CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The increasing levels of negative work conditions and lack of employee well-being (van der Doef and Maes, 1999) have received notable interest in organisations, and a number of initiatives have been introduced to 'alleviate' the negative impact on employees (Daniels and Guppy, 1994). For example, Le Fevre, Matheny, and Kolt (2003) did a literature review on occupational stress and found that work-related stress has been of increasing concern to both employers and governments for over two decades. Thus in recent times, work stress has received greater emphasis by employers as their risk of being held legally liable for damages to stressed staff has increased. In addition, Conner and Douglas (2005) in a study of organisationally-induced stress and strain on professional employees (i.e. executives, managers and health professionals) found that changes in the modern work environment brought on by technological advances, organisational restructuring, and various redesigns elevate levels of work stress. These stressors are existing conditions within the employee's job role or the organisation.

Until recently, it was thought that trauma workers, because of their special training, were immune to traumatic stress reactions and symptoms. In 1978, Figley suggested that family, friends, and professionals are susceptible to developing traumatic stress symptoms from being empathetically engaged with victims of traumatic events. Since then, several authors (Beaton & Murphy, 1995; Danieli, 1985; McCann & Pearlman, 1989; Pearlman & Saakvitne, 1995; 1988b; Stamm, 1995) have argued that traumatic stress symptoms are contagious and can produce similar effects in those who work with trauma victims (Figley, 1995c).

To counter the negative consequences of the work environment, organisations have introduced services such as Employee Assistance Programmes (EAPs). EAP practitioners offer EAP services, and their aim is to assist 'troubled employees' in the workplace. An EAP is designed to assist in alleviating negative conditions and enable employees in the workplace to realise their full potential for the benefit of their organisation and themselves. It is a tangible and practical employee benefit (Daniels, 1997).

Research in the area of working with 'troubled employees' in the workplace, indicates that individuals who assist or help such persons, are influenced by clients' material and that this influences both their quality of life and work life (Bell, Kulkami and Dalton, 2003). Furthermore, the work environment has been researched and found to be a key variable, which influences employee health in the workplace (Catherall, 1995). However, other previous research in this area also indicates that despite negative influences from the work environment, some individuals manage to cope and adapt (Antonovsky, 1979; 1987a; 1987b; 1990). This research further shows that this may be due to individual psychological characteristics, such as their level of sense of coherence, hardiness and locus of control, which are related to employees' health and well-being (Bell, Kulkami and Mauno, 2000; Sexton, 1999; Feldt, Kunnunen and Mauno, 2000) and in South Africa several researchers have found the similar results (Levert, 1999; Ortlepp, 1998; Levert, Lucas and Ortlepp, 2000; Ortlepp and Friedman, 2001).

The literature review will initially provide a background and history of EAPs and discuss the context of EAPs and EAP practitioners in South African work organisations, which will be argued to contribute to adverse impacts on EAP practitioners in the workplace. Secondly, the concept of work environment will be defined, together with its three operational variables, namely, job control, workload and collegial support, which are chosen in the current study. Thirdly, compassion fatigue will be defined, its theoretical framework and its significance within the current study. In addition, the relationship between work environment and compassion fatigue will be discussed. Last but not least, the literature review will define the concept of sense of coherence, which is argued to have a role effect on experiences of compassion fatigue amongst EAP practitioners (Ortlepp, 1998).

A role effect is the ability of a variable such as Sense of Coherence (SOC) in the current study to influence practitioners' experiences of compassion fatigue, which implies that a person with a high SOC will experience less compassion fatigue and visa versa (Baron and Kenny, 1986). This argument will be theoretically discussed and applied to the current research in a later section. Finally, the literature review will discuss the research aims, rationale and hypothesis of the current research, which emerged from the literature.

2.2 Background and history of Employee Assistance Programmes (EAPs)

Arthur (2000, p. 2) argues that an EAP is a workplace-based service, which "includes the provision of confidential assessment, counselling, and therapeutic services for employees and their dependants experiencing a wide range of personal, emotional, and psychological problems, … for advice on domestic, legal, medical and financial matters." Similarly, Alker and McHugh (2000, p. 2) argue that EAPs are defined "as a mechanism for making counselling and other forms of assistance available to a designated workforce on a systematic and uniform basis, and to recognised standards". In addition, Magranahan (1995) argues that EAPs are a "...confidential and professional service provided as an employee benefit which complements and extends in-company resources in the constructive and supportive management of people impacted by concerns in their personal and work lives (cited in Alker and McHugh, 2000, p. 2).

There are various definitions of EAPs within the literature, such as the ones provided above. The above definitions agree on the point that EAPs are workplace programmes are available to management and employees throughout the organisation. Another key similarity is that EAPs offer psychological services, such as counselling, which is an important point that relates to the role of the EAP practitioners in the current research. Similarly, these definitions of EAPs perceive this service as workplace-based and that it is offered to employees as highlighted above.

In the literature there is consensus that there is no single definition of EAPs and no standardised model exists in organisations (Arthur, 2000; Buist, 2000). Miner (1980), together with Schein (1980), argue that because organisations are different from each other, standardised EAP models do not exist, as organisations tailor EAPs to their needs, interests, environment, and dynamics (van der Bergh, 2000; Vosloo and Barnard, 2002; Buist, 2000; Arthur, 2000; Wineger, 2002).

From a historical perspective, at the end of the 20th century, organisations in the United States assisted many employees in numerous forms: social betterment, personal counselling, occupational mental health and 'industrial alcoholism' (Trice and Sonnenstuhl, 1985). During this era, employers and unions alike started to integrate humanitarian values with economic concerns, and consider the likelihood that helping

workers with their personal problems might contribute to increased productivity and profitability (Trice and Sonnenstuhl, 1986).

Historically, Employee Assistance Programmes started in the 1960s in the United States of America, and share some history with Alcoholics Anonymous (AA), which is a support group program for individuals with alcohol problems (Dickman, Emener and Hutchison, 1985). The two are interrelated because alcoholism became an organisational cost, and thus the introduction of EAPs to assist employees with alcoholism problems. Nevertheless, other researchers argue that the earliest forms of employee assistance programs were developed in the mid-1920s (Berridge, 1996).

In addition, EAPs have not always been the way they are today, because their history is closely related to Alcoholics Anonymous (AA) in the United States, during the 1960s, when it was still in its infancy (Van der Bergh, 2000). AA used the disease model. According, to the disease model, “the alcoholic was viewed as a person who was not responsible for his or her behaviour…” (Masi, 1994, p. 9-10). Literature indicates that recently EAPs are different because they are proactive in dealing with organisational challenges of alcoholism, HIV/AIDS, personal issues and performance issues in the organisation, especially in South Africa (Maiden, 1999 and Masi, 1994). In addition, EAPs currently take an ecological perspective, which implies that they view the alcoholic in context and holistically.

In South Africa EAPs started in the 1980s, and adopted the United States model (van der Bergh, 2000). According, to Maiden (1999) the economic crisis in the eighties engendered workplace interventions, such as EAPs to reduce costs and also as a means to increase profitability levels. Many organisations utilise the services of EAPs, as they have a positive influence on productivity (Buist, 2000; Motlhamme, 2000). Evaluation research indicates that there are inconclusive results to support the above proposition (McDonnell, 1989; Maiden, 1988 cited in Highley and Cooper, 1994). However, there is research evidence to support both positions, one is that EAPs are effective in cutting organisational costs and the other is that there is no compelling research evidence to show that EAPs bring about return on investment to the organisation and the employer (McDonnell, 1989; Maiden, 1988 cited in Highley and Cooper, 1994).

Various approaches to successful EAPs have been documented in the literature. The one that stands out argues that EAPs are being more or less deeply rooted in “the organisational processes” and develops into part of “organizational discourse, it reflects and nourishes the organizational culture, and it becomes part of the organizational learning, problem-solving and adaptation mechanisms” (Berridge and Cooper, 1994, p. 4). This indicates the value of EAPs in organisations because EAPs become reflections of organisations. Nonetheless previous research indicates that the South African organisational context presents challenges to such an assertion, which is outside the scope of the current research (Buist, 2000).

Many researchers on EAPs argue that there are two types of EAPs, internal and external (Arthur, 2000; Motlhamme, 2000; Berridge, 1996). An internal EAP is an in-house service, which is situated inside the organisational premises. Internal EAP professionals (EAP practitioners) are employed by the ‘mother organisation’ and in most cases, EAPs are perceived to be extensions of the human resources departments in organisation, because many EAPs report to human resources departments of organisations (Erfurt and Foote, 1985). The main advantage of the internal EAP service is that it is on the organisation’s property, and therefore convenient for the clients. The main advantage of this form of service is that organisations can tailor them according to their needs, in terms of the scope or range of services offered (Sweeney, Hohenshil and Fortune, 2002). In contrast, the major disadvantage is that EAPs are in the organisation’s premises, and confidentiality of those who use the EAP cannot be guaranteed.

Conversely, external EAPs are situated outside the organisation, and often operate as outsourced agencies to provide services to employees and management (van der Bergh, 2000; Vosloo and Barnard, 2002; Buist, 2000; Arthur, 2000). The major benefit of this form of service is less cost to the organisation that has procured the service because it does not employ EAP personnel. Furthermore, client confidentiality is easily maintained, and that organisations benefit because this type of service is less expensive, and therefore results in return on investment (Jones, 1985). However, Harlow (1998, p. 5) argues, “absolute confidentiality in the EAP may be a practical impossibility” regardless of where the EAP is situated.

In spite of the scarcity of research on EAPs in South Africa, research suggests that EAP practitioners in internal EAPs tend to be generalists, whereas in external EAPs they tend to be specialists (Maiden, 1999). South African research seems to further suggest that most organisations use internal EAPs, even though there is a shift from this form of service (Maiden, 1999), No research on the motives for shifts towards internal EAPs exists. In addition, internal EAP practitioners are said to perform duties over and above their EAP role (van der Bergh, 2000; Vosloo and Barnard, 2002; Buist, 2000), which impacts on job demands and job control.

Harper (1999) conducted a research survey on EAPs in ninety-three top South African organisations (i.e. mining, transport, retail, food and beverages), and found that salaried full and part-time EAPs practitioners staffed thirty-eight percent, thirty-eight percent also contracted external EAPs and twenty-three percent incorporated both EAP type. This is believed to be the case in the current research, as EAP practitioners are expected to be full-time employees and part-time practitioners. However, research has been shown to be inconclusive (Berridge, 1996). A shortcoming of this research is that Harper (1999) does not adequately address the rationale for use of internal or external EAPs. Nonetheless, it can be deduced that internal EAP services provide a cost-cutting measure for organisations to employ individuals who will work full-time and part-time as EAPs practitioners, and since one of the rationales for introducing EAPs is cutting costs associated with medical and psychological employee problems (van der Bergh, 2000).

Other researchers found that there is a lack of consensus with reference to what motivates the implementation of EAPs (Motlhamme, 2000; Arthur, 2000; Berridge, 1996; Buist, 2000; Malatji, 2000, Masi, 1984; van der Bergh, 2000; Vosloo and Barnard, 2002). The first and most common motivation is the introduction of EAPs for cost-reduction (economic). Costs to organisations and employers are shown in increases on absenteeism, sick leave, accidents, low staff morale, ineffective decision-making, lateness, grievances and staff turnover (Malatji, 2000). The second motivation is the promotion of employee wellbeing, popularly known as corporate social responsibility or employee-friendly organisational services, which is essentially valuing employees and their wellbeing at home and at work (Blake, 1995).

In summary, McClellan and Miller (1988, p. 26) argue that EAPs are developed for different objectives in mind, which can be categorised as benefit to the employee (e.g., to reduce health risks, promote wellness, improve quality of life) or benefit to the employer (e.g., to improve productivity and profits, resolve management problems, limit employer liability). However, the literature suggests that the focus is shifting towards a more comprehensive employer benefit (Highley and Cooper, 1994; Alker and McHugh, 2000). These changes have profound implications for the way EAPs are organised, staffed, and designed to function (Arthur, 2000).

The background to the EAP services in the workplace indicates that the service does not exist in isolation from organisational issues and challenges. In addition, even though EAP services are implemented to 'alleviate' ill health and lack of wellbeing, they have their problems. In most cases the service is evaluated on how well it reduces employee stress and other negative conditions on the employee, and the impact on the service providers is usually not assessed. Thus, the next section will contextualise the role of Employee Assistance Programme (EAP) practitioners and indicate both the importance of the practitioners' role in contributing to ill-health and lack of wellbeing, which may possibly contribute to experiences of secondary trauma or compassion fatigue.

2.3 Employee Assistance Programme (EAP) Practitioners

Although, the emphasis on EAP practitioner's roles may differ, their roles typically entail providing the following services: evaluation and referral, healthcare programmes, workshops and seminars, assessment, counselling, consultation, and marketing of the EAP (Hosie, West and Mackay, 1993). EAP practitioners offer a wide range of services not only limited to the individual employee level (trauma services, alcoholism, addiction and substance abuse) as was the case during its infancy, but also to the group (e.g. diversity management) or departmental (e.g. team building) and organisational level (e.g. management and supervisor training on EAPs and change management) (van der Bergh, 2000). This is attributed to the changing role of EAPs to become more efficient and effective in dealing with the 'new' challenges, which face employees and organisations in the twenty-first century (Madsen, 2003; Malatji, 2000; Sparks, Faragher and Cooper, 2001; Etter and Grzywacz, 2001).

In relation to the above-mentioned point, other researchers have commented that the EAP practitioner's role entails a heavy workload, considering the range of services they offer and the lack of job resources such as supervision, debriefing and adequate training (Vosloo and Barnard, 2002). In addition, EAP practitioners are required to play multiple roles in organisations, such as counsellor, business consultant and organisational development consultant, which not only influence their roles as EAP practitioners, but also as full-time employees (Vosloo and Barnard, 2002). This point is built on the premise that research indicates that EAP practitioners are also employed as fulltime employees in a number of South African organisations (Maiden, 1999).

In addition, Berridge and Cooper (2000, p. 11) particularly "caution against the potential role overload, role conflict and lack of professional role clarity…" that EAP practitioners experience in the South African workplace. The argument put forth is essentially related to the role of the EAP practitioner as influenced by the work environment, which also influences their well-being and health (Ettner and Grzywacz, 2001).

In a study of the relationship between jobs, work environment, psychological and physical wellbeing, Ettner and Grzywacz (2001) found that employee's health was related to both the psychological (e.g. demands, decision latitude) and psychosocial work environment (e.g. relationships with co-workers, organisational climate), which underlies worker's perceived health. This research supports the view that work environment affects employee health and wellbeing. Nonetheless, other researchers, such as Warr (1994), argue that environmental foundations of the job, such as opportunity for control, opportunity for skill use and variety are important job roles or job characteristics, which also affect employee mental health and wellbeing. In short, the literature supports the view that both the job role and the work environment influence health and well-being. These aspects are treated as the same in the current research.

EAP practitioners are exposed to traumatised and victimised employees in the workplace, from incidents such as violent crimes, sexual violence to occupational and health issues. The role of EAP practitioners is similar to that of a counsellor, which is to deal with work-specific and non-work specific issues, which either directly or indirectly influences the well being of employees at work (Bell, Kulkami and Dalton, 2003).

Previous research indicates that like any other health professionals, EAP practitioners also experience work-related stress, such as stress, burnout (Ortlepp, 1998) and eustress “good stress’ this can be considered to be that amount of stress between too much or too little or an optimal level of stress (Seyle, 1987; Westman & Eden, 1992). In addition, stresses such as role conflict and role ambiguity have been identified as types of work-related stressors that are evident in the EAP practitioner’s role (Carlson & Perrewe, 1999). Role conflict may result from employees facing inconsistent expectations from various parties, or from a perceived incongruency between role demands and personal needs, and values (Leigh et al., 1988). Role ambiguity refers to situations where job responsibilities and accompanying tasks are not clearly defined (Westman & Eden, 1992).

Despite the scant research on the EAP practitioner’s work environment and role, especially in the South African context, there is a need for research to investigate the contributions of these factors to the practitioners’ work environment, work outcomes and their well-being. The current research examines the contributions of certain aspects of the work environment such as job control, workload and collegial support to experiences of compassion fatigue. In addition, it explores the contributions of individual factors, in particular sense of coherence, and examine whether it has a relationship with experiences of compassion fatigue.

A review of the literature indicates that there is no previous research of this nature from earlier studies, especially in the South African context that investigates work environment variables, such as job control, workload and collegial support on a sample of EAP practitioners. A number of local and international studies on the area of organisational psychology, trauma and EAP practitioners have been reviewed in the literature, and none has been found to be similar to the current research (refer to the following studies; van der Bergh, 2000; Beard, 2000; Berridge & Cooper, 2000; Malatji, 2000; Maiden, 1999; Hosie, West and Mackey, 1993; Harlow, 1998; Catherall, 1995; Pearlman & Mac Ian, 1994; Sexton, 1999; Figley, 1995; Ortlepp, 1998). Thus, this sample remains largely unused, due to the relative ‘newness’ and popularity of employee assistance programmes in South Africa (Maiden, 1999).

2.4 Work Environment

Most human beings in the 'modern world' or industrialised society spend most of their waking time at work, hence the world of work provides a significant source and paradigm of wellbeing (Antonovsky, 1987). To support the argument, previous research has linked certain work environments with a lack of psychological wellbeing and physical health in the workplace (Feldt, Kivimaki & Dalton, 2003). Further, in the stress and trauma literature, work environment has been linked to stress, burnout and secondary traumatic stress (Bell, Kulkami & Mauno, 2000; Sexton, 1999; Feldt, Kunnunen & Mauno, 2000) and in South Africa several researchers have found similar links (Levert, 1999; Ortlepp, 1998; Levert, Lucas & Ortlepp, 2000; Ortlepp & Friedman, 2001).

There are several definitions of work environment (Gerber, Nel & Van Dyk, 1995). However, for the purpose of the current research, work environment will refer to features of the organisation that impact on the employee's mental, emotional, psychological, and physical status (Gerber, Nel & Van Dyk, 1995), as experienced by the employee (EAP practitioners). Researchers argue that work environment can be studied at an organisational level (e.g. organisational culture, organisational climate, structure, policies and procedures) and in the case of the current research at an individual level (e.g. role overload, role ambiguity, job control, job demands and collegial support) (Wilson, DeJoy, Vandenberg, Richardson & McGrath, 2004; Feldt, Kivimaki, Rantala & Tolvanen, 2004). In addition, studying work environment at an organisational level requires a comparison of multiple organisations, unlike the individual level, which requires a comparison of individuals' perceptions. In the present research, work environment is investigated from an individual level, and on a sample of EAP practitioners (Levert, 1999).

Cooper and Baglioni's (1988) model of the stress-response suggests that not all individuals perceive the same situation as stressful, this is because the individual differences they bring, such as their personality and life experiences will shape their response to stress. In the structural model proposed by these authors, the experience of stress was found to moderate (perhaps enhanced) by individual characteristics of personality (perceived locus of control, type A behaviour pattern and sense of coherence). In addition to socio-demographic factors and coping strategies, which have consequent effects on people and their organisations. Thus, Cooper and Baglioni

(1988) suggest the experience of stress is the result of an interaction between various sources of pressure and the individual characteristics.

Research in the area of stress has indicated that organisational environmental stressors are important in shaping wellbeing (Maslach & Jackson, 1984). These stressors can be categorised into two characteristics. The first is job demands, which refer to dimensions of the job that necessitate persistent physical and psychological effort and are therefore linked to particular physiological and psychological costs such as stress, burnout (Schaufeli & Enzmann, 1998 cited in Rothmann, Jackson & Kruger, 2003) and possible compassion fatigue. Job demands in the context of the workplace can be viewed to increase workload. In other words, a higher job demand implies a higher workload, due to their relationship in the job content of the EAP practitioner's role. In short, job demands are an equivalent of job workload and in current research workload is used instead of job demands. Furthermore, many roles in the job and constantly having to switch between them can possibly be perceived to encourage perceptions of high job demand, which is essentially high workload. Job demands and in the case of the current research workload has been linked in previous research to general health (Etter & Grzywacz, 2001), and to psychological wellbeing (Daniels & Guppy, 1994). Thus, it will be important to examine its relationship to compassion fatigue.

The second aspect of organisational environmental stressors linked to stress is the extent of job resources (Schaufeli, 1998). The availability of job resources is linked to dimensions of the job that reduce ill-health, stress outcomes and increased social support. Furthermore, the availability of job resources in organisations can reduce costs associated with the psychological and physiological conditions of the job, which in turn sustain feelings of wellbeing and development (Schaufeli & Enzmann, 1998 cited in Rothmann, Jackson & Kruger, 2003). Collegial support has been demonstrated in previous research to be an important job resource, which facilitates better psychological wellbeing and health (Corrigan et al, 1994). Hence, lack of collegial support may lead to increased negative experiences and lack of social coping resources for the EAP practitioner. As a result, collegial support has been included as a key work environment variable in the current research. From previous research on occupational stress, social support and psychological wellbeing (Daniels & Guppy, (1994), it is expected that an individual with high collegial support will experience less

compassion fatigue. However this will be dependent on the level of job control and workload (Warr, 1994). Nonetheless, research remains unclear regarding the relationships.

Previous research in the stress and health literature suggests that employees experience negative outcomes in the workplace or work environment due to several factors. According to the job stress/health models, individuals feel strain/stress due to five job stressors 1) factors intrinsic to the job, 2) role in the organisation, 3) relationships at work, 4) career development, and 5) organisational structure/climate (Cooper et al, 2001; Cooper & Cartwright 1994, as cited in Fisher, Katz, Miller, & Thatcher, 2003; Murphy, 1995), and home/work interface (Fu & Shaffer, 2001). In addition, Fu & Shaffer (2001) argue that domain-specific support is important to 'moderate' the effect of job-specific stress outcomes, hence in the current research collegial support is utilised as a key work environment variable, unlike social support which is a more global measure of support.

Perceptions of the work environment can either be negative or positive, depending on the level of job control, the amount of workload and the quality of collegial support experienced (Feldt, Kinnunen, & Mauno, 2000) by the individual EAP Practitioner. In a study of the predictive relationship between sense of coherence (SOC) and work characteristics (organisational climate and job control), Feldt, Kivimaki, Rantala, and Tolvanen (2004) found that high SOC predicts positive perceptions of organisational climate. In contrast, Feldt, Kinnunen, and Mauno (2000) found that SOC does not generate the ability to produce a good sense of job control, even though it is a comparatively invariable disposition, which influences the ability to mobilise and generate social resources in the workplace. This research was performed on a sample of 615 managers (587 men and 28 women) in a longitudinal study done over a three-year period. The two studies indicate the point that research on sense of coherence is not neat, and that there are contradictory results on the role of the concept.

Another study examined the relationships between psychosocial work characteristics (influence at work, job insecurity, organizational climate, and leadership relations) on general well being (psychosomatic symptoms) and on occupational well-being (emotional exhaustion at work) by making use of sense of coherence (SOC) in a 1-year follow-up study. In addition, this study tested whether SOC mediated the

relationship between psychological work environment and general wellbeing and health (Feldt, Kinnunen & Mauno, 2000). Results based on structural equation modelling, demonstrated that a “good organisational climate and low job insecurity were related to strong SOC, which was, in turn, linked to a high level of general as well as occupational well-being” (Feldt, Kinnunen & Mauno, 2000, p. 1). In addition, employees who experienced changes in organisational climate and leadership relations during the follow-up period, showed changes in SOC which was, in turn, related to changes in their well-being (Feldt, Kinnunen & Mauno, 2000). These two studies indicate that the concept of sense of coherence is linked to the work environment. Furthermore, it would be justifiable to investigate whether this is the case in the current research. This will be achieved by examining the relationship between work environment variables (job control, workload and collegial support) and sense of coherence.

As discussed above, work environment is a broad concept that can be studied at either the individual or organisational level as discussed in the section. In the current research it is studied at an individual level and operationalised as the following measurable independent variables: workload, job control and collegial support. These independent variables will be defined and discussed later. More importantly, determining the causes of secondary traumatic stress within a particular work environment is complex and which is a major factor within research, it is no wonder then that each research study determines its own various causes, alleviators or strengtheners as in the current study. This is due to different conditions and occupations, but there are general similarities within work environment which have been discussed, but not exhausted (Sparks & Cooper, 1999). The following section will define, discuss and indicate previous research on each of the work environment variables in the current study, namely workload, job control to collegial support.

2.4.1 Workload

Workload includes “unavoidable and unnecessary demands on already stretched resources; many things to do in a given time; demands on standards and support; and the demands created by resource problems” (Levert, Lucas & Ortlepp, 2000, p. 36). Other researchers ague that the concept of workload is identical to job demands (Schaufeli and Enzmann, 1998), hence the conceptualisation of workload and rather than job demands in present research. Job demand refers to aspects of the job that require sustained physical and mental effort and are therefore associated with certain physiological and psychological costs (e.g. shift-work, working overtime, meeting deadlines and excessive paperwork) and that when these aspects require sustained effort over a period of time, they create workload on the part of the employee. Put in short, job demands are the requirements and capacity aspects, whereas workload is the outcome and response aspect (Demerouti, Bakker, Nachreiner and Schaufeli, 2001).

Workload may be defined as a psychological stressor, this includes the requirements for working faster and harder, having a great deal to do, not having enough time and having conflicting demands (Karasek, 1979).

Resources refer to characteristics of the person (psychological, emotional, physical, and biological), the work environment (supervisor support, collegial support and home-based social support) and the job (good supervision, adequate salary, recognition and sufficient staff). This may facilitate the reduction or alleviation of adverse conditions experienced by the individual to reduce workload, and the associated physiological and psychological costs, in order to stimulate personal growth and development (Feldt, Kivimaki, Rantala, and Tolvanen, 2004), in this case the EAP practitioner.

Catherell (1995) in a study of vicarious traumatisation argues that organisations should have a responsibility to assist therapists in maintaining realistic limits and boundaries on their work and workload. This argument is based on the point that the counselling role lacks psychological wellbeing because the role exposes counsellors to burnout, secondary trauma and depression (Ortlepp, 1998), and when organisations do not provide realistic limits and assist in ensuring counsellor wellbeing, enduring consequences may result. Such consequences are experiences of fear, anger and trauma symptoms equivalent to their clients such as intrusive thoughts, changes in

interpersonal relationships and worldviews (Sexton, 1999; Pearlman and Saakvitne, 1995b). Further, such experiences undoubtedly influence practitioner's quality of work (e.g. counselling), and more importantly creates a situation where counsellors themselves need assistance to cope with hearing traumatic material clients (Figley, 1995).

This research further argues that comprehensible and manageable workloads must be properly set, and unnecessary commitment to work should be discouraged. This is based on the assertion that excessive workloads increase experiences and exposure to stress, burnout and compassion fatigue (Bell, Kulkami and Dalton, 2003). In past research, the concept of workload has been linked to job stress, and results indicate that high workload increases experiences of stress and burnout (Lazarus and Folkman, 1984). This results support the argument that workload occurs when the person's adaptive cognitive resources are exceeded, which results in work-related stress (Fisher, Katz, Miller and Thatcher, 2003).

Workload has previously been perceived to be synonymous with job demand in the literature, even though there are conceptual differences, which are not comprehensibly discussed and clear within the literature (Sparks and Cooper, 1999). From the discussion, it is expected that workload will have positive relationship with compassion fatigue. This is both due to the nature of the concept and its measurement principles. In other words, an EAP practitioner that has high workload is expected to experience high levels of compassion fatigue. In addition, it is also expected that workload will have a negative relationship with sense of coherence. This means that an EAP practitioner that has high level of sense of coherence will tend to perceive low levels of workload. Nonetheless, research is not clear on the nature of the relationship between the two concepts (Demerouti, Bakker, Nachreiner and Schaufeli, 2001).

2.4.2 Job Control

Job control also referred been to as job autonomy within the literature, can be defined at many levels, such as the social, psychological, political, and physical level (Karasek, 1979). This study selects the psychological level, this is because of the point that the sample consists of EAP practitioners, and the work environment variables (workload, job control and collegial support) are individual variables as discussed earlier in the section (see work environment). According to Spector (1987; 1998), control in the workplace ranges from autonomy (control over the individual's own scheduling and tasks), to participation in decision-making process (control over the organisational decision-making process).

Job control is defined as “the degree to which the job provides substantial freedom, independence, and discretion to the individual in scheduling the work and in determining the procedures to be used in caring it out” (Hackman and Oldham, 1975, p. 162 cited in de Croon, Sluiter, Blonk, Broersen and Frings-Dresen, 2004). Similarly, job control can be loosely defined as the extent to which individuals are free to schedule their work, and may choose how to carry out given tasks. According to Sauter (1989) job control is linked to the idea of control over the working conditions, for the environment to become more rewarding and thus less threatening. In the workplace, issues of rewards relate to increased organisational productivity, job security, wellbeing and reduced job-induced stress.

In the work environment job control is perceived to integrate work outcomes such as quality and quantity to employee’s attitudes towards their jobs (satisfaction, commitment and citizenship) (Feldt, Kivimaki, Rantala and Tolvanen, 2004). Feldt, Kivimaki, Rantala and Tolvanen (2004) found that job control is related to occupational status and position in the place of work. This result may have possible implications to the current research.

Research results understand job control and its relationship to health and wellbeing, exist in the literature (De Croon et al, 2004). This research found that low job control increases ill-health and negative wellbeing and in the same way, high job control increases positive health and wellbeing (De Croon et al, 2004). First, job control is related to the degree to which job aspects, such as workload, are perceived to the stressful. Second, high job control is inversely related to stress that one experiences.

Thirdly, low job control increases individuals' experiences of high job stress (de Croon et al, 2004).

Although the above-mentioned points have not been tested, they provide a way of understanding job control in relation to stress, and in the current study to compassion fatigue. Job control is essential to an individual's sense of meaningfulness (Feldt, Kinnunen and Mauno, 2000: 3). In addition, research demonstrates that high job demands have been regarded as a key source of strain for employees, because lack of job control has become a particularly prevalent stressor over the past two decades (Cooper and Hensman, 1985).

Karasek (1979) developed the job demand-control model (JDC model), which uses a two-dimensional design involving job demands and job control to predict stress-related illness (referred to as strain). "The JDC model assumes that a psychological work environment can be characterised by a combination of demands of the work situation and the amount of control employees have to cope with these demands" (Taris and Feij, 2004, p. 545). Job control is perceived to be an outcome of high work demands (Karasek, 1979). In recent times, the original JDC model as been expanded to include social support following studies demonstrating the moderating effects of social support on job strain (Karasek and Theorell, 1990). In the current research support is researched on the level of collegial support and not social support. This will be discussed later in the section.

Various questions arose from the literature on job demands or workload and control, such as the effects of prolonged exposure to specific job demands and job control on employee's perceptions of their jobs. Despite the number of questions that have been posed in this area, research is not conclusive and neat (Karasek and Theorell, 1990). This is based on the point that there is lack of longitudinal research on this area to examine the effects of the two variables on each other (De Croon et al, 2004). In addition, there exist different conceptualisations of the job demands or workload and job control models, but the most widely used and validated model (Leigh et al, 1988; Etter and Grzywacz, 2001; Feldt et al, 2004) is by Karasek (1979) discussed above.

Despite the debates in the area, Karasek and Theorell (1990) argue that in low demands and low control jobs, low levels of strain are expected. For the high demands

and high job control, high levels of strain are anticipated. These results have important considerations to the current research. The different levels of workload and job control as demonstrated by Karasek and Theorell (1990) is expected to affect compassion fatigue, even though the contributions overtime will not be examined because the current research is cross-sectional in nature. Nonetheless, the samples used in the above studies were different to EAP practitioners because they did not provide psychological services or counselling in their job roles.

Research conducted by Hosie, West and Mackey (1993) on the role of EAP practitioners in the workplace indicates that despite high qualifications obtained by practitioners, they remain in 'marginal' positions in the workplace in relation to structures of many organisations. Further, job control is assumed to be a relatively stable characteristic of the work environment (Feldt et al, 2004). Perceived job control seems to increase confidence, makes tasks less stressful and more intrinsically rewarding (Parker and Price, 1994). This point is important to the current research because it means that EAP practitioners that have low job control will be expected to experience high job-induced stress, in this case secondary traumatic stress or compassion fatigue. Additionally, job control is perceived to increase concentration, commitment, positive health outcomes, coping, performance and turnover (Parker and Price, 1994).

In a study of job control and organisational climate, Feldt et al. (2004) found a significant relationship between job control and components of sense of coherence, especially meaningfulness, and positive social relationships in the workplace for a sense of comprehensibility. In order to manage positive job control, organisations should discontinue being bureaucratic, impersonal and disempowering, since this leads to feelings of helplessness which aggravate the incident of compassion fatigue experienced by human service workers (Catherall, 1995). This could also possibly apply to EAP practitioners, as job control is an organisational variable and role related variable.

In the literature a number of studies and theories have linked job control to both psychological well-being and physical health, and generally found that it is positively related to the concept of general health (psychological and physical wellbeing) (Ganster & Fusilier, 1989; Spector, 1987, 1998). These studies further indicate that job

control is negatively related to job stress, emotional distress, and depression (cited in Liu, Spector, and Jex, 2005). Research findings from previous studies indicate that job control may have an inverse relationship to compassion fatigue. However, within the EAP practice little is known about the impact of job control as a work environment stressor, hence its inclusion in the current study. Furthermore, other researchers as discussed have correlated job control to experiences of stress, and found inverse relationships between high job control and low stress (Feldt, Kivimaki, Rantala and Tolvanen, 2004).

Other researchers in the literature on job control have correlated the concept to wellbeing, and they found positive relationships (De Croon et al., 2004). These results demonstrate the role of the concept in stress and strain area, which could possible apply to compassion fatigue as a form of stress. In addition, various theorists in the psychology literature have argued that human beings have a general drive to control things and events around them, also referred to as a need to indicate mastery over one's environment (Etter & Grzywacz, 2001). This implies that a lack of mastery tends to leave a sense of uncertainty and helplessness, which heighten experiences of stress (Croon et al; 2004), and this may possibly similar to experiences of compassion fatigue.

2.4.3 Collegial Support

Research within the literature has demonstrated that collegial support is not the only important source of support. Other types of social support such as supervisor, family and peer social support are also important (Daniels & Guppy, 1994). However, in the trauma area, collegial support has been found to be an important variable, as it can reduce certain negative experiences associated with the counselling role (Catherall, 1995; Sexton, 1999). This may be due to the nature of the counselling role, which requires confidentiality and ethical considerations on the part of the counsellor and therefore indicating that colleague based social support is important. Hence the inclusion of the variable in the current study due to its appropriateness to the counselling role, which is also performed by EAP practitioners as discussed earlier in the section. Furthermore, collegial support has been found to be a buffer factor (Burke, 1993), which protects employees from life related and work-related stresses and thus becomes a coping resource against certain negative work environment outcomes.

Collegial support refers to the perceived quality of both formal and informal work relationships with colleagues, which in previous research has been found to buffer the negative impacts of stress or trauma experienced at work (Levert et al; 2000). Further, collegial support is an important job resource, which influences individual's experiences of stress, burnout and secondary stress in the work context (Corrigan et al., 1994).

The relationship amongst health professionals in the workplace is considered important, with regards to the quality of support provided to individuals experiencing stress in the workplace (McCann & Pearlman, 1990). Quality of support has also been found in previous research to influence experiences of secondary trauma (Pearlman & Saakvitne, 1995a). Secondary trauma is interchangeably referred to as compassion fatigue in the literature (Figley, 1995). Both concepts have been used in previous research in South Africa (Naidoo, 2000; Ortlepp, 1998; Wilson, 1998). Nonetheless, the concept of compassion fatigue will be used in the current research, due to its theoretical precision and understanding in the trauma literature (Ortlepp & Friedman, 2001). This point will be discussed later.

Colleagues at work can provide support formally, through structures such as support groups (debriefing and staff meetings) and informally, such as socialising and communicating outside work (Catherall, 1995). Other researchers have suggested more formal and comprehensive mechanisms, including clinical supervision or consultation, case conferences, peer process groups, personal psychotherapy, trauma therapy training, professional development and regular organisational team meetings (Neumann & Gamble, 1995). The difference between the former and the latter formal mechanisms lies in the point that the former are indirect methods, whiles the latter are direct methods, which are specific to the trauma area.

In a study of burnout, work environment (workload, collegial support, role conflict and role ambiguity) and sense of coherence of a sample of 94 psychiatric nurses, Levert et al. (2000) found that collegial support was related to different dimensions of burnout (emotional exhaustion & depersonalisation). This demonstrates that collegial support is an important variable in burnout research, which also supports previous research in the area that this variable increases coping mechanisms (Carlson & Perrewe, 1999; Dewe & Guest, 1990; Lazarus, 1994; Le Fevre et al., 2003). In addition, work

environments encouraging team work, employees tend to experience less work-related stresses and burnout (Daniels & Guppy, 1994), in these work environments other employees are perceived to be helpful and compassionate, and management as supportive (Demerouti et al., 2001).

An assumption of the current research is that a particular work environment may or may not provide a favourable environment for experiencing compassion fatigue, which will be examined in the present research. In addition, organisational context or work environment is a significant factor identified as having an influence on mental health professionals (Rosenbloom et al, 1995 cited in Ortlepp, 1998). The level of job control, collegial support and level of workload may facilitate an environment that heightens or alleviates negative experiences resulting from providing counselling to traumatised clients. Thus, the current research will examine the relationship between work environment variables (job control, workload and collegial support) and both collegial support and compassion fatigue to a sample of EAP practitioners. These relationships will also be discussed later in the research to whether it is similar or different to previous research in the area.

2.5 Secondary Traumatic Stress: Compassion Fatigue

Within the workplace the concept of secondary traumatic stress is viewed as an occupational hazard when working with a traumatised client population (Pearlman and Mac Ian, 1995). This is because counsellors and human service practitioners who work with traumatised clients experience persistent emotional disruptions and may themselves become indirect victims of the trauma (Pearlman and Saakvitne, 1995b). There is some evidence to support the view that secondary traumatic stress is an occupational hazard. This is largely due to the point that symptoms of compassion fatigue manifest themselves in emotional, cognitive, behavioural or physical reactions (Catherell, 1995). Further, this impacts negatively on the practitioner's wellbeing and health. Figley (1995a) uses the concepts compassion stress and compassion fatigue interchangeably with secondary traumatic and secondary traumatic stress disorder respectively.

Secondary traumatic stress is a somewhat recent area that has emerged in the field of mental health work with survivors of trauma and individuals who experience trauma (Figley, 1995). Most researchers argue that the area emerged in the 1970s, as an area

of study, whiles other argue that this was earlier in the field of psychotraumatology (Figley, 1983, 1995; Danieli, 1988; Stamm, 1995; Bell, Kulkami and Mauno, 2000; Sexton, 1999; Feldt, Kunnunen and Mauno, 2000; Figley, 1995; Stamm, 1995). This lack of consensus amongst researchers in the area indicates that there is lack of a coherent and consistent body of literature in the area of secondary trauma. In support of the view that secondary trauma area is relatively recent, Danieli (1988) and McCann and Pearlman (1990) argue that recent developments in the literature on trauma has been the emerging literature focusing on the reactions of therapists and other helpers to working with survivors of trauma and individuals with traumatised. Nevertheless, there still remain a small number of researched publications in the area of trauma on mental health professionals (Stamm, 1997).

Most researchers in the area agree that working with clients who have been traumatized has unavoidable, enduring, and often harmful effects on therapists (Yessen, 1995; Rosenbloom, Pratt and Pearlman, 1995), and that these reactions may occur regardless of race, gender, age, or level of training (Edelwich & Brodsky, 1980 cited in Hesse, 2002, p. 6).

Researchers examining this issue do not all agree on what to call this phenomenon or how to define it. After a comprehensive review of the literature, Stamm (1997, p. 5) declared that "the great controversy about helping-induced trauma is not, can it happen, but what shall we call it?". She concluded that there is no consistently used term regarding the impact of being exposed to traumatic material as a consequence of being a therapist. Stamm's (1997) review revealed four terms namely compassion fatigue (CF), countertransference, secondary traumatic stress (STS) and vicarious traumatisation (VT). Other researchers argue this phenomenon can also be coined empathetic stress (Wilson and Lindy, 1994), and others also include burnout (McCann and Pearlman, 1990).

The four concepts from Stamm (1997) and burnout from McCann and Pearlman (1990) will be defined and briefly discussed in this section to show conceptual differences, with the exception of empathetic stress because of lack of research and literature on the concept (Wilson and Lindy, 1994), even though all concepts refer to the trauma of helping another traumatised person. Furthermore, the concept of secondary trauma merged with that of compassion fatigue as argued by Figley (1995). Furthermore, it is

generally accepted that, while the above concepts have significant similarities, there are also differences between these phenomena (Pearlman and Saakvitne, 1995). Some researchers argue that central to these processes is the use of empathy by counsellors (Figley, 1995).

Rogers (1975) developed the concept empathy, which is widely perceived to be an important counselling skill. Empathy or empathic communication is closely related with patient-centred care. Mead and Bower (2002) pointed out that although client-centredness is seen as a vital aspect of good professional communication, there is a lack of clarity about what constitutes this important dimension. Essentially, client centredness involves the exploration of issues from the client's perspective, and communication of this type is more symmetrical in nature than traditional consultations (Ivey and Authier, 1978). In other words, the patient is treated in a holistic way. In addition, Egan (1998) defined two levels of empathy, i.e. basic empathy and advanced empathy, the difference being that advanced empathy goes beyond the client's words to what they imply.

Figley (1995) argues that empathy is a key element in the counsellor's experience of compassion fatigue. This argument is built on the trauma transmission model, which will be discussed in detail in the following section. This model has several components, which function as interacting components that initially produce compassion stress and finally produces compassion fatigue as an end result to the model. Ortlepp (1998) further argues the concept of empathy is important not only to define compassion fatigue, but to also define related concepts such as secondary traumatic stress, countertransference, burnout, and vicarious traumatisation. Figley (1995) and Figley (1995c) gives appropriate consideration to the role of empathy in his trauma transmission models as depicted in figure 1 and figure 2.

2.5.1 Figley's Empathy Model

The use of empathy as briefly discussed above is an important skill in helping clients. Figley (1995b) argues that secondary traumatic stress and/or compassion fatigue is a result of the counsellor's empathetic ability. Figley (1995) claims that compassion fatigue is inevitable to trauma counsellors and many other health professionals. This is in cognisance to the counsellor's degree of life disruption, for instance, in the form of illness or a change in life events or work roles and responsibilities.

Through the use of the trauma transmission model Figley (1995) refined his description of compassion fatigue as a state of exhaustion and dysfunction – biologically, psychologically and socially due to prolonged exposure to compassion stress. According to Figley's (1995) model, compassion stress compromises six interacting elements. Figure 1 indicates the development of compassion stress. The first element is *empathetic ability*, which refers to the ability to register pain, experienced by others, the second is *empathetic concern* (refers to the motivation to act in a manner that reduces the experience of the trauma survivor), the third element is *emotional contagion* (experiencing the feelings of the client as a function of exposure to their trauma and the counsellor's simultaneous identification with the experience of similar feelings to those experienced by the client), the fourth is *empathic response* (the effort to relieve suffering), the fifth *disengagement* (the extent to which the helper can distance himself/herself from the ongoing trauma of the clients) and the sixth is *sense of achievement* (in the effort to help the to relieve suffering (Figley, 1995c).

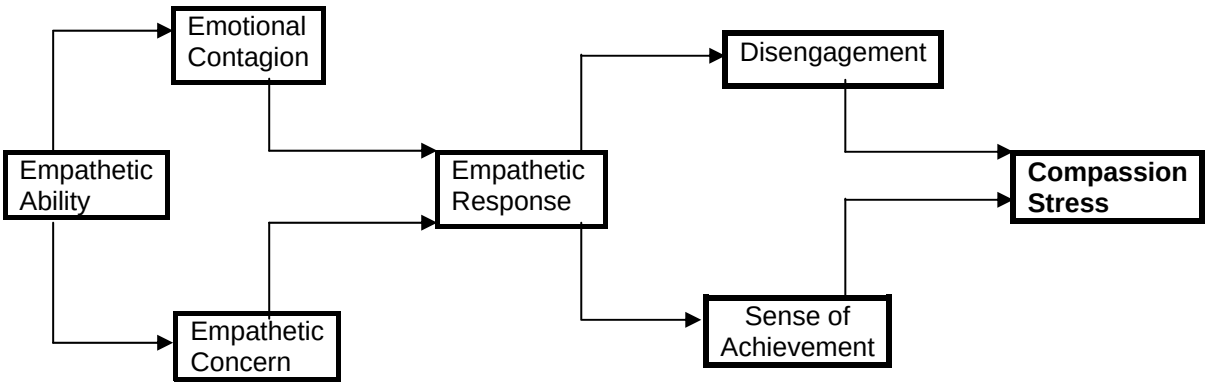

Figure 1: Trauma transmission: A Model of Compassion Stress (Figley, 1995)

Thus, if a sense of achievement is experienced there will be little compassion stress as the counsellor is satisfied with the reduction in suffering. However, if disengagement is experienced the response is more compassion stress present, which in turn increase the risk of compassion fatigue as the counsellor has become actively involved with the trauma, suffering and difficulties of the clients (Figley, 1995). Figure 2 illustrates the progression of compassion stress to compassion fatigue. Compassion stress together with *prolonged exposure* (ongoing responsibility to the client) and *traumatic recollections* (recollections of traumatic memories) produce compassion fatigue.

Degree of life disruption such as change in lifestyle or life events, or lack of professional and emotional support can exacerbate the risk of compassion fatigue (Figley, 1995b; Bride, Robison, Yegidis and Figley, 2004).

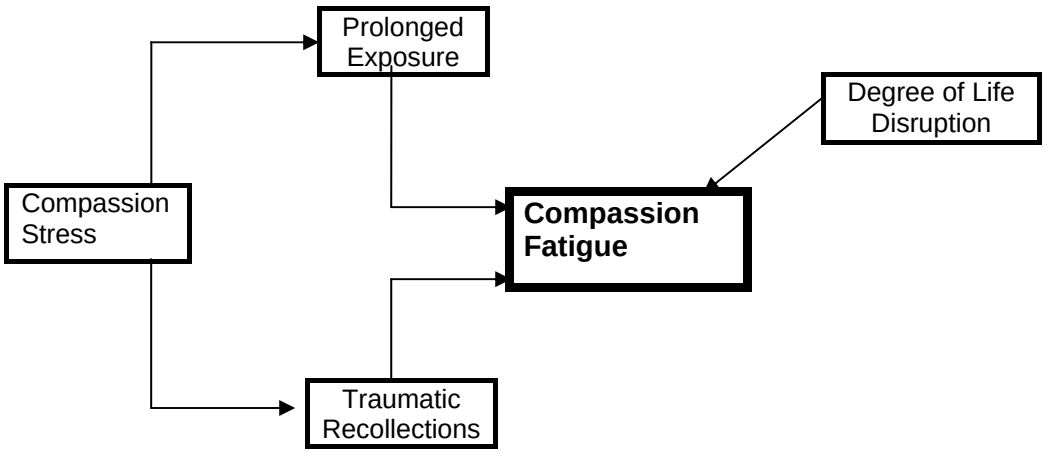

Figure 2: Trauma transmission: A model of Compassion Fatigue (Figley, 1995)

2.5.2 Compassion Fatigue (CF)

Compassion fatigue is a psychological construct, which is studied under secondary traumatic stress disorders (STSD), which emerged mainly from the work of Figley (1993a). Figley (1995) argues that counsellors can experience trauma without being directly threatened with either psychological or physical harm. Simply being aware of the traumatic incident experienced by a significant other can traumatise them. People who normally experience such trauma include friends, family, colleagues and health professionals who offer assistance to the primary victim (Figley and Kleber, 1995). In other words, professionals who come into contact with the primary victim are not the only ones that experience compassion fatigue, but individuals and family whose lives are closely associated with the trauma survivor also experience it.

Symptoms of high levels of compassion are disturbed sleep, anger, fear, suppression of emotions, nightmares, flashbacks, irritability, anxiety, alienation, feelings of insanity, loss of control, and suicidal thoughts have been experienced by counsellors and therapist who have had exposure to trauma victims (Figley, 1995; McCann & Pearlman, 1990; Danieli, 1988; McCann & Pearlman, 1990a. McCann, & Pearlman, 1989; Hyman, 2004; Salston and Figley, 2003; Pearlman & Saakvitne, 1995).

In addition, compassion fatigue is a state of tension and preoccupation with the individual or cumulative trauma of clients as manifested in one or more ways including re-experiencing the traumatic event, avoidance/numbing of reminders of the event, and

persistent arousal, and that the counsellor is absorbing the trauma through the eyes and ears of your clients (Figley, 1995; McCann & Pearlman, 1990; Danieli, 1988; McCann & Pearlman, 1990a. McCann, & Pearlman, 1989; Hyman, 2004; Salston and Figley, 2003; Pearlman & Saakvitne, 1995). Other researchers argue that compassion fatigue can have symptoms similar to burnout: exhaustion, short attention span, feelings of anger or depression, apathy, forgetfulness, somatic complaints, irritability, difficulty in concentrating, and sleep disturbance (McCann & Pearlman, 1990).

This can result in secondary traumatic stress (STS) or secondary traumatic stress disorder (STSD) in the counsellor. Since STS symptoms are considered a normal reaction when working with clients' traumatic material. Many counsellors will at a minimum experience STS and may experience extended symptoms in STSD (Figley, 1995). Figley (1993) argues that the secondary traumatic stress concept includes, but is not limited to, countertransference reactions. Secondary traumatic stress can involve a rapid onset of PTSD-like symptoms, as well as feelings of helplessness, confusion and isolation from supporters (Hyman, 2004).

Figley (1995a) proposed the concept of secondary traumatic stress, in recent times called the phenomenon of compassion fatigue (Figley, 1993a). He defined secondary traumatic stress as “the natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced by a significant other and the stress resulting from helping or wanting to help a traumatised or suffering person” (Figley, 1995, p. 7). In addition, Figley (1995) views the relationship between the client and the counsellor as an empathetic activity, and thus the client is viewed to be a ‘significant other’ in the relationship.

Within the literature there is more than one construct of secondary traumatic stress, as discussed above. This is a limitation on the part of the literature, as there are no clear theoretical justifications for the differences and similarities of the interchangeable use of concepts (Salston and Figley, 2003). Furthermore, other researchers argue that compassion fatigue is a more user friendly term for secondary traumatic stress disorder, which is nearly identical to PSTD, except it affects those emotionally affected by the trauma of another (usually a client or a family member) (Figley, 1995). Figley (1995) suggests the term "compassion fatigue" as an alternative name for secondary

traumatic stress. Nonetheless, the literature is not clear about the differences between the two concepts.

Both posttraumatic stress and compassion fatigue affect individuals in similar ways, but are identified by three categories of symptoms: (1) intrusive thoughts, images and sensations; (2) avoidance of people, places, things and experiences which elicit memories of the traumatic experience, and (3) negative arousal in the forms hypervigiliance, sleep disturbances, irritability and anxiety (Pearlman & Saakvitne, 1995). However, Figley (1995) suggests that this cluster of symptoms becomes classified as a disorder, STSD, when experienced for more than 30 days following exposure to the traumatic event.

Compassion fatigue is trauma specific as it results from the trauma of helping traumatised clients. The symptoms of compassion fatigue are parallel to the symptoms of post-traumatic stress (Figley, 1993a). The symptoms of PTSD and compassion fatigue are the same and can include: recurrent nightmares, recurrent and intrusive distressing recollections of the trauma, flashback episodes, intense psychological distress at exposure to cues that symbolize or resemble an aspect of the traumatic event, restricted range of feelings (i.e. blocking feelings), difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hyper vigilance and exaggerated startle response (Figley, 1995; Hyman, 2004; Bride et al, 2004).

It is believed that secondary trauma can result from exposure to a single traumatic experience (Yessen, 2002). Many researchers use the terms "secondary trauma" and "vicarious trauma" interchangeably to mean the effects on a therapist of any work with traumatized clients. Figley (1995), on the other hand, uses the term compassion fatigue to describe the impact of empathic therapeutic engagement on therapists. His work on CF evolved in relation to Post Traumatic Stress Disorder (PTSD) and recognition that therapists were known to experience symptomatology similar to that experienced by their PTSD clients. He identified the mirroring or contagion effect of symptoms from client to therapist and argued "those who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress" (Figley, 1995, p.1).

Secondary traumatic stress is defined as an outcome or risk that is related to engaging empathetically with another's traumatic material (Stamm, 1995). Figley (1995a) argues that compassion fatigue manifests as a variety of outcomes that affect the health and the wellbeing of counsellors. This may also be the case for EAP practitioners in the current study. The manifestations of compassion fatigue may be categorised as either being intra-subjective or inter-subjective (Figley, 1995a). Intra-subjective are refer to outcomes in the counsellors' individual experiences of secondary trauma at a psychological and physical levels, while inter-subjective outcomes are essentially the effects that exposure to trauma have on the counsellor's social life. Thus, compassion fatigue may result in poor job performance and reducing self-esteem, and thus it impacts on counsellors' experience of their professions (Pearlman & Saakvitne, 1995).

2.5.3 Burnout

Research in the past has conceptualised burnout and compassion fatigue as synonymous, but more recently the two concepts are said to be different. Burnout is "a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who do people work of some kind" (Maslach, 1976, p. 3). Burnout may include exhaustion, depersonalisation, and a reduced feeling of accomplishment (Conrad & Perry, 2000). It can become gradually worse, is fairly predictable, and can often be remedied by a vacation or changing jobs (America's Continuing Education Network, 1999). In addition, burnout is perceived to be a process starts gradually and becomes progressively worse (Maslach, 1982).

Despite the differences that exist between burnout and compassion fatigue as a secondary traumatic stress, both outcomes are experienced due to an inherent vulnerability involved in the need to empathise with the traumatised or suffering clients. Furthermore, both processes are harmful to the personal and professional life of a counsellor, and they are also harmful to the treatment and the client receiving counselling from a counsellor who is experiencing the above outcomes (Pearlman and Saakvitne, 1995). Compassion fatigue is different from burnout in that the cause of compassion fatigue is always related to caring about, taking care of, or exposure to trauma victims, while burnout can result from any type of stress (McCann and Pearlman, 1990). Nevertheless, McCann and Pearlman (1990) argue that burnout of mental health professionals is parallel to traumatised client's experiences of numbing and avoidance patterns.

According to Maslach (1982) the risk for burnout is greater when the individual feels restricted by other people's demands, of demands by the organisation and by those the individual is put to serve and assist. Secondary traumatic stress can involve a rapid onset of PTSD-like symptoms, as well as feelings of helplessness, confusion and isolation from supporters (Figley and Kleber, 1995). The symptoms are disconnected from the counsellor's real life circumstances, but there is a faster recovery than in burnout. Secondary traumatic stress sufferers can experience the full range of intrusive, avoidance and arousal symptoms that are typical of PTSD sufferers. A key element of burnout results from emotional exhaustion.

Research has shown that therapists are particularly vulnerable to burnout because of personal isolation, ambiguous successes and the emotional drain of remaining empathetic (McCann & Pearlman, 1990). Moreover, burnout not only is psychologically debilitating to therapists, but also impairs the therapist's capacity to deliver competent mental health services (Farber, 1983). The literature on burnout, with its twenty-five year history, thoroughly describes the phenomena and prescribes preventive and treatment interventions for helping professionals.

2.5.4 Countertransference

Within the countertransference literature there is some debate over the definition of countertransference, particularly how inclusive the definition should be. Pearlman and Saakvitne (1995a) defined countertransference as "(1) the affective, ideational, physical responses a therapist has to a client, his clinical material, transference and re-enactments, and (2) the therapist's conscious and unconscious defences against affects, intrapsychic conflicts and associations aroused in the former" (p. 23). They also argued that countertransference is a feature of every psychotherapeutic relationship and that unrecognised and unanalysed countertransference reactions inevitably obstruct accurate empathy and the therapeutic process. This concept has its roots in the psychodynamic school of thought (Stamm, 1997).

Wilson and Lindy (1994) identified two types of defensive countertransference reaction by trauma therapists: avoidance reactions and over-identification reactions. Avoidance countertransference reactions are characterised by denial, minimisation, distortion, counter phobic reactions, detachment and disengagement from an empathic stance. In contrast, over-identification involves idealisation, enmeshment, and excessive

advocacy for the client, as well as guilt due to the therapist's perceived failure to provide adequate assistance. These defensive therapist reactions can compromise a client's recovery (Wilson and Lindy, 1994).

McCann and Pearlman (1990) argue that Figley (1983) has described the concept as secondary victimization. The difference between McCann and Pearlman (1990) and Figley (1983) on understanding of secondary trauma indicates two types of conceptualisation in the traumatic stress literature, the first is characteristics of the stressor and the second is individual's personal characteristics, which determine individual's response to trauma. The burnout literature supports the view that it is the nature of the external stressor that causes stress and then burnout. In contrast the countertransference literature supports the view that the underlying individual's unresolved conflicts and traumas determine their experiences of this phenomenon.

2.5.5 Vicarious Traumatisation

McCann and Pearlman (1990) coined the term Vicarious Traumatisation (VT) and they propose that vicarious traumatisation describes the negative cognitive schema and behaviour changes in therapists. Pearlman and associates are clear that VT differs conceptually from STS, CF or countertransference in that such approaches focus on symptoms rather than considering the individual holistically. The VT approach focuses on the individual as a whole, which includes symptoms in the larger context of adaptation as the individual strives for meaning (Pearlman & Saakvitne). According to Pearlman & Saakvitne (1990) aspects of the self that may be disrupted as a consequence of experiencing VT are: (1) frame of reference, (2) self capacity, (3) needs, beliefs and relationships, (4) interpersonal relationships, (5) ego resources, and (6) imagery (Pearlman, 1995).

Vicarious traumatisation as conceptualised originally by McCann & Pearlman (1990) appears to be the most comprehensive account presented so far. "Vicarious traumatisation is the cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client's traumatic material" (Pearlman & Saakvitne, 1995a, p. 31). Whereas countertransference occurs in all psychotherapies and is a temporary response to a particular client, vicarious traumatisation is the result of an accumulation of experiences across many therapy situations. The effects of vicarious traumatisation ripple beyond the particular therapy

to other client-therapist relationships as well as to the therapist's personal and professional life (Neuman and Gamble, 1995).

Many researchers assert that secondary or vicarious traumatisation should not be confused with burnout or countertransference. Yessen (1995) posits that vicarious traumatisation overlaps to some degree with burnout and countertransference. Although trauma workers can experience burnout, secondary or vicarious trauma differs from burnout in that it specifically involves exposure to emotionally trying images and descriptions of suffering (McCann & Pearlman, 1999).

In addition, vicarious traumatisation and secondary trauma differ in both focus and emphasis. Jenkins and Baird (2002, p. 425) argue that the concepts differ on four dimensions "(1) focus on symptomology versus theory". Figley's compassion fatigue concept focuses on symptoms. Pearlman and Saakvitne (1995) and McCann and Pearlman (1990a) focus on theoretical underpinnings of the constructivist self-development theory. The "(2) nature of symptoms (observable reactions versus more covert changes in thinking)". Figley (1983) focuses on the former and Pearlman and Saakvitne (1995) and McCann and Pearlman (1990a) on the latter. The "(3) relevant population". Figley (1983) focused on a population of nurses, police officers and trauma therapist, whiles Pearlman and Saakvitne (1995) have only focussed on mental health professionals and "(4) critical amount of exposure to trauma survivors". Figley (1983) argues that only one exposure to one other traumatised person's material can result on symptoms, and for McCann and Pearlman (1990a) VT results from cumulative exposure to traumatised clients over time.

2.5.6 Constructivist Self-Development Theory

The Constructivist Self-Development Theory (CSDT) aims to understand the underlying psychological impact of exposure to trauma. According to this theory, the experience of secondary exposure to trauma varies across individuals, due to interaction between individual factors (coping style, locus of control, and personality predisposition) and contextual factors (nature and frequency of the traumatic stressor, and support from the environment) (McCann and Pearlman, 1990). The theory further argues that exposure to trauma disturbs and changes the individuals' perceptions of the world, life roles and daily activities. According to McCann and Pearlman (1990) CSDT is an integrative, developmental, relational theory that forms the foundation for

clinical work with survivors and the basis for conceptualising the impact of trauma therapy on the therapist.

The CSDT is built on the underlying foundation that “human beings construct their own personal realities through the development of complex cognitive structures which are used to interpret events” (Epstein, 1989; Mahoney, 1981 and Lyddon, 1988 cited in McCann and Pearlman, 1990, p. 504). These complex structures are said to develop throughout the person’s life, which are referred to as cognitive schemas. These include beliefs, identity, self-world relations, assumptions and expectations about the world and self, and they allow individuals to comprehend, manage and make meaningful sense of their experiences in the world (McCann and Pearlman, 1991a).

A review of literature on adaptation to trauma by McCann and Pearlman (1990) uncovered five primary psychological needs of the counsellor; safety, dependency/trust, power, esteem and intimacy. In recent times needs such as independence and frame of reference were included. Through the demonstration of psychological needs that are perceived to be cognitive schemas, McCann and Pearlman (1990) argue that trauma disrupts these schemas.

In addition, the significance and fundamental role of the schemas determine individual’s experiences of the trauma. An example would be a therapist that provides counselling to a traumatised individual, and because of the trauma a client may have a distorted memory system, which may also manifest on the therapist. This changed memory system can either be temporarily or permanently distorted. This process is referred to as vicarious traumatisation as the therapist experiences disruptive or intrusive disturbances to his/her psychological and interpersonal wellbeing (McCann and Pearlman, 1990).

McCann and Pearlman (1991a) further hypothesised that a traumatic experience can cause serious disruption of certain aspects of a person's life, and that working with trauma survivors can have the same effect for therapists. Aspects of the work include that nature of the clientele, specific facts of the event, organizational factors, and social/cultural issues (violence in the community or insubordination of women). Aspects of the therapist include personality, personal history, current personal circumstances, and level of professional development. Pearlman and Saakvitne (1995) base their understanding of vicarious traumatisation on their own research and

personal experiences working with trauma survivors, on established research in the field, and on discussions with trauma therapists and others who work with trauma victims (police, journalists, emergency room personnel, etc.).

2.5.7 Secondary Trauma: Compassion Fatigue interventions

In the literature various interventions to alleviate the impact of compassion fatigue have been identified. Danieli (1985) commented that counsellors and helping professionals would benefit from five coping strategies: social support, task focussed behaviours, emotional distancing, cognitive self-talk and a group approach to dealing with secondary trauma, so as to normalise counsellor's reactions and provide a safe environment for therapists to diffuse painful or disruptive feelings. Other researchers argue that maintaining professional connection with the colleagues is another key way to cope with and prevent secondary trauma (Pearlman and Saakvitne, 1995b).

McCann and Pearlman (1999) argue that it is important for helping professionals to participate in debriefing sessions, training and supervision. Professional training or development, staff or peer support groups, supervision and consultation are an important way of providing added insight and learning. In addition, physical and psychological self-care is also essential to working with trauma victims, whether as a way to cope with existing symptoms of secondary trauma, or as a way to prevent it (Pearlman and Saakvitne, 1995b).

Pearlman and Saakvitne (1995) identified four important domains to the prevention of secondary traumatisation in mental health care providers: 1) professional strategies, such as balancing caseloads and accessible supervision; 2) organisational strategies, such as sufficient clientele time and safe physical space; 3) personal strategies, such as respecting one's own limits and maintaining time for self-care activities and 4) general coping strategies, such as self-nurturing and seeking connection. Thus far, no studies have evaluated the effectiveness of these prevention strategies.

Catherall (1995) developed a five step plan for institutions and or organisations to use in dealing with secondary trauma that includes 1) identifying staff level of exposure to secondary trauma, 2) developing a plan with the staff for dealing with secondary trauma, such as highlighting avenues for discussion and staff responsibilities, 3) psycho-education for staff on secondary trauma, 4) handing out a "preparedness structure" to staff that highlights the agency's philosophy and plan in dealing with

secondary trauma, and 5) evaluating the effectiveness of the plan and making necessary changes. Pearlman and Saakvitne (1995) emphasise that trauma therapists or helping professionals need to be trained in both trauma and non-trauma issues so that they can remain connected both to their present field of work and also to broader areas of therapeutic training.

2.5.8 Previous Research on Compassion Fatigue

Not much has been written on compassion fatigue in the secondary trauma literature. The number of empirical studies from which this literature is derived is small, and is described as being anecdotal (Sexton, 1999). A number of researchers argue that research on compassion fatigue is largely anecdotal because it is based on experiences of therapist, in qualitative accounts (observations, interviews, and focus groups) (Figley, 1983, 1995; Danieli, 1988; Stamm, 1995; Bell, Kulkami and Mauno, 2000; Sexton, 1999; Feldt, Kunnunen and Mauno, 2000; Figley, 1995; Stamm, 1995).

In a validation study of secondary traumatic stress or compassion fatigue and vicarious trauma on 99 sexual assault or domestic violence counsellors, Jenkins and Baird (2002) found concurrent validity between compassion fatigue and vicarious trauma measures. This result indicates that trauma therapist experiences compassion fatigue and vicarious trauma similarly and also differently. This is because vicarious trauma is cognitive, whereas compassion fatigue is social or emotional in nature.

In another local study on the relationship between levels of compassion fatigue and coping styles on a sample of 32 trauma unit nurses, Nkosi (2002) found that the participants were at extremely high levels or risk for developing compassion fatigue, positive relationships between coping strategies of escape, self-control, acceptance, and confronting.

In Another study on the relationship between sense of coherence, indicators of secondary traumatic stress (compassion fatigue, burnout, silencing response and compassion satisfaction) and work-related experiences of trauma counsellors (programme co-ordination, self-efficacy and stakeholder commitment on a sample of 130 trained non-professional trauma counsellors working in the South African banking sector. Ortlepp and Friedman (2001) found significant relationship between sense of coherence and secondary traumatic stress indicators. More specifically, there was a

negative relationship between compassion fatigue and sense of coherence together with its components (manageability, meaningfulness and comprehensibility). In addition, sense of coherence's component of manageability moderated the relationship between stakeholder commitment and compassion fatigue.

Previous similar research highlighted above, indicates that the concept of compassion fatigue is negative in nature and that it impacts negatively on the helping professional's working life and general life. In addition, from the literature and previous studies, compassion fatigue is expected to relate negatively to sense of coherence and collegial support, but positively to workload and job control. Nonetheless, research findings on the relationship between the work environment variables, compassion fatigue and sense of coherence is not consistent, as discussed in the area.

In summarising, it can be seen that several views have been offered but none has been able to comprehensively demonstrate the mechanism that accounts for the transmission of traumatic stress from one individual to another. But, the underlying assumption can be hypothesised that the caregiver's level of empathy with the traumatised individual plays a significant role in this transmission (Figley, 1995). Similarities and differences between the concepts have been provided. From the nature of the population selected (EAP practitioners) in the current research, who offer 'broad-brush' services, of which trauma counselling is one, compassion fatigue seems to be sensible concept to select because Figley (1995) argues that compassion fatigue results from a single exposure to one traumatised client, which is perceived to be the case in current research. In addition, Figley's (1995) view of experiences to exposure with traumatised clients is the most widely used and supported in the secondary trauma literature (Hyman, 2004; Salston and Figley, 2003; Jenkins and Bairds, 2002; Bride et al, 2004). Based on the present author's understanding compassion fatigue includes both characteristics of secondary trauma and symptoms similar to those in PTSD as well as cognitive shifts that are intrinsic in the concept of vicarious traumatisation.

2.6 Sense of Coherence

Aaron Antonovsky introduced sense of coherence. This concept changed thinking about health and disease, which was traditionally viewed in terms of the medical model, which is pathogenic in orientation, to the origins of disease and what influences individuals towards health (Antonovsky, 1987a and 1987b). Antonovsky's approach is based on an individual perspective on the factors that influence people's health, despite being faced with stressors. In support of this perspective, Antonovsky introduced the concept salutogenesis, which involves searching 'why is it that certain individuals in the population remain healthy regardless of the incidences of ever-present stressors' (Antonovsky, 1987a and 1987b). Furthermore, this perspective involves the exploration of factors contributing to people health, despite continual experiences of persistent stressors.

Antonovsky argues that sense of coherence stabilises around 30 years of age, and that "this development occurs in proportion to one's experiences of the world as predictable and consistent, as well the ability to shape life outcomes" (Antonovsky, 1993a; Antonovsky and Sagy, 1986 cited in Ortlepp and Friedman, 2001: 40). In addition, Sense of Coherence comes about due to the availability of 'generalised resistance resources' (GRR), which refers to any features of the person, group, or environment that enable the individual to remain healthy despite negative impacts on health and wellbeing. GRR refers to any resources, which may be materialistic (food and money), cognitive (intelligence or knowledge), interpersonal (social support), as well as macro social (religion) (Figley, 1995). Thus an individual with a high SOC will organize GRR to fight negative health, in contrast with a low negative SOC individual who will be unable to utilise sufficient resources.

Antonovsky defined sense of coherence (S0C) as:

> "A global orientation that expresses the extent to which one has a pervasive, 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: 19).

The key learning point from the above definition of SOC is that the concept is a global stress buffer, unlike other concepts that a context and situation specific (e.g. supervisor support, family support and collegial support). In addition, SOC does not only buffer the impact of negative stressors and traumas, but allows individuals to utilise resources in their environments so as to alleviate negative consequences which may originate from the work environment and EAP practitioner role.

2.6.1 Characteristics of SOC

Sense of coherence (SOC) consists of three dimensions: comprehensibility, manageability and meaningfulness (Antonovsky, 1987). *Comprehensibility* is "the extent to which the individual perceives confronting stimuli" developing from the "internal and external environment as making cognitive sense, as information that is ordered, consistent, structured and clear, rather than noisy, chaotic, disordered, random, accidental and inexplicable" (Cilliers, 2001: 53). *Manageabilit*y is the degree to which the "individual perceives that resources at his/her disposal are adequate to meet the demands" created by the continuous stimuli, and that "events are perceived to be bearable" therefore the individual can manage to cope by meeting the challenges posed (Cilliers, 2001: 53). *Meaningfulness* refers to the degree to which the person perceives and feels that life is making emotional sense (Rothman, Jackson and Kruger, 2003). These three concepts or dimensions of SOC are strongly interrelated, and Antonovsky (1987a, 1993) has stressed that they should not be measured as distinct constructs. In the current research SOC will be measured as a single construct and will not be measured as three dimensions.

Antonovsky (1987a, 1991) argues that the strength of SOC is influenced by childhood and adolescent experiences; and that the individual is able to adjust through the nature of the current working environment. Nonetheless, the ability to cope with stressors may also be shaped by later adulthood experiences. One example that has been highlighted in the literature is experiences of trauma, and in the current research compassion fatigue as a form of secondary trauma. Empirical research on secondary trauma indicates that for people it changes a both the individual's cognitive schema and interpersonal relations, which are related to their ability to cope and manage life and work-related stressors, and in so doing impacts on their level of stress (Hyman, 2004; Salston and Figley, 2003; Jenkins and Bairds, 2002; Bride et al, 2004). In the

work contexts, as in life, consistent experiences help provide a basis for comprehensibility, a good load-balance for manageability, and participation in decision-making for meaningfulness (Antonovsky, 1987a,b; 1991).

Although the strength of the SOC is largely shaped by life experiences in childhood and adolescence, it is capable of adjustment, by the nature of the work environment and job role, such as trauma counselling (Antonovsky, 1987; Antonovsky, 1991). Therefore, according to Antonovsky (1987b) SOC provides a theoretical model for the analysis of working conditions, through which SOC and thus the ability to cope with stressors may also be shaped in a stronger or a weaker direction in later adulthood.

The psychosocial work characteristics selected on the current study is viewed by Antonovsky (1991) as important in shaping an individual's SOC. Even though, empirical research supporting this hypothesis is not inconclusive (Feldt, Kinnunen and Mauno, 2000). Furthermore, taking part in collective decision-making reinforces an individual's dimension of manageability, because perceived social resources, such as the support and advice of colleagues, have an important active function to an individual. In addition, comprehensibility at work is strengthened considerably when the work environment enables an employee to see the entire spectrum in the workplace and his or her place in it, fosters confidence and feelings of security, and supports communicability in social relations (Antonovsky, 1987b).

SOC is essentially a measure of an individual's resilience in the face of stress, and capacity to cope with it (Cilliers, 2001). However, while conventional coping measures assess preferences for particular coping strategies, SOC measures the individual's capacity to respond to stressors by the appropriate application of a variety of coping and other strategies (Antonovsky, 1987). Individuals with high SOC scores are those likely to perceive stressors as predictable and explicable, and have confidence in their capacity to overcome stressors. Low SOC measures the relative absence of these beliefs (Antonovsky, 1990).

When the level of an individual's SOC is shaped by the nature of the current working environment, it can be assumed that SOC, in turn, is a major determinant of an individual's state of health and well-being (Antonovsky, 1992). This central hypothesis of SOC theory, that the stronger the SOC the better the location on the health-disease

continuum' (Antonovsky, 1987a), has also been supported by several empirical studies (Cilliers, 2001; Feldt et al, 2000; Feldt et al, 2004; Levert et al, 2000; Ortlepp, 1998).

2.6.2 Previous research on Sense of coherence

Feldt et al. (2004) found a significant relationship between job control and components of sense of coherence, in a study of job control and organisational climate. This research indicates the importance of a good level of sense of coherence, and its role in the work environment. Thus, it will be important to examine the relationship between sense of coherence and work environment variables in the current research.

Empirical research conducted Ortlepp and Friedman (2001) on a study of the relationship between SOC and indicators of secondary traumatic stress in a sample of 130 trained non-professional trauma counsellors employed in the South African banking sector. Ortlepp and Friedman (2001) found SOC to be a consistent moderator of between the work-related experiences of the trauma counsellors and indicators of secondary stress. In another study, conducted by Levert et al. (2000) on the relationship between work environment (workload, collegial support, role conflict and role ambiguity), burnout and sense of coherence on a sample of 94 psychiatric nurses. Found that sense of coherence moderated the relationship between work environment and burnout, although the moderation was not strong (Levert et al., 2000).

Sense of coherence is hypothesised in the current research to have a moderating role on the relationship between the work environment variables and compassion fatigue. According to Baron and Kenny (1986), a moderator can be qualitative or quantitative. In the current research SOC is quantitative (level of individual SOC). Antonovsky (1991) argues that SOC plays an important primary role in minimising and buffering the susceptibility of counsellors. This is hypothesised to be the case in the current research on a sample of EAP practitioners to secondary traumatic stress (compassion fatigue). More importantly, a moderator is a variable which shapes the direction and/or potency of the relationship between the independent variable and dependent variable. In other words, EAP practitioners who report a good experience of the work environment (high job control, low workload and high collegial support) will have a stronger SOC, which will also be related to a low level of compassion fatigue.

As discussed, personality may also be considered as a moderator, as some personality types (e.g., type A) may be more susceptible to stress than others (Cooper et al., 2001). Although personality characteristics have been identified as relevant, relatively little attention in empirical research has been paid to it (Cooper et al, 2001). Often research goes directly to identifying environmental and work environment problems (Cooper, Dewe, and O'Driscoll, 2001), but personality is seldom a consideration. Therefore in the current research, personality is considered in order to identify whether personality disposition in the concept of sense of coherence buffers the effects of work environment on compassion fatigue.

2.7 Focus of the Research

The literature review has defined the concepts of work environment, compassion fatigue and sense of coherence. As mentioned previously, work environment influences the level of stress an individual may experience in the workplace (Sexton, 1990). This is also linked to job resources, such as collegial support to deal with compassion fatigue in the workplace (Schaufeli and Enzmann, 1998 cited in Roman, Jackson and Kruger, 2003). In addition, higher workload and low job control are further viewed as influencing negative wellbeing and health (Carlson and Perrewe, 1999). In the case of the current research, low job control and high workload are believed to lead to experiences of compassion fatigue. Thus compassion fatigue, as a form of secondary trauma experienced by EAP practitioners, is related to the work environment (Ortlepp, 1998). Although, other researchers have argued and found that traumatic materials also influence the counsellor's psychological wellbeing and health (Wilson, 1998; Naidoo, 2000).

Sense of coherence on the other hand, influences the manner in which an individual experiences stressors and more importantly, the way she/he manages the stressors in their lives, which lead to the argument that SOC has a role effect on the relationship on work environment (Levert et al, 2000; Ortlepp, and Friedman, 2001) and compassion fatigue.

The final section of the literature review will focus on the research aims, summary of rationale and hypotheses of the current research.

2.8 Research Aims

The primary aim of the current research was to investigate the relationship between the EAP practitioner's work environment (WE), sense of coherence (SOC) and their influence on compassion fatigue (CF) as an outcome experienced by practitioners working with traumatised clients or patients in an organisation. The secondary aim was to explore whether sense of coherence (SOC) has a moderating effect on the relationship between work environment variables and compassion fatigue. In addition, the current research aims to add to the scant literature on Employee Assistance Programmes (EAPs), specifically on the EAP practitioners employed in the South African organisational context, which is argued to be unique in historical, political and more recently legislative terms (van der Bergh, 2000; Bendix, 2001). Thus, the current research will contribute to a larger body of knowledge on the impact of the work environment on stress, secondary trauma and wellbeing at work.

2.9 Summary of Research Rationale

Employee Assistance Programmes (EAPs) are a relatively new workplace service in South Africa, in contrast to many other 'western countries' such as the United States of America (Vosloo and Barnard, 2002; Harper, 1999; Maiden, 1992). Hence, various authors have argued that there is a need for research in this area, in the South African context (Beard, 2000; Berridge and Cooper, 2000; Malatji, 2000). Further, existing research in this area has largely focussed on either the EAP service itself or the EAP clients, and not on the wellbeing of EAP Practitioners. Furthermore, previous research has not addressed the role of personality characteristics, such as sense of coherence, in experiences of trauma, especially secondary trauma in the organisational literature (Ortlepp, 1998).

Other previous research in the area of SOC and CF or burnout has focussed on other health professionals, such as trauma professionals (Nkosi, 2002, Ortlepp, 1998), psychiatric nurses (Levert, 1999), and counsellors (Wilson, 1998), predominantly employed in a hospital setting. The current research focuses on EAP Practitioners employed in organisational settings. EAP Practitioners are not only limited to the psychological health profession, but are also in medical and physical health professions, which is a further difference between previous research in this area and the current study. In addition, previous research has conceptualised work environment

at an organisational level (Levert, 1999), thus the current research conceptualises work environment at an individual level.

It is well documented in the literature that organisations in South Africa are faced with challenges and problems of HIV/Aids, substance abuse, stress, trauma, violence and other adverse impacts (Buist, 2000; Malatji, 2000; Maiden, 1999). With reference to organisations with EAPs, it is the EAP practitioner who deals with employee problems, which can impede the latter's work (Hosie, West and Mackey, 1993). In addition, it is possible that the nature of the EAP practitioner's role may also have adverse impacts on the wellbeing of the practitioners, such as stress, burnout and compassion fatigue. However, research on the wellbeing of EAP practitioners in the South African workplace context is scant.

The adverse impact that EAP practitioners experience in the workplace due to stress experienced from employee problems, go beyond losses to the organisation and effectiveness of the EAP, which have been the focus of EAP research (Harlow, 1998). They influence the psychological and physical health of EAP practitioners, and more importantly their quality of working life, within and outside the work environment (Sammut, 1997 cited in Levert, 1999: 34). Hence, the inclusion of the concept of compassion fatigue in the current study, which is argued to influence the overall quality and quantity of an individual's life (Figley, 1995).

Furthermore, compassion fatigue has traditionally been studied in the area of trauma and trauma counselling (Figley, 1995; Ortlepp, 1998). Other research has shown that counsellors working with clients, who are not traumatised in terms of the Post-Traumatic Stress Disorder (PTSD) classification, show symptoms of secondary traumatisation (Catherall, 1995; Pearlman and Mac Ian, 1994; Sexton, 1999). The current research, studies compassion fatigue outside the traditional perspective and argues that EAP practitioners are 'broad brush', which implies that they provide services in a wide range of areas including but not limited to trauma. Thus the current research both challenges and adds to literature from studying compassion fatigue outside the traditional trauma perspective.

2.10 Research Hypotheses

On the basis of the ideas and arguments presented in the literature, and results presented from previous empirical research in the area of secondary traumatic stress and/or compassion fatigue, work environment (job control, workload and collegial support) and sense of coherence, the following four hypotheses and sub-hypotheses were set.

Hypothesis 1: There is a relationship between Work Environment (job control, workload, collegial support) and Compassion Fatigue.

Hypothesis 1a: There is a negative relationship between job control and compassion fatigue.

Hypothesis 1b: There is a positive relationship between workload and compassion fatigue.

Hypothesis 1c: There is a negative relationship between collegial support and compassion fatigue.

Hypothesis 2: There is a relationship negative between Sense of Coherence and Compassion Fatigue.

Hypothesis 3: There is a relationship between Work Environment (job control, workload, collegial support) and Sense of Coherence.

Hypothesis 3a: There is a positive relationship between job control and sense of coherence.

Hypothesis 3b: There is a negative relationship between workload and sense of coherence.

Hypothesis 3c: There is a positive relationship between collegial support and sense of coherence.

Hypothesis 4: Sense of Coherence moderates the relationship between work environment variables (job control, workload and collegial support) and compassion fatigue.

Hypothesis 4a: Sense of Coherence moderates the relationship between job control and compassion fatigue.

Hypothesis 4b: Sense of Coherence moderates the relationship between workload and compassion fatigue.

Hypothesis 4c: Sense of Coherence moderates the relationship between collegial support and compassion fatigue.