightly to 52.97 (SD= 7.22). While this level of burnout is still considered moderate, it again suggests the trainees, on average, may have felt more overwhelmed at Time 2 (Stamm, 2010). This finding is consistent with literature that has observed burnout levels increase in trainee therapists as the pace and pressure of employing interventions rises (Tryssenaar & Perkins, 2001). An inverse relation was found between burnout and sense of coherence (-0.77; $p < 0.01$). This finding is in line with research which has identified higher levels of burnout can deplete sense of coherence in a sample of South African counselors (Fourie et al., 2007; Ortlepp & Friedman, 2002). Additionally, heightened levels of secondary traumatic stress were found to increase burnout in the trainee therapists at Time 2 (r = 0.49; $p < 0.01$). This again supports the observation that burnout and secondary traumatic stress can act in tandem to seriously heighten stress levels in the trainee therapists, hereby contributing to increased overall compassion fatigue (Collins & Long, 2003).

Concerning the positive avenues of therapeutic work, the trainees' compassion satisfaction increased from a mean of 41.80 (SD =12.79) at Time 1 to a mean of 49.13 (SD = 6.49) at Time 2. Observably, the trainees seemed to feel more invigorated and motivated as they encountered more clients and experienced greater levels of compassion fatigue. This is consistent with literature suggesting "optimism coexists with apprehension in the novice therapist" (Skovholt & Rønnestad, 2003, p. 53).Unlike Time 1, however, there was no positive correlation between compassion satisfaction and secondary traumatic stress (r = -0.13; 0.49). Instead, there was a negative correlation between compassion satisfaction and burnout (r = -0.70; $p < 0.01$). In line with the literature, as trainee therapists' manifested more burnout their "sustaining beliefs" would have gradually depleted along with an overwhelming feeling that they were "out-of-touch" with who they wanted to be (Stamm, 2010, p. 21). Additionally, compassion satisfaction was positively associated with sense of coherence at Time 2 (r = 0.65; $p < 0.01$). Trainees, therefore, with greater levels of satisfaction at Time 2, also had more manageability, comprehensibility and meaningfulness. This supports research which has found sense of coherence is associated with more role satisfaction in caregivers (Ortlepp &

Friedman, 2002). It also highlights the direct effect that sense of coherence can have on potential "professional productivity and sustained motivation" (Stamm, 2002, p. 107).

Despite the positive relation between sense of coherence and compassion satisfaction, if secondary traumatic stress and burnout continue to increase the way it has since Time 1, there may be "no energy available to sustain the vision of a better world in which one could find satisfaction" (Stamm, 2002, p. 113). An increase in compassion fatigue may diminish the trainees' energy to find the meaning, manage, and comprehend necessary to sustain a level of compassion satisfaction concerning therapeutic work. Therefore, under the pressure of increasing compassion fatigue, caregivers require support from supervisors, colleagues or health care professionals (Stamm, 2010). This seems to support literature arguing that trainees need supervision and support as they initially grapple with practitioner demands (Collins & Long, 2003; Hill, Sullivan, Know & Schlosser, 2007). It also supports the notion that future research should explore the role of personal psychotherapy in relation to compassion fatigue in a sample of trainee therapist. At Time 2, all trainee therapists in this sample were in their own personal psychotherapy (WITS, 2011). It is unclear whether or not psychotherapy had a positive impact on the trainees' sense of coherence as this goes beyond the scope of the research but it is recommended that future research explore this relationship. Indeed, personal psychotherapy may have helped trainee therapists sustain a fairly stable sense of coherence and compassion satisfaction in the face of increasing levels of compassion fatigue.

As expected, the present study also found evidence that perhaps the relation between sense of coherence and compassion fatigue/compassion satisfaction is an indirect relationship that is mediated by coping strategies .This suggests that sense of coherence does not always operate on its own as an internalised coping resource for the preservation of health (Geyer, 1997). Instead, sense of coherence can act as a selective resource for choosing coping strategies (Boss & Mulligan, 2003). These coping strategies, in turn, seem capable of mediating training experiences. In particular, at Time 2, avoidance-orientated coping strategies mediated the relation between sense of coherence and secondary traumatic stress, as well as sense of coherence and burnout. This implies that, on average, trainees with lower sense of coherence were more likely to generate distance away from their stressful and overwhelming environment. In addition, they were more likely to report higher levels of compassion fatigue. This finding seems to support literature proposing trainee therapists may adopt an avoidant defensive maneuver, namely a premature closure, when feeling overwhelmed by professional challenges (Skovholt & Rønnestad, 2003). The result is also consistent with the notion that low sense of coherence is associated with less approach orientated strategies during stressful encounters (McSherry & Holm, 1994).

It was also thought that trainee therapists may select avoidance-orientated coping because it stopped their sense of coherence from becoming infected and overwhelmed by compassion fatigue. As described this mediation effect was present, but there was an inverse relation between avoidance-oriented coping and sense of coherence (r = -0.68; $p < 0.01$). In other words, while trainees tended to generate distance from their stressful training stressors in order to cope, they were actually reducing the effectiveness of their manageability, meaningfulness and comprehensibility. This finding is in line with the literature that proposes trainees who avoid therapeutic challenges may be involved in a maladaptive, inappropriate and professionally inadequate way of functioning (Skovholt & Rønnestad, 2003). It may be maladaptive precisely because avoidance-orientated coping strategies are associated with decreased sense of coherence and increased secondary traumatic stress and burnout. It seems that using avoidance-orientated coping, trainees may feel increasingly anxious, fragile and professionally ineffective. This fragile and unbalanced professional process has been documented in qualitative literature (Rønnestad & Skovholt, 2003).

Furthermore, coping mediated the relation between sense of coherence and compassion satisfaction at Time 2. This implies that the levels of sense of coherence influenced the choice of coping strategy, which in turn had an effect on the reported levels of compassion satisfaction. Trainees, however, that employed avoidance-orientated coping had decreased levels of compassion satisfaction (r = -0.42; p = 0.02). Avoidance-orientated coping, therefore, not only increased compassion fatigue in the trainees but it decreased their feelings of satisfaction, vigour and motivation. In addition, sense of coherence was positively associated with compassions satisfaction (r = 0.65; $p < 0.01$) at Time 2. However, sense of coherence was also inversely related with avoidance-orientated coping (r = -0.68; $p < 0.01$).This suggests that as trainees' that used their sense of coherence as a selective resource to use avoidance-orientated coping, indirectly lowered their compassion satisfaction which directly impeded manageability, meaningfulness and comprehensibility.

Accordingly, avoidance-orientated coping strategies were detrimental to the trainees' compassion satisfaction at Time 2. This again supports research which highlights the maladaptive impacts of avoidance-oriented coping, especially in this population of training therapists (Cicognani et al., 2009; Green, et al., 2010). The mediation result also highlights an important difference between a healthy disengagement (Figley, 2002b, p. 1438), and maladaptive avoidance-orientated coping in trainee therapists. A healthy disengagement "prevents compassion stress" and enhances "self-care" (Figley, 2002b, p. 1438). In contrast, maladaptive avoidance-orientated coping strategies appear to decrease compassion satisfaction and sense of coherence while exacerbating compassion fatigue. Future research may want to explore which avoidance-orientated coping strategies contribute to either a maladaptive or adaptive disengagement from therapeutic stressors. This may help the trainees feel

more effective and less "bogged down" when dealing with therapeutic challenges (Stamm, 2010, p. 21).

Furthermore, problem-focused coping was significantly related to sense of coherence, compassion satisfaction, and burnout. It seemed that as trainee therapist utilised more problem-focused coping strategies they were able to increase their manageability, comprehensibility and meaningfulness (r = 0.46; p =0.01). Along with an increase in sense of coherence, problem-focused coping also increased compassion satisfaction (r = 0.46; p =0.01) and decreased burnout (r = -0.39; p = 0.04). This implies that a goal-orientated coping strategy, which involves supervision (Cooper et al., 2008; Green et al., 2010; Ming-sum, 2005), increased sense of coherence and compassion satisfaction, as well as decreased the pace and stress of burnout, in this sample of trainee therapists at the four month mark of training (Time 2). Considering this finding, perhaps, future research should explore the relation between supervision, sense of coherence and the negative and positive avenues of therapeutic work. Nevertheless, problem-focused coping seems adaptive and appeared to give the trainees a "sense of control" over burnout (Green, et al., 2010, p. 735).

What is important, about the above findings for developing professionals is that if trainees continue to select avoidance-orientated coping strategies to deal with their training as usual challenges, their levels of compassion satisfaction and sense of coherence will continue to diminish. As a consequence, the trainees may be unable to sustain a level of productivity, motivation or satisfaction in their professional work (Stamm, 2002). In turn, increased compassion fatigue can induce feelings of being trapped, disconnected, exhausted and overwhelmed (Figley, 2002; Stamm, 2010). Prolonged and cumulative use of avoidance-orientated coping, therefore, may leave the trainees susceptible to increasing compassion fatigue. In turn the trainee therapists may be left stagnating and deteriorating in a rather unproductive developmental manner (Rønnestad & Skovholt, 2003). Important to mention however, is that it was not possible to examine the medium to longer term effects of poor compassion satisfaction in training therapists. Very little research has explored the effects of poor compassion satisfaction in the beginning stages of training. Future research should explore the medium to long term consequences of low compassion satisfaction during training and also explore how compassion satisfaction during the earlier phases of training may impact on performance later on in the training programme.

5.4. Time 3: Professionally Adapted Sense of Coherence

In accordance with the literature and the proposed framework, it was thought that adaptive shifts would be observed in the trainee therapists' sense of coherence after six months of training (Hill et al., 2007; Tryssenaar & Perkins, 2001). Accordingly, Time 3 was conceptualized after about sixth months

of training. At this time the trainees had encountered on average 5.95 (SD = 4.46) clients in a psychotherapeutic setting. The trainees mean age had also increased to 26.24 (SD = 4.30). Added to this, the trainees sense of coherence had increased from 136.19 (SD = 17.60) at Time 2 to 142.00 (15.56) at Time 3. After six months of training, therefore, trainee therapists were felt more confident that they could manage, comprehend and put meaning to internal and external environments as predictable and that there was a high probability that things would develop as well as could be expected (Antonovsky, 1987; Fourie et al., 2007). It must be reiterated, however, that due to the trainees' age, their sense of coherence was not, as yet, settled and was expected to still be in a state of adaptation (Antonovsky, 1987). Nevertheless, changes in sense of coherence are considered "rare and occur only because they initiate a new pattern of life experiences" (Antonovsky, 1987; Nilsson et al., 2003, p. 302). As will be discussed below, a new sense of coherence pattern may have emerged for the trainee therapists regarding their six month experiences through therapeutic training as usual.

The increase in trainee therapists' sense of coherence suggests that since the start of training, the trainees have moved from a less enduring sense of confidence to a more durable feeling of confidence in themselves and their surroundings (Antonovsky, 1987). In line with professional developmental literature, it seems the trainees have "gradually increased in ability to relate in a functional way" (Skovholt & Rønnestad, 2003, p. 48). They began with a sense of coherence that was, on average, satisfactory when compared to the general population (*M* =136.19; SD = 17.60) (Antonovsky, 1993; Rice, 2000; Runeson et al., 2002). However, as the literature suggests, the "map gleaned from one's personal life is no longer adequate for the specific challenge" of therapeutic work (Skovholt & Rønnestad, 2003, p. 3). The trainees required a change in their sense of coherence or a new map of how to manage, comprehend and find meaning in the context of therapeutic challenges.

Accordingly, before Time 3, trainee therapists seemed to use their sense of coherence to select and grapple with coping strategies (Time 2). Coping was used as an intervening, process or mediating variable (Baron & Kenny, 1986) (Time 2). The trainees were seemingly trying to find a "plausible mechanism" (Haine, Ayers, Sandler, Wolchik & Weyer, 2003 p. 622) through which the associations between sense of coherence and the positive (compassion satisfaction) and negative (compassion fatigue) avenues of therapeutic work could be negotiated. Arguably they were searching to replace their "conventional map" (conventional sense of coherence) with a more "professional map" (professional sense of coherence) (Skovholt & Rønnestad, 2003, p. 51). It was hypothesised that at Time 3, the trainee therapists' would internalise this professional map with the internalisation of adaptive problem-focused coping strategies into their sense of coherence. It was thought that such coping involved useful strategies such as supervision (instrumental support), planned self-care (planning) and goal-orientated strategies (active coping) which are all necessary for effective coherence in the face of therapeutic stressors (Shapiro, Brown & Biegel, 2007; Hill et al., 2007). In

this way, it was thought that sense of coherence and problem-focused coping would be one and same – something of an individually based problem-focused coping resource capable of predicting compassion satisfaction and compassion fatigue in a professionally robust manner.

Despite the above assumptions, at Time 3, sense of coherence was not related to a coping strategy. This suggests that sense of coherence and coping were not related and were not one and the same as hypothesised. This finding, therefore, appears somewhat contrary to suggestions that sense of coherence is an "individually based coping resource" (Geyer, 1997, p. 1772). However, sense of coherence was inversely correlated with burnout (r = -0.66; p <0.01) where coping was not related to this aspect of compassion fatigue. Trainee therapists', therefore, with higher sense of coherence after six months of training may have felt they had sense of coherence at their own disposal to meet the demands posed on them by burnout (Antonovsky, 1987). Perhaps, in this instance, the trainees had adequately integrated how to use their own sense of coherence as an internalised coping resource for the preservation of health in spite of burnout levels (Geyer, 1997).

In contrast, sense of coherence was not associated with compassion satisfaction or secondary traumatic stress. Instead, problem-focused coping was directly and positively associated with both compassion fatigue (r = 0.48; p =0.03) and compassion satisfaction (r = 0.48; p =0.03). This suggests that when trainee therapists employed more problem focused coping at Time 3, both compassion satisfaction and secondary traumatic stress increased at the basically the same pace. Perhaps, the trainees learned to develop "flexible" and "adaptive boundaries" (Skovholt & Rønnestad, 2003, p. 3). When secondary traumatic stress increased, trainees used more problem-focused coping. As problem solving coping increased, in turn, so did their reported levels of compassion satisfaction. The manner, in which this pattern of relating is organised, seems to allow the trainee therapists the ability to engage with secondary stress material while sustaining an increasing level of satisfaction. Essentially, they can "manage strong emotions to maintain a positive sense of self and connect with others" (Pearlman & Saakvitne 1995, p. 152). This process may describe how "meaningful contact with people" can be a "catalyst for growth" in the trainee therapist (Rønnestad & Skovholt, 2003, p. 33).

In line with the literature, therefore, trainee therapists after 6 months of training seem to have sorted and selected which methods and resources are useful for resisting practitioner stressors and promoting growth (Antonovsky, 1987; Geyer, 1997, p. 1772). As Skovholt and Rønnestad (2003, p. 4) suggests the "requirements for the novice are to access, integrate, synthesise and adapt information". It seems by Time 3 the trainees have undergone or at least begun such a process. Indeed, compared to Time 2, trainee therapists' avoidance-orientated coping strategies were no longer associated with compassion satisfaction or burnout, as they had been at Time 2. Trainees with lower

sense of coherence appear to have stopped generating distance from stressors, perhaps realising such a coping style only served to promote burnout and decrease compassion satisfaction or perhaps in response to supervisory monitoring mechanisms that were likely to pick up on maladaptive disengagement processes. In turn the trainee therapists appear to have built up a more solid and cogent sense of coherence framework. Along with this "renewed internal focus" (Rønnestad & Skovholt, 2003, p. 29), the trainees may feel more enduring, confident and adapted which is something previous qualitative literature has also found (Hill et al., 2007; Skovholt & Rønnestad, 2003).

In conclusion, trainee therapists with high sense of coherence at the beginning of psychotherapeutic training were less likely to struggle with therapeutic stressors. However, most participants, seemed to have struggled at time 2 as sense of coherence processes became somewhat strained under the pressure of increasing compassion fatigue. To manage this context, the trainee therapists' sense of coherence was found to be indirectly associated with each of compassion fatigue and compassion satisfaction as it was mediated by coping, specifically avoidance-orientated coping. Ultimately, after six months (Time 3), the trainee therapists' sense of coherence increased. This may have been because their sense of coherence was more stable and professionally organised. Indeed, the trainees relied less on sense of coherence and more on problem-focused coping to deal with the continuing demands on therapeutic work. In addition, trainees who used problem-focused coping were more likely to report compassion satisfaction but also more secondary traumatic stress possibly because they were more present, less avoidant, and able to engage more emotionally with clients but at the same time feel sure that they could cope and feel satisfied in their work.

5.5. Additional Analysis

This research also found that sense of coherence was related to compassion satisfaction and compassion fatigue across all three time periods in the six months of training. Time does moderate sense of coherence and each of compassion satisfaction and compassion fatigue levels in the trainee therapists. This seems to support literature which suggests that "studying counsellor/therapist development is to study how practitioners experience themselves as counsellors/therapists on a wide range of parameters related to their work overtime" (Rønnestad & Skovholt, 2003, p. 7). More specifically, the greatest difference in the trainees' sense of coherence occurred between Time 2 and Time 3. This implies that approximately between four and six months of training, the trainee therapists gradually showed more manageability, comprehensibility and meaningfulness then they had at Time 2 when they first encountered clients. This appears to support Tryssenaar and Perkins, (2001, p. 6) who found that after the "4th to the 6th month of practice", developing therapists showed adaptive functioning in their professional and personal lives. This findings also seems in line with Rønnestad and Skovholt (2003, p. 28) who found that trainee functioning can "shift dramatically over time".

Concerning compassion fatigue, it appears that those with higher sense of coherence had greater levels of secondary stress at Time 1, but lower levels of burnout, when compared to those with low sense of coherence. This is contrary to the research which has found that caregivers with greater sense of coherence have less secondary traumatic stress (Ortlepp & Friedman, 2002). It is, however, in line with research which has found that higher sense of coherence was related with lower burnout. A reason, perhaps, for the higher secondary traumatic stress in those with stronger sense of coherence may be that such trainees were more likely to have been "approach-orientated" as they felt confident that they could face the anxiety and "ambiguity of professional work" (McSherry & Holm, 1994, p. 8; Skovholt & Rønnestad, 2003, p. 45). This approach-orientated confidence may have raised anxiety levels to the extent that the trainees demonstrated reasonably high levels of secondary traumatic stress. In contrast, those with low sense of coherence may have avoided concerns and worries around professional work and in this way they were less "preoccupied with the thoughts of helping people" demonstrating less secondary traumatic stress (Stamm, 2010, p. 21).

At Time 2, the trainees with higher sense of coherence had less secondary traumatic stress and burnout then those with lower sense of coherence. This supports research findings suggesting higher sense of coherence is associated with lower secondary traumatic stress and burnout (Fourie et al., 2007; Ortlepp & Friedman, 2002). The trainees with lower sense of coherence may have had their "feeling of confidence" that they could manage, comprehend and put meaning to internal and external environments "shattered", when exposed to clients for the first time (Antonovsky, 1987, p. 19; Janoff-Bulman, 2002 p. 90). In contrast those with higher sense of coherence did experience higher levels of secondary traumatic stress and burnout at Time 2, but to a far lesser degree than those with lower sense of coherence. Perhaps, due to having more manageability, comprehensibility and meaningfulness, trainees with higher sense of coherence had their "enduring feeling of confidence" strained rather than shattered (Antonovsky, 1987, p. 19).

Nevertheless, after six months of training, regardless of high or low sense of coherence, the trainee therapists had similar levels of compassion fatigue. This seems to show how contact with clients, along with the structures of training may be a "catalyst for growth" (Rønnestad & Skovholt, 2003, p. 35), at least in terms of a more robust manageability, comprehensibility and meaningfulness in relation to the negative avenues of therapeutic work. It may be that as the trainees begin to learn to cope with their client encounters through they demonstrated similar levels of robustness in light of compassion fatigue. This is in line with the observation that "professional development supports a close and reciprocal relationship between how counselors handle challenges and difficulties in the client relationship and experiences are professional growth or stagnation" (Rønnestad & Skovholt, 2003, p. 40).

Additionally, trainee therapists with higher sense of coherence had higher levels of compassion satisfaction compared to those with lower sense of coherence at Time 1 and Time 2. This highlights how trainee therapist with more manageability, comprehensibility and meaningfulness were more likely to feel satisfied, motivated and invigorated around training or therapeutic work form roughly the beginning four to six months of training. Once again, this finding supports the literature that caregivers with higher sense of coherence have greater role satisfaction and work-wellness (Fourie, et al., 2007; Ortlepp & Friedman, 2002). However, after six months of training (Time 3), the trainees had similar compassion satisfaction levels regardless of their sense of coherence. Similarly to compassion fatigue, this may indicate how trainee therapist sense of coherence may become more professionally robust and tapered to therapeutic demands.

Collectively, it seems that at Time 1, sense of coherence is conventional and directly predicts the negative (compassion fatigue) and positive (compassion satisfaction) avenues of therapeutic work. At time 2, perhaps, due to the strain of client exposure and training workloads, sense of coherence becomes strained or possibly shattered based on how high or low the trainees' sense of coherence may be. In turn, sense of coherence begins to have an indirect relation with compassion fatigue and compassion satisfaction. In this way "meeting clients for the first time" does indeed seem to be a "critical incident for the student and represents an important phase in training" (Rønnestad & Skovholt, 2003, p. 13). However, by after six months (Time 3), sense of coherence levels become less important as they seem to have been tapered through training and integrated with coping strategies capable of proficiently predicting burnout, secondary traumatic stress and compassion satisfaction in a therapeutic context.

5.6. Implications

Sense of coherence appears to be associated with both the negative (compassion fatigue) and positive (compassion satisfaction) avenues of therapeutic work and training. Enhancing sense of coherence may foster trainee motivation and arrest anxiety and stress around therapeutic responsibilities. Additionally, trainee therapists with low sense of coherence may struggle through training, especially as they are more likely to utilise avoidance-orientated coping to manage stress and anxiety. Indeed, avoidance-orientated coping strategies may need to be monitored as they seem to decrease trainee manageability, comprehensibility and meaningfulness during the initial months of training. In contrast, problem-focused coping strategies seem to enhance trainee therapists' sense of coherence and should be fostered. Collectively, it may be of benefit to monitor trainees' sense of coherence around the six month mark of training as it seems to represent an important development surge in professional manageability, comprehensibility and meaningfulness. Trainee therapists after

six months of training who demonstrate decreasing sense of coherence may require further monitoring and evaluation around maladaptive coping strategies as a means of protecting them from continued burnout and debilitating levels of secondary traumatic stress.

5.7. Limitations

There are a number of limitations to this research. Firstly, the researcher himself is a master's student at the WITS University from which the sample is drawn. Participants may have been weary of providing training data to their fellow classmate and this may have influenced the both the number of participants as well as the results themselves. However, efforts such as mechanisms to maintain anonymity and increase research distancing were put in place to minimize these potential effects. Despite the data being normal across all three time periods, the sample size did decrease over time which makes the data somewhat unrepresentative of the trainee therapist population. The study was also conducted on students who were undergoing training in a programme with a psychodynamic focus, which may further limit the generalizability of the results. It would have been more beneficial to have had a variety of trainee therapists trained in different therapeutic disciplines. Indeed, various therapeutic interventions require different responsiveness to self-inspection and so the trainee's sense of coherence may have been evaluated under a different type of scrutiny in relation to their chosen therapeutic framework.

A final limitation of the current research pertains to the very strength of this research design. This research yielded a massive dataset of rich data that complicated the task of reporting on the findings. A decision was made to limit the scope of this study and to locate the study within the hypothesis testing paradigm. As such, it was not possible to report on other equally important aspects of the data such as both within and between subjects repeated measures analyses. These findings will be reported on elsewhere. With a longitudinal design such as this one, it would be ideal to look at the data within such a paradigm. However, given the paucity of literature exploring the topic, coupled with the inconsistencies in the literature about the effect of sense of coherence on negative and positive trainee outcomes, it was a mandatory prerequisite to explore the basis of some of these inconsistent findings. The current study identified that perhaps time is a variable that has not been accounted for in other studies as it interacts with sense of coherence to predict each of compassion satisfaction and compassion fatigue. This potentially accounts for some of the discrepancies in the literature. It is hoped that, with this part of the literature seemingly untangled for now, future research will then explore longitudinal relationship changes within a repeated measures paradigm.

5.8. Overall Conclusion

This research quantitatively and longitudinally explored sense of coherence and coping strategies over six months in a professional psychology training programme. Particular focus was on how sense of coherence and coping was related to the negative (compassion fatigue) and positive (compassion satisfaction) avenues of therapeutic work. Based on literature, an empirically proposed, developmental framework of trainee therapist development was derived to quantitatively explore trainee therapists' progress over a six month period of training. A secondary aim was to investigate the direct and indirect effect sense of coherence had on compassion satisfaction and compassion fatigue in a sample of trainee therapists. It was found that after two months of training, sense of coherence was directly associated with compassion satisfaction and compassion fatigue. Those with higher sense of coherence had higher secondary traumatic stress, lower burnout and higher compassion satisfaction at this time. Following four months of training and after trainee therapists had encountered clients for the first time, the relation between sense of coherence and compassion satisfaction/fatigue was indirectly mediated by coping. Avoidance-orientated coping strategies appeared particular maladaptive, while problem-focused coping was found to be adaptive. After six months of training, sense of coherence levels were less important as those with high or low sense of coherence showed similar levels of compassion fatigue and compassion satisfaction. It appears that after six months of training, sense of coherence becomes less important as adaptive coping strategies begin to adequately predict the fatigue (compassion fatigue) and satisfaction (compassion satisfaction) in a training psychotherapeutic context.

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Appendix A: Participant Information Sheet

School of Human & Community Development
University of the Witwatersrand
Private Bag 3, WITS, 2050
Tel: (011) 717 4500
Fax: (011) 717 4559

Hello

My name is Tyrone Edgar and I am a clinical psychology master's student at the University of the Witwatersrand (WITS). In partial fulfilment of the requirements for my degree I am conducting research to explore the ways in which trainee therapists experience and deal with their training experiences. Part of the broader aim of this research is to identify ways in which trainee therapists could be better supported in the work that they do. I would like to invite you to participate in this research.

Participation will entail completing a series of questionnaires about your training experiences. You will be asked to complete these questionnaires on three separate occasions over a 6 month period. In particular, you will be invited to participate in the study sometime in March, May and July. On each occasion it should take you about 10 minutes to complete the questionnaires.

Participation is entirely voluntary and no person will be advantaged or disadvantaged in any way for choosing to participate or not participate in this study. All of your responses will be completely confidential. In addition, you may refuse to answer any questions you would prefer not to and you may choose to withdraw from the study at any point.

If you choose to participate in this study, please proceed with completing the questionnaires. Completion of the questionnaires will be taken as your consent to participate in this study. Please return the questionnaires on completion by placing them into a sealed box that will be located in your respective master rooms and/or at the lecture room exist. This will further ensure confidentially.

There is a slight possibility that talking about your work as a trainee therapist may cause you mild distress. If this happens, please notify me immediately, and I will assist you in securing free counselling. Alternatively, feel free to contact one of the following free counselling resources:

- Lifeline (011-728-1347)
- Counselling and Careers Development Unit (CCDU) (+27 11 717-9140/32)

If you are interested in the study, a summary of the findings will be made available in a research report after April 2012 and you are welcome to contact me regarding the summary. I can be contacted via email at tyetyger@gmail.com. Alternately my supervisor Dr. Esther Price can be contacted by e-mail at esther.price@wits.ac.za.

Tyrone Edgar Supervisor: Dr. Esther Price

Appendix B: Demographic Questionnaire

ID: _____

Please write the last three digits of your student number alongside ID. Please complete the following information by marking the appropriate box with a cross (X) and answering the questions where applicable:

Age: _____ **Gender:**

Male	Female

What master's module course are you currently completing? (Please cross one)

Community-based Counselling	Clinical Psychology	Educational Psychology	Research Psychology	Industrial psychology

Have you counselled a client or clients in accordance with your course module this year?

Yes	No

If you have counselled clients in accordance with your course model, how many clients have you counselled? _____.

Please indicate if you have experienced one or more of these traumatic events and how many times: (Please cross)

	Traumatic Event	**I personally experienced this traumatic event**	**How many times have you experienced this traumatic event**		
			Once	**Twice**	**3 or more times**
1.	Robbery, hijacking, Smash & Grab or Burglary				
2.	Close person died of suicide or homicide				
3.	Been Attacked, Mugged or Beaten up				
4.	Motor vehicle accident that resulted in death or severe injury				
5.	Any kind of unwanted sexual activity				
6.	Served in armed forces (incl. police and army)				
7.	Natural disasters or fire with loss of life or property				
8.	Any others _____				

Are you in full time private therapy and for how long have you been in therapy? (Please cross)

NO	**YES**	0-3 Months ago	3-6 Months ago	6-12 Months ago	12-18 Months ago	18-24 Months ago	More than 24 Months ago

Appendix C: The Professional Quality of Life Scale (ProQOL)

When you counsel people you have direct contact with their lives. As you may have found, your compassion for those you counsel can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as trainee therapists. Consider each of the following questions about you and your current training situation. Select the number that honestly reflects how frequently you experienced these things in the **last 30 days**.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

____ **1.** I am happy.
____ **2.** I am preoccupied with more than one person I counsel.
____ **3.** I get satisfaction from being able to counsel people.
____ **4.** I feel connected to others.
____ **5.** I jump or am startled by unexpected sounds.
____ **6.** I feel invigorated after working with those I counsel.
____ **7.** I find it difficult to separate my personal life from my life as a counsellor.
____ **8.** I am not as productive at work because I am losing sleep over the stressful experiences of a person I counsel.
____ **9.** I think that I might have been affected by the distress of those I counsel.
____ **10.** I feel trapped by my job as a counsellor.
____ **11.** Because of my counselling, I have felt "on edge" about various things.
____ **12.** I like my work as a counsellor.
____ **13.** I feel depressed because of the stressful experiences of the people I counsel.
____ **14.** I feel as though I am experiencing the distress of someone I have counselled.
____ **15.** I have beliefs that sustain me.
____ **16.** I am pleased with how I am able to keep up with counselling techniques and protocols.
____ **17.** I am the person I always wanted to be.
____ **18.** My work makes me feel satisfied.
____ **19.** I feel worn out because of my work as a counsellor.
____ **20**. I have happy thoughts and feelings about those I counsel and how I could counsel them.
____ **21.** I feel overwhelmed because my case work/study load seems endless.
____ **22.** I believe I can make a difference through my work.
____ **23.** I avoid certain activities or situations because they remind me of the stressful experiences of the people I counsel.
____ **24.** I am proud of what I can do to help.
____ **25.** As a result of my counselling, I have intrusive, stressful thoughts.
____ **26.** I feel "bogged down" by the system.
____ **27.** I have thoughts that I am a "success" as a counsellor.
____ **28.** I can't recall important parts of my work with stressful clients.
____ **29.** I am a very caring person.
____ **30.** I am happy that I chose to do this work.

Appendix D: The Brief COPE Scale (BCOPE)

I am interested in how people respond when they confront difficult or stressful events in their lives. This questionnaire asks you to indicate ways that you are coping with your work as a master's student. When answering these questions think about how you have dealt with stress over the past couple of weeks or months. There are lots of ways to deal with stress. There are no right or wrong answers. Think of your experience in a broad sense; how it affects your life on any level (i.e. personal, family, job, and so forth). (Circle the appropriate number.)

		I haven't been doing this at all	***I've been doing this a little bit***	***I've been doing this a medium amount***	***I've been doing this a lot***
1.	I've been turning to work or other activities to take my mind off stressful things.	1	2	3	4
2.	I've been concentrating my efforts on doing something about the stressful situation I'm in.	1	2	3	4
3.	I've been saying to myself "this isn't real."	1	2	3	4
4.	I've been using alcohol or other drugs to make myself feel better.	1	2	3	4
5.	I've been getting emotional support from others.	1	2	3	4
6.	I've been giving up trying to deal with the stress.	1	2	3	4
7.	I've been taking action to try to make the stressful situation better.	1	2	3	4
8.	I've been refusing to believe that the stressful situation has happened.	1	2	3	4
9.	I've been saying things to let my unpleasant feelings escape.	1	2	3	4
10.	I've been getting help and advice from other people.	1	2	3	4
11.	I've been using alcohol or other drugs to help me get through the stress.	1	2	3	4

		I haven't been doing this at all	*I've been doing this a little bit*	*I've been doing this a medium amount*	*I've been doing this a lot*
12.	I've been trying to see the stress in a different light, to make it seem more positive.	1	2	3	4
13.	I've been criticizing myself.	1	2	3	4
14.	I've been trying to come up with a strategy about what to do.	1	2	3	4
15.	I've been getting comfort and understanding from someone.	1	2	3	4
16.	I've been giving up the attempt to cope.	1	2	3	4
17.	I've been looking for something good in what is happening.	1	2	3	4
18.	I've been making jokes about the stress.	1	2	3	4
19.	I've been doing something to think about the stress less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping	1	2	3	4
20.	I've been accepting the reality of the fact that the stress has happened.	1	2	3	4
21.	I've been expressing my negative feelings.	1	2	3	4
22.	I've been trying to find comfort in my religion or spiritual beliefs.	1	2	3	4
23.	I've been trying to get advice or help from other people about what to do.	1	2	3	4
24.	I've been learning to live with the stress.	1	2	3	4
25.	I've been thinking hard about what steps to take.	1	2	3	4
26.	I've been blaming myself for things that happened.	1	2	3	4
27.	I've been praying or meditating.	1	2	3	4
28.	I've been making fun of the situation.	1	2	3	4

Appendix E: The Orientation to Life Questionnaire (OLQ)

Here is a series of questions relating to various aspects of our lives. Each question has seven possible answers. Please mark the number, which expresses your answer with numbers 1 and 7 being extreme answers. If the words under 1 are right for you, circle 1; if the words under 7 are right for you, circle 7. If you feel differently, circle the number which best expresses your feeling. Please give only one answer to each question.

1. **When you talk to people, do you have the feeling that they don't understand you?**

1	2	3	4	5	6	7
Never						Always have this feeling

2. **In the past, when you had to do something which depended upon co-operation with others, did you have the feeling that it:**

1	2	3	4	5	6	7
Surely wouldn't get done						Surely would get done

3. **Think of the people with whom you come into contact daily, aside from the ones to whom you feel closest. How well do you know most of them?**

1	2	3	4	5	6	7
You feel that they are strangers						You know them very well

4. **Do you have the feeling that you don't really care about what goes on around you?**

1	2	3	4	5	6	7
Very seldom or never						Very often

5. **Has it happened in the past that you were surprised by the behaviour of people whom you thought you knew well?**

1	2	3	4	5	6	7
Never happened						Always happened

6. **Has it happened that people whom you counted on disappointed you?**

1	2	3	4	5	6	7
Never happened						Always happened

7. **Life is:**

1	2	3	4	5	6	7
Full of interest						Completely routine

8. Until now your life has had:

1	2	3	4	5	6	7
No clear goals or purpose at all						Very clear goals and propose

9. Do you have the feeling that you're being treated unfairly?

1	2	3	4	5	6	7
Very often						Very seldom or never

10. In the past ten years your life has been:

1	2	3	4	5	6	7
Full of changes without your knowing what will happen next						Completely consistent and clear

11. Most of the things you do in the future will probably be:

1	2	3	4	5	6	7
Completely fascinating						Deadly boring

12. Do you have the feeling that you are in an unfamiliar situation and don't know what to do?

1	2	3	4	5	6	7
Very often						Very seldom or never

13. What best describes how you see life:

1	2	3	4	5	6	7
One can always find a solution to painful things in life						There is never a solution to painful things in life

14. When you think about your life, you very often

1	2	3	4	5	6	7
Feel how good it is to be alive						Ask yourself why you exist at all

15. When you face a difficult problem, the choice of a solution is:

1	2	3	4	5	6	7
Always confusing and hard to find						Always completely clear

16. Doing the things you do every day is:

1	2	3	4	5	6	7
A source of deep pleasure and satisfaction						A source of pain and boredom

17. Your life in the future will probably be:

1	2	3	4	5	6	7
Full of changes without your knowing what will happen next						Completely consistent and clear

18. When something unpleasant happened in the past your tendency was:

1	2	3	4	5	6	7
"To eat yourself up" about it						To say "ok that's that, I have to live with it and go on"

19. Do you have very mixed-up feelings and ideas?

1	2	3	4	5	6	7
Very Often						Very seldom or never

20. When you do something that gives you a good feeling:

1	2	3	4	5	6	7
It's certain that you'll go on feeling good						It's certain that something will happen to spoil the feeling

21. Does it happen that you have feelings inside you would rather not feel?

1	2	3	4	5	6	7
Very Often						Very seldom or never

22. You anticipate that your personal life in the future will be:

1	2	3	4	5	6	7
Totally without meaning or purpose						Full of meaning and purpose

23. Do you think that there will always be people whom you'll be able to count on in the future?

1	2	3	4	5	6	7
You're certain there will be						You doubt there will be

24. Does it happen that you have the feeling that you don't know exactly what's about to happen?

1	2	3	4	5	6	7
Very often						Very seldom or never

25. Many people - even those with a strong character - sometimes feel like sad sacks (losers) in certain situations. How often have you felt this way in the past?

1	2	3	4	5	6	7
Never						Very often

26. When something happened, have you generally found that:

1	2	3	4	5	6	7
You overestimated or underestimated its importance						You saw things in the right proportion

27. When you think of the difficulties you are likely to face in important aspects of your life, do you have the feeling that:

1	2	3	4	5	6	7
You will always succeed in overcoming the difficulties						You won't succeed in overcoming the difficulties

28. How often do you have the feeling that there's little meaning in the things you do in your daily life?

1	2	3	4	5	6	7
Very Often						Very seldom or never

29. How often do you have feelings that you're not sure you can keep under control?

1	2	3	4	5	6	7
Very Often						Very seldom or never

Appendix F: Ethics Clearance Certificate

University of the Witwatersrand, Johannesburg

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Student Number: 0719790W

Mr TJ Edgar
P O Box 2301
Pinegowrie
Gauteng
2123

12 May 2011

Dear Mr Edgar

APPROVAL OF PROPOSAL FOR THE DEGREE OF MASTER OF ARTS IN CLINICAL PSYCHOLOGY

I am pleased to be able to advise you that the readers of the Graduate Studies Committee have approved your proposal entitled *"Sense of coherence and coping as predictors of compassion satisfaction and fatigue in psychology trainee therapists"* and you have now been admitted to full candidature. I confirm that Dr E Price has been appointed you supervisor in the Department of Psychology.

The research report is normally submitted to the Faculty Office by 15 February. All students are required to RE-REGISTER at the beginning of each year.

You are required to submit 2 bound copies and one unbound copy plus 1 CD in pdf (Adobe) format of your research report to the Faculty Office. The 2 bound copies go to the examiners and are retained by them and the unbound copy is retained by the Faculty Office as back up.

Please note that should you miss the deadline of 15 February you will be required to submit an application for extension of time and register for the research report extension. Any candidate who misses the deadline of 15 February will be charged fees for the research report extension.

I should be glad if you keep us informed of any changes of address during the year.

Note: All MA and PhD candidates who intend graduating shortly must meet your ETD requirements at least 6 weeks after your supervisor has received the examiners reports.

Yours sincerely

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UNIVERSITY OF THE WITWATERSRAND
2011 -05- 16
FACULTY OF HUMANITIES
JOHANNESBURG

Appendix G: Plagiarism Declaration

Masters in Psychology

Surname: Edgar

First Name/s: Tyrone James

Student No.: 0719790w

Supervisor: Dr. Esther Price

Title: Sense of coherence and coping as predictors of compassion satisfaction and fatigue in psychology trainee therapists

Total Word Count: 26356

Declaration:

I, *Tyrone James Edgar*, know and accept that plagiarism (i.e. to use another's work and to pretend that it is one's own) is wrong. Consequently, I declare that

- The research report is my own work
- I have correctly acknowledged all direct quotations and paraphrased ideas/content. In addition, I have provided a complete, alphabetised reference list, as required by the APA method of referencing.
- I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her own work.
- I understand that the University of the Witwatersrand my take disciplinary action against me if there is a belief that this is not my own unaided work, or that I failed to acknowledge the source of the ideas in my writing.
- The word count (excluding reference list, etc) given above is correct.

Signed: 

Date 12 December, 2011