EMOTIONAL INTELLIGENCE, COPING AND HEALTH OF NON-PROFESSIONAL COUNSELLORS

Juanca Aucamp, Hons. (BA)

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Study Leader: Dr W.J. Coetzer

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REMARKS

The reader is reminded of the following:

- The editorial style as well as the reference used in this mini-dissertation follow the format prescribed by the Publication Manual (5th edition) of the American Psychological association (APA). This practice is in line with the policy of the Programme in Industrial Psychology of the North-West University (Potchefstroom) to use APA in all scientific documents as from January 1999.

- The mini-dissertation is submitted in the form of a research article. The editorial style specified by the South African Journal of Industrial Psychology (which agrees largely with the APA style) is used, but the APA guidelines were followed in the constructing tables.

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ABSTRACT

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Key terms: Emotional intelligence, coping, health, well-being, non-professional counsellors

Apart from the exceptional landscapes, ideal weather, cultural diversity and other characteristics that typify South Africa, crime and HIV/AIDS are two of the most pressing phrases linked to our country. Victims of crime are at high risk of suffering from post-traumatic stress disorder. Many interventions have been initiated by the government to assist victims in overcoming the effects of crime, HIV/ AIDS and other social health problems on an emotional level, one of which is counselling. The paradigm shift from curing towards caring for HIV/AIDS positive individuals increased the demand for non-professional counsellors. However, without acquiring critical skills and attributes such as emotional intelligence, coping skills and so forth during a professional training programme, non-professional counsellors are at higher risk of suffering from secondary stress disorder. A neglected area as far as non-professional counsellors is concerned, is the well-being of the counsellors. It therefore becomes necessary to conduct research on the health of non-professional counsellors.

The objective of this research was to determine the relationship between emotional intelligence, coping and health of non-professional counsellors in the North-West and Gauteng provinces. A cross-sectional survey design with an availability sample (N = 172) was taken from clinics and institutions where counselling was provided to victims of HIV/AIDS and social problems in the North-West and Gauteng Provinces. The Emotional Intelligence Scale, COPE and Health Subscale of the ASSET were used as measuring instruments.

The factor analysis confirmed two factors for emotional intelligence, consisting of emotion expression and appraisal and emotion utilisation. Four factors were confirmed for coping, namely approach coping, avoidance, turning to religion and seeking emotional support. Health was found to comprise psychological health and physical health. Pearson product-moment correlation coefficients were used to specify the relationships between the variables.

Results showed a statistically significant positive correlation between emotion expression and appraisal, emotion utilisation, as well as approach to coping and seeking emotional support. Emotion utilisation was statistically significantly positively correlated with seeking emotional support. Approach to coping was statistically significantly positively correlated with seeking emotional support, while avoidance was statistically significantly positively correlated with physical health. Turning to religion was statistically significantly positively correlated with seeking emotional support, and psychological health was statistically significantly positively correlated with physical health.

Multiple regression analyses showed that nine per cent of the variance in psychological health was predicted by emotion expression, appraisal and emotion utilisation, whereas 19 per cent of the variance in psychological health was predicted by emotional intelligence and approach to coping strategies. The only significant predictors of psychological health were emotion utilisation and avoidance. Furthermore, the multiple regression analyses also showed that 15 per cent of the variance in physical health was predicted by emotion expression and appraisal, emotion utilisation, approach coping, avoidance, turning to religion and seeking emotional support. The only significant predictor of physical health was avoidance.

Recommendations were made for future research.

OPSOMMING

Titel: Emosionele intelligensie, coping-strategieë en gesondheid van nie-professionele beraders

Sleuterterme: Emosionele intelligensie, coping-strategieë, gesondheid, welstand, nie-professionele beraders

Bo en behalwe die uitsonderlike natuurlewe, ideale weersomstandighede, kulturele diversiteit en ander eienskappe wat Suid Afrika tipeer, is geweld en MIV/VIGS twee van die algemeenste woorde wat met hierdie land geassosieer word. Slagoffers van misdaad dra die risiko om aan post-traumatise stressversteuring te lei. Talle intervensies is geïnisieer deur die regering om slagoffers te help om die effek van geweld, MIV/VIGS en ander sosiale gesondheidsprobleme op 'n emosionele vlak te oorkom. Een van hierdie inisiatiewe is berading. Die paradigmaskuif vanaf genesing na versorging van MIV/VIGS-individue verhoog die aanvraag na nie-professionele beraders. Die feit dat daar nie kritiese vaardighede en vermoëns soos emosionele intelligensie, coping-vaardighede, en dies meer oorgedra word tydens 'n professionele opleidingsprogram nie, veroorsaak dat nie-professionele beraders 'n hoër risiko loop om aan 'n sekondêre stressiekte te ly. Min aandag word egter geskenk aan die algehele gesondheidstoestand en welstand van nie-professionele beraders en dit dra by tot die noodsaaklikheid van hierdie navorsing.

Die doelwit van hierdie navorsing is om die verhouding tussen emosionele intelligensie, coping-strategieë en gesondheid van nie-professionele beraders in die Noordwes- en Gautengprovinsies te bepaal. 'n Dwarsdeursnee-opname-ontwerp met 'n beskikbaarheidsteekproef (N = 172) is geneem by klinieke en instansies waar berading aangebied word vir slagoffers van MIV/VIGS en ander sosiale probleme in die Noordwes- en Gautengprovinsies. Die Emosionele Intelligensieskaal, COPE en Gesondheidsubskaal van die ASSET is gebruik as meetinstrumente.

Faktoranalise het twee faktore vir emosionele intelligensie bevestig, wat bestaan het uit emosionele uitdrukking en waardering, en emosionele benutting. Vier faktore is bevestig vir coping, en dit is benaderings tot coping, vermyding, mense wat hulle wend tot geloof en

soeke na emosionele bystand. Daar is gevind dat welstand saamgestel is uit psigologiese welstand en fisiese welstand.

Die Pearson produk-momentekorrelasiekoëffisiënt is gebruik om die verhouding tussen veranderlikes te spesifiseer. Resultate het getoon dat daar 'n statisties-beduidende korrelasie bestaan tussen emosionele uitdrukking en vergoeding, emosionele gebruik, asook benadering tot coping-strategieë en soeke na emosionele bystand. Emosionele gebruik is statisties-beduidend positief gekorreleer met soeke na emosionele bystand en benadering tot coping-strategieë is statisties-positief gekorreleer met die soeke na emosionele bystand. Vermyding is statisties-beduidend positief gekorreleer met fisiese gesondheid, terwyl mense wat hulle wend tot geloof statisties-beduidend positief gekorreleer is met die soeke na emosionele bystand. Psigologiese gesondheid is statisties-beduidend positief gekorreleer met fisiese gesondheid.

Meervoudige regressie-analises het getoon dat nege persent van die variansie in psigologiese welstand voorspel is deur emosionele uitdrukking, waardering en emosionele benutting, waar 19 persent van die variansie van psigologiese welstand voorspel is deur emosionele intelligensie en coping-strategieë. Die enigste betekenisvolle voorspeller van psigologiese welstand was emosionele benutting en vermyding. Hierdie analise toon ook dat 15 persent van die variansie in fisiese welstand voorspel is deur emosionele uitdrukking en waardering, emosionele benutting, benadering tot coping, vermyding, wend tot geloof, en soeke na emosionele bystand. Die enigste beduidende voorspeller van fisiese welstand was vermyding.

Aanbevelings is gemaak vir toekomstige navorsing.

CHAPTER 1

INTRODUCTION

This mini-dissertation focuses on emotional intelligence, coping and health of non-professional counsellors.

Chapter 1 contains the problem statement, research objectives and research methodology that were used. The chapter starts out with a problem statement, giving an overview of previous related research conducted on emotional intelligence, coping and health among non-professional counsellors, linking it to the objectives set for this research project. A discussion of the research method follows, with details regarding the empirical study, research design, participants, measuring instruments and statistical analyses. It concludes with a chapter summary and an overview of the chapters that comprise this mini-dissertation.

1.1 PROBLEM STATEMENT

The significant increase of HIV/Aids infections poses a threat to the social development of South Africa. Statistics indicated that at the end of 2003, an estimated number of 5,1 million adults were globally affected with HIV/Aids (Ministry of Health, 2004). An estimated 29,5% of pregnant women were living with HIV (Ministry of Health, 2004) with the most affected living in KwaZulu-Natal, Gauteng and Mpumalanga. In Gauteng alone, the number of pregnant women affected increased from 29,4% in 2000 to 33,1% in 2004, and in the North-West, these numbers increased from 22,9% in 2000 to 26,7% in 2004 (Ministry of Health, 2004). Until 1998, South Africa had one of the fastest expanding epidemics in the world, but the level of HIV prevalence is now growing more slowly (Ministry of Health, 2004).

The nature of HIV/AIDS requires a paradigm shift from curing towards caring - since there is no cure for HIV/AIDS, and interventions have to be adjusted to care for the physical, as well as the psychological well-being of the HIV-positive individual and his or her significant others (Van Dyk, 2001). The increase in HIV/Aids infections resulted in an increasing demand for counselling of people with HIV/Aids along with their families. This, together with the increase in social health problems and crime such as drug abuse, violence and robberies on the one hand, and the limited supply of professionally trained counsellors on the

other hand (Du Plessis, 1986), have resulted in an increased utilisation of non-professional counsellors.

Non-professional counsellors are crisis workers, defined as front-line first responders to whom potential exposure to occupational trauma is a fact of daily life (Beaton & Murphy, 1995). Most non-professional counsellors are volunteers who provide their services on a part-time basis without receiving financial remuneration. They do not even participate in a formal selection procedure (Wilson, 1998). They receive some form of short-term training in a specific field and do not necessarily have a formal qualification. People who have not received formal clinical training in professional programmes of psychology, psychiatry, social work, and psychiatric nursing are also considered to be non-professional counsellors (Krupenia, 1984). This system has been in place for a number of decades (Fourie, 2004), and non-professional counsellors work under a variety of job titles, such as community support worker, human services worker, social work assistant, alcohol or drug counsellor, child care worker, community outreach worker, and case manager.

Non-professional counsellors have been shown to have a positive influence in the human service field (McClam, 2002), but are, however, exposed to high levels of stress, anxiety and other psychological problems (Slaski & Cartwright, 2002). They often encounter situations where clients/victims are emotionally traumatised and they work directly with victims and survivors of catastrophic events, something that poses a psychological threat to the caregiver. The engagement in therapeutic work with trauma survivors can, and does, impact on the counsellor (Figley, 1995). Research also indicates that these helpers are subjected to stressors which can produce an array of psychological, social, and physical reactions, and even burnout (Everley, 1995). Specific stress experienced by counsellors is called secondary traumatic stress (STSD) and stress disorder (STS) or compassion stress and fatigue (Dutton & Rubinstein, 1995; Figley, 1995). Compassion fatigue is a state of tension and preoccupation with traumatised patients by re-experiencing traumatic events, avoidance/numbing of reminders, and persistent arousal (e.g. anxiety) associated with the patient (Dutton & Rubinstein, 1995).

Common stressors amongst human service workers are poor working conditions, lack of control, poor social relations and a lack of social support, work overload, lack of rewards and

monotonous work (Oginska-Bulik, 2005). Schaufeli and Enzmann (1998) also make a distinction between two types of stressors experienced by the helping profession, namely job-related stressors and client-related stressors. Job-related stressors refer to the working conditions under which non-professional counsellors work (e.g. lack of job security). This also includes system-related stressors such as low pay, temporary positions, poor working conditions, and low employee status (Schaufeli & Enzmann, 1998). Client-related stressors refer to the confrontation non-professional counsellors have with death and the dying (Schaufeli & Enzmann, 1998). Oginska-Bulik (2005) mentions that stress among human service workers can also be a result of clients' behaviour, which can be demanding and aggressive.

The work of non-professional counsellors is linked with emotional experiences (Oginska-Bulik, 2005), and specifically the expression of emotions (either positive or negative) towards the client. Oginska-Bulik (2005) mentions that emotional dissonance, which applies to the frequency of having displayed emotions (usually positive) that are not in line with those genuinely felt (neutral or negative) is perceived as very stressful; for example, smiling at a difficult client may create emotional dissonance. It is also mentioned that frequent experiences of emotional dissonance lead to a loss of the capability to regulate one's own emotions, which means the loss of a particular internal resource. On the other hand, the ability to recognise people's emotions and to regulate one's own emotions seems to be very important in human service work (Oginska-Bulik, 2005). This particular ability is called emotional intelligence and has been introduced by Salovey and Mayer (1990).

Emotional intelligence is the ability to perceive, appraise, and express emotions accurately; the ability to access and generate feelings when they facilitate thought; the ability to understand emotion and emotional knowledge; and the ability to regulate emotions to promote emotional and intellectual growth (Salovey & Mayer, 1995). Emotional intelligence is also defined as the array of non-cognitive capabilities, competencies and skills that influences a person's ability to succeed in coping with environmental demands and pressures (Bar-On, 1996). Emotional intelligence adds another dimension to human intelligence. Cognitive intelligence has dominated work in the area of intelligence and refers to the capacity of an individual to understand, learn, recall, think rationally, solve problems and apply learning (Kaplan & Sadock, 1991). Emotional intelligence, on the other hand, recognises the personal and social dimensions of intelligence (Bar-On, 1997). Emotional

intelligence also helps to account for the individual differences observed in the responses to stressful encounters and the individual's general sense of health and well-being (Gerits, Derksen, & Verbruggen, 2004).

Mayer and Salovey (1995) indicate that the regulation of disturbed feelings and emotions can lead to poorer health if an individual does not process the relevant emotional information. In demanding and challenging environments, such as those of non-professional counsellors, emotional intelligence influences the selection and control of coping strategies for use within the immediate situation (Matthews & Zeidner, 2000). Emotional intelligence can thus be used to select and control coping strategies.

Law (2004) found that emotional intelligence is a better predictor of active coping and problem-solving than sense of coherence. Coping has been conceptualised as an individual's pattern of response to external negative events (Carver, Scheier, & Weintraub, 1989). Kleinke (1991, p.3) defines coping as, "the efforts we make to manage situations we have appraised as potentially harmful or stressful". The definition of coping has three key features: (1) it implies that coping involves a certain amount of effort and planning; (2) the definition does not imply a positive outcome; (3) the definition emphasises coping as a process, taking place over time (Kleinke, 1991). Coping also refers to perceptual, cognitive or behavioural responses that one uses to manage, avoid or control situations that could be regarded as difficult (Zeidner & Endler, 1996). Active coping, on the one hand, is more adaptive, and refers to active steps to change a stressful situation or to ameliorate its effects, including both emotion and problem-focused strategies (Kleinke, 1991). Passive coping, on the other hand, is less adaptive, and refers to giving up, avoiding, or inhibiting an active response (Kleinke, 1991).

Poor processing of emotional information is similar to denial and avoidance as described in literature on traumatic stress (Hunt & Robbins, 2001). Individuals who process emotional information deal with the traumatic memories through a process of narrative development, and the memories become easier to deal with. Individuals who use avoidance, on the other hand, tend to steer clear of situations which remind them of the traumatic event and do not deal with their traumatic memories; memories which may then return to active memory at some point in future (Hunt & Robbins, 2001). Processing information is generally a more effective coping strategy than avoidance.

Coping, according to Lazarus (1993), refers to the thoughts and behaviours used to manage the internal and external demands of situations that are appraised as stressful (Folkman & Moskowitz, 2004). Lazarus and Folkman (1984) identified two forms of coping, namely problem-focused coping and emotion-focused coping. Problem-focused coping is the attempt to understand and define a problem and to work out possible solutions. This strategy can be outer-directed or inner-directed. Outer-directed strategies are oriented towards altering the situation or the behaviours of others (Lazarus & Folkman, 1984). Inner-directed coping strategies include the efforts we make to reconsider our attitudes and needs and to develop new skills and responses. Emotion-focused coping strategies refer to managing emotional distress. These strategies include physical exercise, mediation, expressing feelings, and seeking support (Kleinke, 1991).

Individuals employing coping efforts characterised by problem-focused coping suffer from less psychological distress at lower to moderate stress levels (Wang & Yeh, 2005). On the other hand, the greater the perceived stress, the more emotion-focused coping behaviours may be needed (Wang & Yeh, 2005). Results also indicate that the use of avoidance and emotional disturbance behaviour might reduce individual's ability to reduce distress, therefore making the subject more vulnerable to its negative consequences (Wang & Yeh, 2005).

Stress at work has an effect on physical health, well-being, and life expectancy (Figley, 1995). Negative consequences of not being able to cope effectively with stress can also affect physical health (e.g. high blood pressure, headaches, indigestion, fatigue, insomnia, etc.), psychosocial health (e.g. anxiety, irritability, anger, depression, mood swings, hypersensitivity, etc.) and behavioural health (e.g. smoking, overeating, loss of appetite, increased use of alcohol or drugs, isolation, impatience, etc.) (Figley, 1995).

Optimal health is defined as a feeling of well-being, an ability to cope with the demands of life, physical and mental fitness, and freedom from disease and disability (Love, Gardner, & Legion, 1997). Different dimensions of health include the physical or nutritional dimension, intellectual well-being, interpersonal or social wellness, emotional wellness, spiritual wellness, occupational wellness and environmental wellness (Love, et al., 1997).

Research has indicated that emotional intelligence has an influence on stress and affects mental health such as depression, hopelessness and suicide ideation (Ciarrochi, Deane, & Anderson, 2002). Oginska-Bulik (2005) also found in her study that employees reporting high emotional intelligence perceived lower levels of occupational stress and suffered less from negative health outcomes. It seems that emotional intelligence plays the buffering role in preventing workers from negative health outcomes, especially from depression symptoms.

Since non-professional counsellors are rapidly growing in numbers due to an increasing demand, it is necessary to look after their well-being in order to help them to help others. No results focusing on the relationship between emotional intelligence, coping and health of non-professional counsellors in the South-African context could be obtained. It is therefore the objective of this research to determine whether such a relationship does exist.

This research will attempt to answer the following questions:

- How are emotional intelligence, coping strategies and health conceptualised in the literature?
- What is the relationship between emotional intelligence, coping strategies and health, according to the literature?
- How valid and reliable are the measuring instruments of emotional intelligence, coping strategies and health for non-professional counsellors?
- What is the relationship between emotional intelligence, coping strategies and health of non-professional counsellors?
- Does the experience of emotional intelligence and positive coping strategies result in lower levels of psychological and physical (ill) health in a sample of non-professional counsellors?
- What are the differences in emotional intelligence, coping strategies and health experienced, based on certain demographic factors?

1.2 RESEARCH OBJECTIVES

The research objectives are divided into a general objective and specific objectives.

1.2.1 General objectives

The general objective of this research is to determine the relationship between emotional intelligence, coping and health of non-professional counsellors.

1.2.2 Specific objectives

The specific research objectives are:

- To conceptualise emotional intelligence, coping strategies and health from the literature.
- To determine the relationship between emotional intelligence, coping strategies and health according to the literature.
- To determine the validity and reliability of the measuring instruments of emotional intelligence, coping strategies and health for non-professional counsellors in the North-West and Gauteng provinces.
- To determine the relationship between emotional intelligence, coping strategies and health in a sample of non-professional counsellors.
- To determine whether higher levels of emotional intelligence and positive coping strategies will result in lower levels of psychological and physical (ill) health in a sample of non-professional counsellors.
- To determine the differences in emotional intelligence, coping strategies and health experienced, based on certain demographic factors.
- To make recommendations for future research.

1.3. RESEARCH METHOD

The research method consists of a literature review and an empirical study. The results obtained from the research are presented in the form of a research article.

1.3.1 Literature review

A literature study will be undertaken to gather information on emotional intelligence, coping strategies and health of non-professional counsellors.

1.3.2 Research design

A cross-sectional survey design will be used to collect the data and to attain the research objectives. Cross-sectional survey designs are used to examine groups of subjects in various stages of development simultaneously (Burns & Grove, 1993) over a short period of time, which can vary from one day to a few weeks (Du Plooy, 2001). The survey is a data-collection technique in which questionnaires are used to gather data about an identified population. This design is also used to assess interrelationships among variables within a population (Shaughnessy & Zechmeister, 1997). The cross-sectional survey design is best suited to address the descriptive and predictive functions associated with the correlational design, whereby relationships between variables are examined.

1.3.3 Participants

The study population will consist of non-professional counsellors in especially the HIV/Aids-and-trauma-counselling environment. A non-probability or convenient sampling technique will be used, which means that every element in the population has a known non-zero probability of selection (Struwig & Stead, 2001).

1.3.4 Measuring battery

Three questionnaires will be administered to measure emotional intelligence, coping and health. A biographical questionnaire will be included in order to describe the population.

The Emotional Intelligence Scale (EIS) (Schutte et al., 1998) assesses perception, understanding, expression, regulation and harnessing of emotions in the self and others. The brevity of the scale and its accumulating reliability and validity evidence make this scale a reasonable choice for those who are seeking a brief self-report measure of global emotional intelligence. The model of Emotional Intelligence of Salovey and Mayer (1990) provides the

conceptual foundation of the items used in this scale. A factor analysis of a larger pool of items suggested a one-factor solution of 33 items. The 33-item scale showed evidence of predictive validity, where college students' emotional intelligence scores predicted their end-of-the-year grade average. Potential uses of this scale involve exploring the nature of emotional intelligence, including the determinants of Emotional Intelligence, the effects of emotional intelligence and whether emotional intelligence can be enhanced (Schutte et al., 1998). Research done by Vosloo (2005) within South African groups indicated a six-factor structure with alpha coefficients ranging from 0,54 to 0,73.

The COPE Questionnaire (COPE) (Carver et al., 1989) will be used to determine participants' coping strategies. The COPE is a multidimensional coping questionnaire that indicates the different ways in which people cope under different circumstances (Carver et al., 1989). It measures 13 different coping strategies. There are five subscales that measure different aspects of problem-focused coping: Active Coping (AC), Planning (P), Suppressing of Competing Activities (SCA), Restraint Coping (RC) and Seeking Social Support for Instrumental Reasons. Another five subscales measure aspects of emotionally focused coping: Seeking Social Support for Emotional Reasons, Positive Reinterpretation and Growth, Acceptance, Denial, and Turning to Religion. Four subscales measure coping responses that are used less frequently: Focus on and Venting of Emotions, Behavioural Disengagement, Mental Disengagement and Alcohol-Drug Disengagement (Carver et al., 1989). Carver et al. (1989) reported Cronbach alpha coefficients varying from 0,46 to 0,86 and from 0,42 to 0,89 (applied after two weeks). Research done by Du Toit (1999) specifically with South African groups found acceptable validity for the COPE scale.

The Health Subscales of ASSET (which stands for 'An Organisational Stress Screening Evaluation Tool') were developed by Cartwright and Cooper (2002) to assess respondents' level of health. The Health Subscales consist of 19 items arranged on two subscales: Physical Health and Psychological Well-Being. All items on the Physical Health subscale relate to physical symptoms of stress. The role of this subscale is to provide insight into physical health, not an in-depth clinical diagnosis. The items listed on the Psychological Health subscale are symptoms of stress-induced mental ill health. Johnson and Cooper (2003) found that the Psychological Health subscale has good convergent validity with an existing measure of psychiatric disorders, the General Health Questionnaire (GHO-12; Goldberg & Williams, 1998). Coetzer (2004) obtained the following Cronbach alpha coefficients among a sample of

613 employees in an insurance company in South Africa: Physical Health 0,79 and Psychological Health 0,89. Van der Linde (2004) found the following results among a sample of protection officers: Physical Health 0,81 and Psychological Health 0,88.

A *biographical questionnaire* will be developed to gather information concerning the demographic characteristics of the participants. Information gathered will include age, gender, race, home language, education, marital status and years employed in current position.

1.3.5 Statistical analysis

The statistical analysis will be carried out with the help of the SPSS-programme (SPSS Inc., 2007). Descriptive statistics (e.g. means, standard deviations, skewness and kurtosis) will be used to analyse the data. Cronbach alpha coefficients will be used to determine the internal consistency, homogeneity and un-dimensionality of the measuring instruments (Clark & Watson, 1995). Coefficient alpha contains important information regarding the proportion of variance of the items of a scale in terms of the total variance explained by that particular scale.

Pearson product-moment correlation coefficients will be used to specify the relationships between the variables. In terms of statistical significance, it is decided to set the value at a 95% confidence interval level ($p \leq 0,05$). Effect sizes (Steyn, 1999) will be used to determine the practical significance of the findings. A cut-off point of 0,30 (medium effect, Cohen, 1988) is set for the practical significance of correlation coefficients.

Stepwise multiple regression analyses will be conducted to determine the percentage variance in the dependent variables that is predicted by the independent variables. The effect size (which indicates practical significance) in the case of multiple regressions are given by the following formula (Steyn, 1999):

$$f^2 = R^2 / 1 - R^2$$

A cut-off point of 0,35 (large effect, Steyn, 1999) was set for the practical significance.

Multivariate analysis of variance (MANOVA) will be used to determine the significance of differences between the levels of emotional intelligence, coping strategies and health of demographic groups. MANOVA tests whether or not mean differences among groups in a combination of dependent variables are likely to have occurred by chance (Tabachnick & Fidell, 2001). In MANOVA, a new dependent variable that maximises group differences was created from the set of dependent variables. Wilk's Lambda will be used to test the likelihood of the data, on the assumption of equal population mean vectors for all groups, against the likelihood on the assumption that the population mean vectors are identical to those of the sample mean vectors for the different groups. When an effect is significant in MANOVA, one-way analysis of variance (ANOVA) will be used to discover which dependent variables have been affected. Seeing that multiple ANOVA's will be used, a Bonferroni-type adjustment will be made for an inflated Type I error. Tukey tests will be done to indicate which groups differed significantly when ANOVA's were performed.

1.4 DIVISION OF CHAPTERS

The roll-out of chapters in this mini-dissertation will be as follows:
Chapter 1: Introduction
Chapter 2: Research article
Chapter 3: Conclusions, limitations and recommendations

1.5 CHAPTER SUMMARY

Within this chapter an overview was given of the problem statement and research objectives. The measuring instruments and research method that will be used in this research were explained, followed by a brief overview of the chapters that will follow.

The empirical study will be discussed in Chapter 2, and conclusions, limitations and recommendations will be highlighted in Chapter 3.

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CHAPTER 2

RESEARCH ARTICLE

EMOTIONAL INTELLIGENCE, COPING AND HEALTH OF NON-PROFESSIONAL COUNSELLORS

J Aucamp

WorkWell: Research Unit for People, Policy and Performance, Faculty of Economic and Management Sciences, North-West University (Potchefstroom Campus)

ABSTRACT

The objective of this study was to determine the relationship between emotional intelligence, coping, and health of non-professional counsellors. A cross-sectional survey design with an availability sample (N = 172) was taken from clinics and institutions where counselling was provided to victims of HIV/AIDS and social problems in the North-West and Gauteng Provinces. The Emotional Intelligence Scale, COPE and Health Subscale of the ASSET were used as measuring instruments. Results showed that emotional utilisation, approach coping and seeking emotional support were related to emotional expression and appraisal. Emotion utilisation was related to seeking emotional support. Approach coping was shown in the results to be related to seeking emotional support. Avoidance was related to physical health. The results also indicated that turning to religion was related to seeking emotional support. Psychological health was correlated positively with physical health.

OPSOMMING

Die doelwit van hierdie studie was om die verhouding tussen emosionele intelligensie, copingstrategieë, en welstand van nie-professionele beraders vas te stel. 'n Dwarsdeursnee-opname-ontwerp met 'n beskikbaarheidsteekproef (N = 172) is geneem van klinieke en instansies wat berading bied aan persone met MIV/VIGS asook ander sosiale probleme in die Noordwes- en Gautengprovinsies. Die Emosionele Intelligensieskaal, COPE en Gesondheidsubskaal van die ASSET is as meetinstrumente gebruik. Resultate het getoon dat emosionele verbruik, benaderingcopingstrategie en soeke na emosionele bystand verwant is aan emosionele uitdrukking en vergoeding. Emosionele gebruik het verband gehou met soeke na emosionele bystand. Benaderingcopingstrategie is in die resultate getoon om verband te hou met soeke na emosionele bystand. Vermyding is verwant aan fisiese gesondheid. Die resultate het getoon dat wending tot geloof verwant is aan soeke na emosionele bystand. Psigologiese gesondheid het positief gekorreleer met fisiese gesondheid.

Violent crime and trauma are currently normative within South African society (Hamber & Lewis, 1997). Being perceived as a violent country, murder, rape, armed robbery and muggings occur with extreme frequency (Newman, 1999). An average of 25 000 murders are committed every year in South Africa (Newman, 1999), implying a ratio of 57 murders per 100 000 people. Compared to the international average, 5 murders per 100 000 people, this is problematic. Further research indicated that over a period of five years, 70 per cent of the urban population in South Africa was victimised at least once (Van Dijk, 1996). The experience of being violently victimised has become a statistically normal feature of everyday life (Hamber & Lewis, 1997).

Whilst coping with trauma patients, the serious increase of HIV/AIDS infections also poses a threat to the social development in South Africa. Statistics indicated that at the end of 2003, an estimated number of 5,1 million adults were globally affected with HIV/AIDS (Ministry of Health, 2004). In 2004, an estimated 29,5% of pregnant women were living with HIV (Ministry of Health, 2004) with the most affected living in KwaZulu-Natal, Gauteng and Mpumalanga. In Gauteng alone, the number of pregnant women affected increased from 29,4% in 2000 to 33,1% in 2004 and in the North-West these numbers increased from 22,9% in 2000 to 26,7% in 2004 (Ministry of Health, 2004). Until 1998, South Africa had one of the fastest expanding epidemics in the world, but the level of HIV prevalence is now growing more slowly (Ministry of Health, 2004).

Counselling has become an essential aspect of dealing with HIV/AIDS and crime-related trauma in South Africa, and the need for counsellors is increasing parallel to the figures of HIV/AIDS and crime. The National Crime Prevention Strategy (NCPS) (Camerer, 2003) supports the initiative of providing counselling to victims of crime since it may actually serve to reduce the effects of crime on the victim. In the field of HIV/AIDS, the counsellor's role is requested when healthcare personnel are required to inform a patient of his or her status. Conveying such status alone is not sufficient, as it is also necessary to discuss things such as protecting sexual partners and unborn babies, and high-risk behaviours (such as drug abuse). It is critical to provide patients with knowledge about their disease. Pre-test counselling is also provided to an individual before an HIV test, to ensure that the individual has sufficient information to make an informed decision regarding having an HIV test (Department of Health, 1997). In other words, not only does a counsellors' services become requisite when an individual has difficulty coping with an unwanted status, but also before tests are carried

out. Counsellors work with individuals, in a private and confidential setting, to explore feelings of distress, or dissatisfaction with life. They provide a safe environment, empathy and encouragement to clients to think clearly about their situation and perhaps consider a new viewpoint (Department of Health, 1997). Counsellors do not provide clients with advice or direct or force a client to a solution, but rather assist them to choose freely a way forward by reducing confusion and promoting understanding of their outlook and behaviour. According to the Department of Health (1997), there is a range of methods or types of counselling, each with its own theoretical basis such as:

1. Professionally trained counsellors;
2. Professionals who do counselling as a component of their other major occupational responsibilities;
3. Non-professional paid full-time or part-time lay counsellors; and
4. Non-professional volunteers and community-based workers.

Non-professional counsellors are crisis workers defined as front-line first responders to whom potential exposure to occupational trauma is a fact of daily life (Beaton & Murphy, 1995). Most non-professional counsellors are volunteers who provide their services on a part-time basis without receiving financial remuneration. They do not even participate in a formal selection procedure (Wilson, 1998). They receive some form of short-term training in a specific field and do not necessarily have a formal qualification. People who have not received formal clinical training in professional programmes of psychology, psychiatry, social work, and psychiatric nursing are also considered to be non-professional counsellors (Krupenia, 1984). Being in place for a number of decades (Fourie, 2004), non-professional counsellors work under a variety of job titles, i.e. community support worker, lay counsellors, human services worker, social work assistant, alcohol or drug counsellor, child care worker, community outreach worker, and case manager. Since non-professional counsellors indirectly assist professional counsellors in dealing with trauma and HIV/AIDS, and given that South Africa does not have an adequate number of counsellors to deal with social health problems, non-professional counsellors are exposed to the same emotionally challenging situations as professional counsellors. The difference is that they do not have access to the same resources as professional counsellors.

The following differences between professional counsellors and non-professional/lay counsellors were identified (Wilson, 1998):

- Lay counsellors are usually volunteers who receive no or little financial remuneration for their services;
- Lay counsellors generally provide their services on a part-time basis only;
- Lay counsellors normally receive some form of short-term training in a specific field, whereas professional therapists are required to complete a formal qualification; and
- Lay counsellors are volunteers, while professional therapists are required to go through a selection process prior to completing their qualifications.

Furthermore, research shows that caring for people who have experienced stressful or negative life events puts the caregivers at risk for developing stress-related symptoms similar to those of the victims (Barnes, 1998; Figley, 1995). This phenomenon is called secondary traumatic stress (STS), also known as compassion fatigue, and is a result of caregivers' vicarious exposure to traumatic events through contact with the victims. STS is almost identical to posttraumatic stress disorder (PTSD) except that STS is an indirect exposure to a traumatic event whereas with PTSD the traumatic event is directly experienced (Figley, 1995). Symptoms associated with STS are feelings of exhaustion and hopelessness, health problems, paranoia, and early burnout (Hamber & Lewis, 1997). Emotional and relationship problems and substance abuse may also occur amongst victims of STS. Individuals who suffer from STS can act out victim-aggressor patterns or over-identify with victims (Hamber & Lewis, 1997). Danieli (1985) suggested that the source of the negative emotions arising in therapists as the result of dealing with a clients' victimisation is the nature of victimisation itself.

STS or compassion fatigue poses a problem in that non-professional counsellors may be reluctant to identify themselves as suffering from symptoms of secondary traumatic stress (Boss, 1999). They usually overestimate their capacities to resist stressors inherent to counselling and underestimate their need for receiving respect and validation through others (Fourie, 2004). The consequence of not really dealing with one's own emotions and not processing emotional information is an indication of a lack of emotional intelligence.

Emotional intelligence

According to Schutte et al. (1998), there is continuing controversy over how to define and measure emotional intelligence, and how significant the concept of emotional intelligence is in predicting various aspects of life success. Two predominant viewpoints are those adopting an ability emotional intelligence approach, and those adopting a trait emotional intelligence approach. Emotional intelligence is often characterised as a cognitive ability involving the cognitive processing of emotional information (Salovey & Mayer, 1995). According to Salovey and Mayer (1995), emotional intelligence is the ability to perceive accurately, appraise, and express emotions; the ability to access and generate feelings when they facilitate thought; the ability to understand emotion and emotional knowledge; and the ability to regulate emotions to promote emotional and intellectual growth. Mayer and Salovey (1995) indicate that the regulation of disturbed feelings and emotions can lead to poorer health if an individual does not process the relevant emotional information. In demanding and challenging environments such as those of non-professional counsellors, emotional intelligence influences the selection and control of coping strategies to use within the immediate situation (Matthews & Zeidner, 2000). Emotional intelligence can thus be used to select and control coping strategies. The lack of processing emotional information is similar to denial and avoidance as described in literature on traumatic stress (Hunt & Robbins, 2001).

Four branches of emotional intelligence are identified by Mayer, Caruso and Salovey (2000), namely:

- **Emotional perception**

The ability to register, attend to and decipher emotional messages as they are expressed in a variety of contexts (e.g. facial expressions, tone of voice and acting). The person can easily sense facial expressions of irritability and can therefore manage a potentially conflicting social situation better.

- **Emotional integration**

The ability to access and generate feelings which facilitate thought by giving information about their mood state. Therefore, people are more likely to view things from an optimistic

perspective when happy, a pessimistic perspective when sad and a threat-perspective when anxious or angry.

- **Emotional understanding**

The ability to comprehend the implications of emotions, by understanding how one emotion leads to another, how emotions change over time, and how the temporal patterning of emotions can affect relationships.

- **Emotional management**

The ability to regulate one's emotions, to choose to be open to experiencing emotions and to control the way in which these are expressed.

Individuals who process emotional information deal with the traumatic memories through a process of narrative development, and the memories become easier to deal with (Hunt & Robbins, 2001). Individuals who use avoidance tend to steer clear of situations which remind them of the traumatic event and do not deal with their traumatic memories; memories which may then return to active memory at some point in the future (Hunt & Robbins, 2001). Processing information is generally a more effective coping strategy than avoidance. Coping, according to Lazarus (1993), refers to the thoughts and behaviours used to manage the internal and external demands of situations that are appraised as stressful (Folkman & Moskowitz, 2004).

Coping

Lazarus and Folkman (1984) identified two forms of coping, namely problem-focused coping and emotion-focused coping. Problem-focused coping is the attempt to understand and define a problem and to work out possible solutions. This strategy can be outer-directed or inner-directed. Outer-directed strategies are oriented toward altering the situation or the behaviours of others (Lazarus & Folkman, 1984). Inner-directed coping strategies include efforts we make to reconsider our attitudes and needs and to develop new skills and responses. Emotion-

focused coping strategies refer to managing emotional distress. These strategies include physical exercise, mediation, expressing feelings, and seeking support (Kleinke, 1991).

Individuals employing coping efforts characterised by problem-focused coping suffered less from psychological distress at lower to moderate stress levels (Wang & Yeh, 2005). On the other hand, the greater the perceived stress, the more emotion-focused coping behaviours may be needed (Wang & Yeh, 2005). Results also indicate that the use of avoidance and emotional disturbance behaviour might reduce individual ability to reduce distress therefore making the subject more vulnerable to its negative consequences (Wang & Yeh, 2005).

Common stressors amongst human service workers are poor working conditions, lack of control, poor social relations and a lack of social support, work overload, lack of rewards and monotonous work (Oginska-Bulik, 2005). Schaufeli and Enzmann (1998) also make a distinction between two types of stressors experienced by the helping professions, namely job-related stressors and client-related stressors. Job-related stressors refer to the working conditions under which non-professional counsellors work such as a lack of security. These also include system-related stressors such as low pay, temporary positions, poor working conditions, and low employee status (Schaufeli & Enzmann, 1998). Client-related stressors refer to the confrontation that non-professional counsellors have with death and the dying (Schaufeli & Enzmann, 1998). Oginska-Bulik (2005) mentions that stress among human service workers can also be a result of clients' behaviour, which can be demanding and aggressive. By coping effectively with these stressors, individuals will be more efficient in their role as counsellors with the main objective of helping victims of trauma or HIV/AIDS to cope with their situation.

Counsellors working in stressful situations need to be very attentive to their own psychological wellness since remaining healthy is as essential to the counsellor who wants to remain efficient as it is to the victim who wants to heal (Fourie, 2004). Not being able to cope effectively with stress can affect physical health (e.g. high blood pressure, headaches, indigestion, fatigue, insomnia, etc.), psychosocial health (e.g. anxiety, irritability, anger, depression, mood swings, hypersensitivity, etc.) and behavioural health (e.g. smoking, overeating, loss of appetite, increased use of alcohol or drugs, isolation, impatience, etc.) (Figley, 1995). Maslach and Jackson (1979) mentioned that those individuals doing "people work" and who spend time with clients under conditions of chronic stress and tension often

show signs of emotional, physical and occupational fatigue. This goes hand in hand with an array of feelings of helplessness and hopelessness, disillusionment, a negative self-concept, negative attitudes towards work, people and life itself (Maslach & Jackson, 1986). According to Maslach and Jackson (1986), helplessness, hopelessness, disillusionment, a negative self-concept, negative attitudes towards work, people and life itself are all symptoms of ill health and burnout which may be manifested when one experiences prolonged emotional exhaustion and stress.

Health

Optimal health is defined as a feeling of well-being, an ability to cope with the demands of life, physical and mental fitness, and freedom from disease and disability (Love, Gardner, & Legion, 1997). Different dimensions of health include the physical or nutritional dimension; intellectual well-being; interpersonal or social wellness; emotional wellness; spiritual wellness; occupational wellness and environmental wellness (Love et al., 1997).

The engagement in therapeutic work with trauma survivors can, and does, impact on the counsellor (Figley, 1995). Research indicates that these helpers are subjected to stressors which can produce an array of psychological, social, and physical reactions and even burnout (Everley, 1995). Specific stress experienced by counsellors is called secondary traumatic stress (STSD) and stress disorder (STS) or compassion stress and fatigue (Dutton & Rubinstein, 1995; Figley, 1995). Compassion fatigue is a state of tension and preoccupation with traumatised patients by re-experiencing traumatic events, avoidance/numbing of reminders, and persistent arousal (e.g. anxiety) associated with the patient (Dutton & Rubinstein, 1995).

Research has indicated that emotional intelligence has an influence on stress and affects mental health negatively, giving rise to conditions such as depression, hopelessness and suicide ideation (Ciarrochi, Deane, & Anderson, 2002). Oginska-Bulik (2005) also found that employees reporting high emotional intelligence perceived lower levels of occupational stress and suffered less from negative health outcomes. Emotional intelligence has been found to be negatively correlated with psychological distress and depression (Slaski & Cartwright, 2003). This might be because people who report high emotional intelligence are more willing to seek professional and non-professional help for personal-emotional problems, depression and

suicide ideation (Ciarrochi & Deane, 2001). It seems that emotional intelligence plays the buffering role in preventing workers from negative health outcomes, especially from depression symptoms.

Oginska-Bulik (2005) mentions that emotional dissonance, which applies to the frequency of having displayed emotions (usually positive) that are not in line with those genuinely felt (neutral or negative) is more perceived as stressful; for example, smiling at a difficult customer may create emotional dissonance. It is also mentioned that frequent experiences of emotional dissonance lead to a loss of the capability to regulate one's own emotions, which implies the loss of a particular internal resource. Mayer and Salovey (1995) indicate that the regulation of disturbed feelings and emotions can lead to poorer health if an individual does not process the relevant emotional information. In demanding and challenging environments such as those of non-professional counsellors, emotional intelligence influences the selection and control of coping strategies for use within the immediate situation (Matthews & Zeidner, 2000).

Within South Africa, no studies could be found on the relationship between emotional intelligence, coping and health, thus rendering the current study relevant.

The above-mentioned discussion leads to the following hypotheses:

H_1: There are statistically and practically significant relationships between emotional intelligence, coping and health in a sample of non-professional counsellors.

H_2: Emotional intelligence and positive coping strategies will lead to lower levels of psychological (ill) health.

H_3: Emotional intelligence and positive coping strategies will lead to lower levels of physical (ill) health.

H_4: Differences exist between demographic groups of non-professional counsellors regarding levels of emotional intelligence, coping strategies and health.

METHOD

Research design

A cross-sectional survey design was used to collect the data and to attain the research objectives. Cross-sectional designs were used to examine groups of subjects in various stages of development simultaneously (Burns & Grove, 1993) in a short period of time, which can vary from one day to a few weeks (Du Plooy, 2001). The survey is a data collection technique in which questionnaires were used to gather data about an identified population. This design was also used to assess interrelationship among variables within a population (Shaughnessy & Zechmeister, 1997). The cross-sectional research design was best suited to address the descriptive and predictive functions associated with the correlational design, whereby relationships between variables are examined.

Participants

An availability sample (N = 172) was taken from clinics and institution where counselling was provided to victims of HIV/AIDS and other social problems in the North-West and Gauteng Provinces. A total of 400 non-professional counsellors were targeted, but only 181 (45%) booklets were received back of which 172 (95%) could be used. Descriptive information of the sample is given in Table 1.

Table 1
Characteristics of Participants

Item	Category	Frequency	Percentage
Age	20-29	68	39,50
	30-39	60	34,80
	40-49	26	15,10
	50-69	11	6,50
	Missing values	7	4,10
Gender	Male	35	20,30
	Female	135	78,50
	Missing values	2	1,20
Marital status	Single	105	61,00
	Engaged	13	7,60
	Married	42	24,50
	Divorced	5	2,90

Table 1 (continue)

Characteristics of Participants

Item	Category	Frequency	Percentage
	Separated	3	1,70
	Missing values	4	2,30
Province	Gauteng	53	30,80
	North West	109	63,40
	Missing values	10	5,80
Education/ Qualification	Grade 10 and lower	7	4,10
	Grade 11	36	20,90
	Grade 12	109	63,40
	Diploma	8	4,60
	Degree	7	4,00
	Post Degree	1	0,60
	Missing values	4	2,30
Language	Afrikaans	18	10,50
	English	16	9,30
	African Languages	136	84,70
	Missing values	2	1,20

Table 1 shows that the majority of participants were single females (78,5%) between the ages of 20 and 29 (39,5%) with a Grade 12 (63,4%) qualification. A total of 63,4% of the participants reside in the North-West Province and the language spoken by most was Setswana (52,9%).

Measuring battery

Three questionnaires were administered to measure emotional intelligence, coping and health. A biographical questionnaire was also included in order to describe the population.

The Emotional Intelligence Scale (EIS) (Schutte et al., 1998) assessing perception, understanding, expression, regulation and harnessing of emotions in the self and others, was used to measure emotional intelligence. The brevity of the scale and its accumulating reliability and validity evidence made this scale a reasonable choice for those who are seeking a brief self-report measure of global emotional intelligence. The model of Emotional Intelligence of Salovey and Mayer (1990) provided the conceptual foundation of the items used in this scale. A factor analysis of a larger pool of items suggested a one-factor solution of 33 items. The 33-item scale showed evidence of predictive validity, where college

students' emotional intelligence scores predicted their end-of-the-year grade average. Potential uses of this scale involve exploring the nature of emotional intelligence, including the determinants' Emotional Intelligence, the effects of emotional intelligence and whether emotional intelligence can be enhanced (Schutte et al., 1998). Research done by Vosloo (2005) within South African groups indicated a six-factor structure with alpha coefficients ranging from 0,54 to 0,73.

The COPE Questionnaire (COPE) (Carver, Scheier, & Weintraub, 1989) was used to determine participants' coping strategies. The COPE is a multidimensional coping questionnaire that indicates the different ways in which people cope under different circumstances (Carver et al., 1989). It measures 13 different coping strategies. There are five subscales that measure different aspects of problem-focused coping: Active Coping (AC), Planning (P), Suppressing of Competing Activities (SCA), Restraint Coping (RC) and Seeking Social Support for Instrumental Reasons. Another five subscales measure aspects of emotionally focused coping: Seeking Social Support for Emotional Reasons, Positive Reinterpretation and Growth, Acceptance, Denial, and Turning to Religion. Four subscales measure coping responses that are used less: Focus on and Venting of Emotions, Behavioural Disengagement, Mental Disengagement and Alcohol-Drug Disengagement (Carver et al., 1989). Carver et al. (1989) reported test-retest reliability varying from 0,46 to 0,86 and from 0,42 to 0,89 (applied after two weeks). Research done by Du Toit (1999) specifically with South African groups found acceptable validity for the COPE scale.

The Health subscales of ASSET (which stands for 'An Organisational Stress Screening Evaluation Tool') were developed by Cartwright and Cooper (2002) to assess the respondents' level of health. The Health Subscales consist of 19 items arranged on two subscales: Physical Health and Psychological Well-Being. All items on the Physical Health subscale relate to physical symptoms of stress. The role of this subscale is to provide insight into physical health, not an in-depth clinical diagnosis. The items listed on the Psychological Health subscale are symptoms of stress-induced mental ill health. Johnson and Cooper (2003) found that the Psychological Health subscale has good convergent validity with an existing measure of psychiatric disorders, the General Health Questionnaire (GHO-12; Goldberg & Williams, 1988). Coetzer (2004) obtained the following Cronbach alpha coefficients among a sample of 613 employees in an insurance company in South Africa: Physical Health 0,79 and

Psychological Health 0,89. Van der Linde (2004) found the following results among a sample of protection officers: Physical Health 0,81 and Psychological Health 0,88.

A *biographical questionnaire* was developed to gather information concerning the demographic characteristics of the participants. Information gathered included age, gender, race, home language, education, marital status and years employed in current position.

Statistical analysis

The statistical analysis was carried out with the help of the SPSS-programme (SPSS Inc., 2007). Descriptive statistics (e.g. means, standard deviations, skewness and kurtosis) was used to analyse the data. Cronbach alpha coefficients were used to determine the internal consistency, homogeneity and un-dimensionality of the measuring instruments (Clark & Watson, 1995). Coefficient alpha contains important information regarding the proportion of variance of the items of a scale in terms of the total variance explained by that particular scale.

Pearson product-moment correlation coefficients were used to specify the relationships between the variables. In terms of statistical significance, it was decided to set the value at a 95% confidence interval level ($p \leq 0,05$). Effect sizes (Steyn, 1999) were used to determine the practical significance of the findings. A cut-off point of 0,30 (medium effect, Cohen, 1988) was set for the practical significance of correlation coefficients.

Stepwise multiple regression analyses were conducted to determine the percentage variance in the dependent variables that were predicted by the independent variables. The effect size (which indicates practical significance) in the case of multiple regressions are given by the following formula (Steyn, 1999):

$$f^2 = R^2 / 1 - R^2$$

A cut-off point of 0,35 (large effect, Steyn, 1999) was set for the practical significance.

Multivariate analysis of variance (MANOVA) was used to determine the significance of differences between the levels of emotional intelligence, coping strategies and health of

demographic groups. MANOVA tests whether or not mean differences among groups in a combination of dependent variables are likely to have occurred by chance (Tabachnick & Fidell, 2001). In MANOVA, a new dependent variable that maximises group differences was created from the set of dependent variables. Wilk's Lambda was used to test the likelihood of the data, on the assumption of equal population mean vectors for all groups, against the likelihood on the assumption that the population mean vectors are identical to those of the sample mean vectors for the different groups. When an effect was significant in MANOVA, one-way analysis of variance (ANOVA) was used to discover which dependent variables had been affected. Seeing that multiple ANOVA's were used, a Bonferroni-type adjustment was made for inflated Type I error. Tukey tests were done to indicate which groups differed significantly when ANOVA's were performed.

RESULTS

A principal component factor analysis was performed on the 33 items of the EIS on the total sample of non-professional counsellors in the North-West and Gauteng provinces. Analysis of the eigen values (larger than 1) and the scree plot indicated that two factors could be extracted, explaining 27,67% of the total variance. Next, a principle axis factor analysis was followed using a direct oblimin rotation to perform further factor analysis.

The results of the factor analysis on the EIS are indicated in Table 2. The loading of variables on factors, as well as communalities and percentage of variance, is indicated. Variables are ordered and grouped by size of loading to facilitate interpretation. Labels for each factor are suggested in a footnote.

Table 2

Factor Loadings, Communalities (h^2), Percentage Variance for Principal Factors Extraction and Direct Oblimin Rotation on the EIS Items

Item	F_1	F_2	h^2
EI2	0,68	0,00	0,39
EI1	0,57	0,00	0,40
EI6	0,52	0,00	0,23
EI25	0,52	0,00	0,32
EI24	0,52	0,00	0,36
EI14	0,49	0,00	0,29

Table 2 (continue)

Factor Loadings, Communalities (h^2), Percentage Variance for Principal Factors Extraction and Direct Oblimin Rotation on the EIS Items

Item	F_1	F_2	h^2
EI19	0,46	0,00	0,26
EI12	0,46	0,00	0,24
EI23	0,43	0,00	0,39
EI15	0,42	0,00	0,23
EI18	0,40	0,00	0,19
EI9	0,39	0,00	0,20
EI28	0,36	0,00	0,11
EI11	0,34	0,00	0,19
EI3	0,31	0,00	0,25
EI4	0,30	0,00	0,10
EI27	0,00	-0,65	0,38
EI26	0,00	-0,55	0,33
EI31	0,00	-0,45	0,35
EI17	0,00	-0,43	0,25
EI10	0,00	-0,41	0,20
EI20	0,00	-0,40	0,20
EI30	0,00	-0,40	0,27
EI21	0,00	-0,37	0,23
EI22	0,00	-0,37	0,25
EI16	0,00	-0,36	0,27
EI32	0,00	-0,33	0,14
Percentage variance explained	19,25	3,87	

F_1 Emotion Expression and Appraisal, F_2 Emotion Utilisation

Inspection of Table 2 shows that two factors were extracted, accounting for 27,67% of the total variance in the data. Variables were reasonably well defined by this factor solution. Communality values, as seen in Table 2, tended to be moderate. With a cut-off of 0,30 for inclusion of a variable in interpretation of a factor, five of the 33 items did not load on the two factors.

The first factor dealt with the expression of emotion such as knowing when to express personal emotions, compliment others when they have done something well, knowing why my emotions change and being aware of my emotions as I experience them. The first factor also dealt with the appraisal of emotions such as remembering times when faced with similar obstacles and re-evaluating what is important to me. This factor was labelled *Emotion Expression and Appraisal.* The second factor had items that related to using emotions, such as using good moods to help myself to keep trying in the face of obstacles, helping other

people feel better when they are down and being able to solve problems when I am in a good mood. This factor was labelled *Emotion Utilisation.*

A principal component factor analysis was performed on the 53 items of the COPE on the total sample of non-professional counsellors in the North-West and Gauteng provinces. Analysis of the eigen values (larger than 1) and the scree plot indicated that four factors could be extracted, explaining 33,26% of the total variance. Next, a principle axis factor analysis was followed using a direct oblimin rotation to perform further factor analysis.

The results of the factor analysis on the COPE are indicated in Table 3. The loading of variables on factors, as well as communalities and percentage of variance, is indicated. Variables are ordered and grouped by size of loading to facilitate interpretation. Labels for each factor are suggested in a footnote.

Table 3

Factor Loadings, Communalities (h^2), Percentage Variance for Principal Factors Extraction and Direct Oblimin Rotation on COPE items

Item	F_1	F_2	F_3	F_4	h^2
COPE28	0,60	0,00	0,00	0,00	0,47
COPE21	0,59	0,00	0,00	0,00	0,33
COPE43	0,57	0,00	0,00	0,00	0,47
COPE53	0,54	0,00	0,00	0,00	0,38
COPE24	0,53	0,00	0,00	0,00	0,37
COPE11	0,51	0,00	0,00	0,00	0,29
COPE23	0,49	0,00	0,00	0,00	0,33
COPE22	0,47	0,00	0,00	0,00	0,23
COPE56	0,46	0,00	0,00	0,00	0,26
COPE37	0,42	0,00	0,00	0,00	0,20
COPE55	0,39	0,00	0,00	0,00	0,22
COPE46	0,39	0,00	0,00	0,00	0,23
COPE8	0,34	0,00	0,00	0,00	0,30
COPE31	0,33	0,00	0,00	0,00	0,18
COPE26	0,32	0,00	0,00	0,00	0,18
COPE61	0,00	0,62	0,00	0,00	0,43
COPE58	0,00	0,59	0,00	0,00	0,35
COPE50	0,00	0,55	0,00	0,00	0,42
COPE32	0,00	0,55	0,00	0,00	0,36
COPE16	0,00	0,53	0,00	0,00	0,27
COPE36	0,00	0,51	0,00	0,00	0,40
COPE47	0,00	0,45	0,00	0,00	0,28

Table 3 (continue)

Factor Loadings, Communalities (h^2), Percentage Variance for Principal Factors Extraction and Direct Oblimin Rotation on COPE items

Item	F_1	F_2	F_3	F_4	h^2
COPE19	0,00	0,42	0,00	0,00	0,27
COPE60	0,00	0,38	0,00	0,00	0,23
COPE48	0,00	0,36	0,00	0,00	0,20
COPE13	0,00	0,33	0,00	0,00	0,14
COPE2	0,00	0,31	0,00	0,00	0,14
COPE12	0,00	0,00	-0,75	0,00	0,57
COPE29	0,00	0,00	-0,70	0,00	0,59
COPE59	0,00	0,00	-0,63	0,00	0,59
COPE45	0,00	0,00	-0,60	0,00	0,45
COPE57	0,00	0,00	0,00	0,71	0,50
COPE9	0,00	0,00	0,00	0,56	0,42
COPE18	0,00	0,00	0,00	0,55	0,31
COPE27	0,00	0,00	0,00	0,55	0,37
COPE42	0,00	0,00	0,00	0,52	0,44
COPE49	0,00	0,00	0,00	0,49	0,33
COPE44	0,00	0,00	0,00	0,40	0,27
COPE1	0,00	0,00	0,00	0,39	0,20
COPE17	0,00	0,00	0,00	0,37	0,20
Percentage Variance	15,20	8,18	5,25	4,64	

F_1 Approach Coping, F_2 Avoidance, F_3 Turning to Religion, F_4 Seeking Emotional Support

Inspection of Table 3 shows that four factors were extracted, accounting for 33,26% of the total variance in the data. Variables were reasonably well defined by this factor solution. Communality values, as seen in Table 3, tended to be moderate. With a cut-off of 0,30 for inclusion of a variable in interpretation of a factor, 13 of 53 items did not load on the four factors.

The first factor dealt with approaching the problem, redefining it as something positive or a learning experience, and accepting that it has happened. This factor was labelled *Approach Coping*. The second factor had items that related to avoidance, such as daydreaming, and items related to ignoring the fact. This factor was labelled *Avoidance*. The third factor had items related to turning to religion by finding comfort in religion, praying more than usual and putting one's trust in God. This factor was labelled *Turning to Religion*. The fourth factor was made up of items related to seeking support. This factor was labelled *Seeking Emotional Support*.

A principal component factor analysis was performed on the 18 items of the Health Subscales. Analysis of the eigen values (larger than 1) and the scree plot indicated that two factors could be extracted, explaining 40,75% of the total variance. Next, a principle axis factor analysis was followed using a direct oblimin rotation to perform further factor analysis.

The results of the factor analysis on the Health Subscale are indicated in Table 4. The loading of variables on factors, as well as communalities and percentage of variance, is indicated. Variables are ordered and grouped by size of loading to facilitate interpretation. Labels for each factor are suggested in a footnote.

Table 4

Factor Loadings, Communalities (h^2), Percentage Variance for Principal Factors Extraction and Direct Oblimin Rotation on the Health Subscale Items

Item	F_1	F_2	H^2
YH17	0,76	0,00	0,52
YH15	0,75	0,00	0,58
YH18	0,61	0,00	0,40
YH14	0,59	0,00	0,45
YH11	0,59	0,00	0,38
YH16	0,49	0,00	0,36
YH10	0,40	0,00	0,31
YH9	0,35	0,00	0,10
YH8	0,31	0,00	0,10
YH4	0,00	0,74	0,45
YH6	0,00	0,51	0,35
YH5	0,00	0,50	0,29
YH2	0,00	0,49	0,21
YH3	0,00	0,49	0,26
YH1	0,00	0,48	0,27
YH13	0,00	0,47	0,38
YH7	0,00	0,37	0,37
YH12	0,00	0,35	0,31
Percentage variance explained	31,54	9,21	

F_1 Psychological Health, F_2 Physical Health

Inspection of Table 4 shows that two factors were extracted, accounting for 40,75% of the total variance in the data. Variables were reasonably well defined by this factor solution. Communality values, as seen in Table 4, tended to be moderate.

The first factor dealt with health problems associated with psychological symptoms such as constant irritability, inability to listen to other people, mood swings and feeling unable to cope. This factor was labelled *Psychological Health.* The second factor had items that related to physical health problems, such as lack of appetite or over-eating, indigestion or heartburn, and muscular tension, aches and pains. This factor was labelled *Physical Health.*

The descriptive statistics and alpha coefficients of the two factors of the EIS, four factors of the COPE and two factors of the Health Subscale are indicated in Table 5.

Table 5

Descriptive statistics and Alpha coefficients of the EIS, COPE, and Health Subscales

Item	Mean	*SD*	Skewness	Kurtosis	α
Emotional Intelligence					
Emotion Expression and Appraisal	75,74	11,12	-0,76	0,92	0,82
Emotion Utilisation	52,70	7,97	-0,74	0,94	0,78
Coping					
Approach Coping	48,33	6,96	-0,39	-0,55	0,82
Avoidance	28,00	6,97	0,08	-0,62	0,78
Turning to Religion	13,92	2,91	-1,84	3,09	0,83
Seeking Emotional Support	28,32	5,37	-0,77	0,36	0,79
Health					
Psychological Health	15,75	5,15	0,64	0,05	0,82
Physical Health	19,98	5,49	0,05	-0,41	0,79

Table 5 indicates that acceptable Cronbach alpha coefficients varying from 0,78 to 0,83 were obtained. These alpha coefficients compare reasonably well with the guideline of 0,70 (0,55 in basic research), demonstrating that a large proportion of the variance is explained by the dimensions (internal consistency of the dimensions) (Nunnally & Bernstein, 1994). It is evident from Table 5 that most of the scales of the measuring instruments have relatively normal distributions, with low skewness and kurtosis, except for Turning to Religion.

The product-moment correlation coefficients between emotion expression and appraisal, emotion utilisation, approach coping, avoidance, turning to religion, seeking emotional support, psychological health and physical health are provided in Table 6.

Table 6

Product-moment correlation coefficients between the EIS, COPE and Health subscales

Item	1	2	3	4	5	6	7
1. Emotion Expression and Appraisal	.	.	.	.	.	.	.
2. Emotion Utilisation	0,57*++	.	.	.	.	.	.
3. Approach Coping	0,45*+	0,30*	.	.	.	.	.
4. Avoidance	-0,10	0,12	0,16*	.	.	.	.
5. Turning to Religion	0,20*	0,23*	0,20*	0,30*	.	.	.
6. Seeking Emotional Support	0,47*+	0,33*+	0,47*+	0,10	0,34*+	.	.
7. Psychological Health	-0,26*	-0,26*	-0,15*	0,28*	0,05	-0,16*	.
8. Physical Health	-0,15	-0,09	-0,03	0,35*+	0,11	-0,04	0,58*++

* $p \leq 0,05$ - statistically significant

+ $r > 0,30$ - practically significant (medium effect)

++$r > 0,50$ - practically significant (large effect)

Table 6 shows a statistically significant positive correlation (practically significant, large effect) between emotion expression and appraisal and emotion utilisation, and a statistically significant positive correlation (practically significant, medium effect) with approach coping and seeking emotional support. Emotion utilisation is statistically significantly positively correlated (practically significant, medium effect) with seeking emotional support. Approach coping is statistically significantly positively correlated (practically significant, medium effect) with seeking emotional support. Avoidance is statistically significantly positively correlated (practically significant, medium effect) with physical health. Turning to religion is statistically significantly positively correlated (practically significant, medium effect) with seeking emotional support. Psychological health is statistically significantly positively correlated (practically significant, large effect) with physical health. Hypothesis 1 is therefore only partially accepted as not all the factors of the measuring instruments had statistical and practically significant correlations.

The results of a multiple regression analysis with psychological health as dependent variable and emotion expression and appraisal, emotion utilisation, approach coping, avoidance, turning to religion and seeking emotional support as independent variables are reported in Table 7.

Table 7

Multiple regression analyses with psychological health as dependent variable

	Model	Unstandardised Coefficients		Standardised Coefficients	*t*	*p*	*F*	*R*	R^2	ΔR^2
		B	SE	Beta						
1	(Constant)	27,30	2,90		9,43	0,00	8,09*	0,30	0,09	0,09
	Emotion Expression and Appraisal	-0,08	0,04	-0,17	-1,87	0,06				
	Emotion Utilisation	-0,11	0,06	-0,17	-1,86	0,06				
2	(Constant)	22,42	3,41		6,57	0,00	6,35*	0,43	0,19	0,10
	Emotion Expression and Appraisal	-0,02	0,05	-0,03	-0,32	0,75				
	Emotion Utilisation	-0,16	0,06	-0,24	-2,78	0,01*				
	Approach Coping	-0,07	0,06	-0,10	-1,16	0,25				
	Avoidance	0,23	0,06	0,31	3,98	0,00*				
	Turning to Religion	0,12	0,14	0,07	0,89	0,38				
	Seeking Emotional Support	-0,06	0,08	-0,07	-0,77	0,44				

* $p< 0, 05$

Table 7 shows that 9 per cent of the variance explained in Psychological Health was predicted by emotion expression and appraisal and emotion utilisation (F = 8,09, p<0,05). There were, however, no significant predictors of psychological health. When the coping strategies were added into the multiple regression analysis, the statistical significance of R^2 increased (ΔR^2 = 0,10). Table 7 shows that 19 per cent of the variance explained in Psychological Health was predicted by emotional intelligence and the coping strategies (F = 6,35, p<0,05). The only significant predictors of psychological health were emotion utilisation and avoidance. This indicates that when participants experienced higher levels of emotion utilisation, the experience of psychological health would decrease, whilst the use of avoidance as a coping strategy would result in psychological health problems. Hypothesis 2 is therefore only partially accepted.

The results of a multiple regression analysis with physical health as dependent variable and emotion expression and appraisal, emotion utilisation, approach coping, avoidance, turning to religion and seeking emotional support as independent variables are reported in Table 8.

Table 8

Multiple regression analyses with physical health as dependent variable

	Model	Unstandardised Coefficients		Standardised Coefficients	*t*	*p*	*F*	*R*	R^2	ΔR^2
		B	SE	Beta						
1	(Constant)	25,68	3,19		8,04	0,00	1,92	0,15	0,02	0,02
	Emotion Expression and Appraisal	-0,07	0,05	-0,14	-1,55	0,12				
	Emotion Utilisation	-0,01	0,06	-0,01	-0,10	0,92				
2	(Constant)	17,92	3,72		4,82	0,00	4,87*	0,39	0,15	0,13
	Emotion Expression and Appraisal	-0,02	0,05	-0,04	-0,39	0,70				
	Emotion Utilisation	-0,07	0,06	-0,10	-1,16	0,25				
	Approach Coping	-0,03	0,07	-0,03	-0,37	0,71				
	Avoidance	0,28	0,06	0,36	4,52	0,00*				
	Turning to Religion	0,11	0,15	0,06	0,70	0,49				
	Seeking Emotional Support	-0,03	0,09	-0,03	-0,31	0,75				

* $p < 0,05$

Table 8 shows that 15 per cent of the variance explained in Physical health could be predicted by emotion expression and appraisal, emotion utilisation, approach coping, avoidance, turning to religion and seeking emotional support ($F = 4,87$, $p<0,05$). The only significant predictor of physical health was avoidance. Hypothesis 3 is therefore rejected due to the fact that avoidance as a coping strategy will result in higher levels of physical (ill) health.

MANOVA analyses were used to determine the relationship between emotional intelligence and different demographic characteristics, namely gender, language, educational level, and province. Demographic characteristics where first analysed for statistical significance using Wilk's Lambda statistics. The results of the comparisons are given in Table 9.

Table 9

MANOVAS - Differences in emotional intelligence of demographic groups

Variable	Value	*F*	Df	*P*	Partial Eta Squared
Gender	0,99	0,59	2,00	0,56	0,01
Language	0,98	0,86	4,00	0,49	0,11
Education	0,87	1,49	16,00	0,10	0,70
Province	0,99	0,27	4,00	0,89	0,00

* Statistically significant difference $p < 0,05$

In an analysis of Wilk's Lambda values, no statistically significant differences ($p < 0,05$) regarding emotional intelligence levels could be found between the gender groups, language groups, the education levels of individuals and the province in which they reside.

MANOVA analyses were used to determine the relationship between coping strategies and different demographic characteristics, namely gender, language, educational level, and province. Demographic characteristics where first analysed for statistical significance using Wilk's Lambda statistics. The results of the comparisons are given in Table 10.

Table 10

MANOVAS - Differences in coping strategies of demographic groups

Variable	Value	*F*	Df	*P*	Partial Eta Squared
Gender	0,95	2,12	4,00	0,81	0,05
Language	0,82	4,13	8,00	0,00*	0,10
Education	0,81	1,03	32,00	0,42	0,05
Province	0,86	3,20	8,00	0,00*	0,07

* Statically significant difference $p < 0,05$

In an analysis of Wilk's Lambda values, no statistically significant differences ($p < 0,05$) regarding coping strategies could be found between gender groups and education levels of individuals. However, statistically significant differences ($p < 0,05$) were found for language groups and the provinces which the participants cited. The relationship between coping

strategies and these demographic variable levels that showed statistically significant differences were further analysed using ANOVA.

Table 11

Differences in coping strategies based on language groups

Item	Afrikaans	English	African	*P*	Partial Eta Squared
Approach Coping	47,89	47,63	48,72	0,77	0,00
Avoidance	23,50[b]	24,31	29,07[a]	0,00*	0,09
Turning to Religion	14,00	12,27	14,08	0,07	0,03
Seeking Emotional Support	24,83[b]	27,38	28,77[a]	0,01*	0,06

Statistically significant difference $p < 0, 05$
[a] Group differs statistically significant from coping strategy (in row) where [b] is indicated

Table 11 shows that there were statistically significant differences between the use of avoidance and seeking emotional support as coping strategies based on language groups. It seems that African language groups used more avoidance and sought more emotional support as coping strategies than Afrikaans-speaking participants.

Table 12

Differences in coping strategies based on provinces

Item	North-West	Gauteng	*P*	Partial Eta Squared
Approach Coping	48,41	48,43	0,81	0,00
Avoidance	29,34[a]	24,98[b]	0,00*	0,08
Turning to Religion	13,92	13,89	0,97	0,00
Seeking Emotional Support	29,01	27,16	0,09	0,03

Statistically significant difference $p < 0, 05$
[a] Group differs statistically significant from coping strategy (in row) where [b] is indicated

Table 12 shows that there were statistically significant differences between the use of avoidance as a coping strategy based on the province where the participants were sited. It seems that participants from the North-West province used avoidance more readily as a coping strategy than the participants in the Gauteng province.

MANOVA analyses were used to determine the relationship between health levels and different demographic characteristics, namely gender, language, educational level, and province. Demographic characteristics were first analysed for statistical significance using Wilk's Lambda statistics. The results of the comparisons are given in Table 13.

Table 13

MANOVAS - Differences in health levels of Demographic Groups

Variable	Value	*F*	Df	*P*	Partial Eta Squared
Gender	0,98	1,76	2,00	0,18	0,02
Language	0,98	1,00	4,00	0,41	0,01
Education	0,92	0,81	16,00	0,68	0,04
Province	0,96	1,67	4,00	0,16	0,02

* Statistically significant difference $p < 0,05$

In an analysis of Wilk's Lambda values, no statistically significant differences ($p < 0,05$) regarding health could be found between gender groups, education levels and provinces in which participants reside.

Hypothesis 4 is therefore only partially accepted.

DISCUSSION

The aim of this study was to determine the relationship between emotional intelligence, coping and health of non-professional counsellors. The use of non-professional counsellors is still a relatively new idea, and little or no research has been conducted on the emotional intelligence, coping and health of non-professional counsellors in South Africa.

The statistical analysis was carried out with the help of the SPSS-programme (SSPS Inc., 2007). The factor analysis confirmed two factors for emotional intelligence, consisting of emotion expression and appraisal and emotional utilisation. It has been suggested that the EIS is better used as a one-factor solution scale (Schutte et al., 1998); however, other research has found the scale to also be valid when more than three factors are extracted (Ciarrochi et al., 2002). In a research study conducted by Law (2004) on emotional intelligence, sense of coherence and coping behaviour, the author found that the research group (undergraduate

psychology students) manifested appraisal and expression of emotion as the stronger emotional intelligence component. Four factors were confirmed for coping, which are approach coping, avoidance, turning to religion and seeking emotional support. Carver et al. (1989) found that the active coping and planning items all loaded together on one factor. Similarly, items reflecting the seeking of social support all loaded together on a single factor, independent of the basis for seeking social support. In the present study similar results were obtained, where items from the active coping and planning subscales both loaded on factor 1 (approach coping). Factor 2 (avoidance) represented the subscale for denial. Items for turning to religion loaded on factor 3 (turning to religion) and seeking emotional support loaded on factor 4 (seeking emotional support). Health was found to comprise psychological health and physical health. The Health Subscales consist of 18 items arranged on two subscales: Psychological Health and Physical Health. All items on the Psychological Health subscale related to health problems such as irritability, inability to listen to other people, mood swings, and so forth. The items listed on the Physical Health subscale were related to health problems such as overeating, lack of appetite, heartburn and the like.

Descriptive statistics (e.g. means, standard deviations, skewness and kurtosis) was used to analyse the data. The following Cronbach alpha coefficients were obtained for the two factors of the EIS, four factors of the COPE and two factors of the Health Subscale: Emotional Expression and Appraisal (0,82); Emotional Utilisation (0,78; Approach Coping (0,82); Avoidance (0,78); Turning to Religion (0,83); Seeking Emotional Support (0,79); Psychological Health (0,89) and Physical Health (0,79). In Law's (2004) study the reliability indices for the EIS were reported as 0,79 for expression and appraisal of emotion and 0,73 for utilisation of emotion, which are lower than those found in the present study. In a South African study, Van der Bank (2002) reported the following comparable reliability indices for the COPE: approach coping (0,63); seeking emotional support (0,83); turning to religion (0,94); focus on and venting of emotions (0,70); avoidance (0,53). Coetzer (2004) obtained the following Cronbach alpha coefficients on the two factors of the Health Subscale from a sample of 613 employees in an insurance company in South Africa; Psychological Health (0,89) and Physical Health (0,79).

In the light of the above it can be concluded that the descriptive statistics and alpha coefficients of the two factors of the EIS, four factors of the COPE and two factors of the Health Subscale showed acceptable Cronbach alpha coefficients. The results and conclusions

obtained in this study can thus be assumed to have a reliable basis. Most of the scales of the measuring instruments have relatively normal distributions, with low skewness and kurtosis, except for Turning to Religion.

Pearson product-moment correlation coefficients were used to specify the relationships between the variables. Not all the factors of the measuring instruments had statistically and practically significant correlations; however, results indicated that when expressing and utilising emotions, participants tended to apply approach coping and also sought emotional support. Results also imply that when utilising emotions, applying approach coping strategies and turning to religion one will seek emotional support. When avoidance was used as a coping strategy, results showed a statistically significant positive correlation with physical health. Being in a state of psychological health means that one will tend to also experience physical health. Hypothesis 1 was therefore only partially accepted as not all the factors of the measuring instruments had statistically and practically significant correlations.

In Law's (2004) study, emotional intelligence had a stronger correlational relationship with coping than a sense of coherence. It was concluded that individuals with high emotional intelligence have developed more effective coping strategies than individuals who do not have well-developed emotional abilities (Law, 2004). In a study conducted on protection services members, Van der Linde (2004) found that high levels of burnout may lead to either physical or psychological health problems. This study also confirmed that physical health is related to psychological health (Van der Linde, 2004). Very little literature is available regarding the relationship between emotional intelligence, coping and health. Both emotional intelligence and coping have been established as contributing to well-being and/or health, but the dynamics between them remain inadequately researched and therefore unknown.

Stepwise multiple regression analyses were conducted to determine the percentage variance in the dependent variables that is predicted by the independent variables. The analysis showed that 19 per cent of the variance in psychological health was predicted by emotional intelligence and the coping strategies. The only significant predictors of psychological health were emotion utilisation and avoidance. This indicates that when participants experienced higher levels of emotion utilisation, the experience of psychological health would decrease, whilst the use of avoidance as a coping strategy will result in psychological health problems. Hypothesis 2 was therefore only partially accepted.

Furthermore, the multiple regression analyses also showed that 15 per cent of the variance in physical health was predicted by emotion expression and appraisal, emotion utilisation, approach coping, avoidance, turning to religion and seeking emotional support. The only significant predictor of physical health is avoidance, which implies that avoidance as a coping strategy will result in higher levels of physical (ill) health. Hypothesis 3 is therefore rejected due to the fact that avoidance as a coping strategy will result in higher levels of physical (ill) health.

Occupational stress and low organisational commitment explained 15% of the variance in physical ill-health and 30% of the variance in psychological ill-health in a study conducted by Jackson and Rothmann (2006) of educators in the North-West Province. In a study regarding the relationship between emotional intelligence and physical and psychological health, the hypothesis that emotional intelligence is negatively correlated with poor general health was confirmed (Tsaousis & Nikolaou, 2005). The same study confirmed that lower levels of emotional intelligence will lead to poor health behaviour such as smoking, drinking, and so forth.

Multivariate analysis of variance (MANOVA) was used to determine the significance of differences between the levels of emotional intelligence, coping strategies and health of demographic groups. Results obtained showed that African language groups used avoidance and seeking emotional support more as coping strategies than Afrikaans language groups. It also seems that participants in the North-West province used avoidance more as a coping strategy than the participants from the Gauteng province. In a research study conducted by Jackson and Rothmann (2006) on educators in the North-West province, the authors found that the effects of stress were high for physical ill-health and average for psychological ill-health. Very little literature is available regarding the demographics of coping in the South African context and specifically in the North-West and Gauteng provinces.

RECOMMENDATIONS

The findings of this study suggest the value that emotional intelligence development, as projected by Bar-On (1997), Goleman (1995) and Salovey and Mayer (1990), has for psychological well-being in general. Emotional intelligence training programmes which

include enhanced coping abilities, improved interpersonal skills and higher levels of wellness will be beneficial towards the counselling environment. Such emotional intelligence enhancement or training could be integrated into the existing curricula of schools, since peers can also function as non-professional counsellors as long as HIV/AIDS remains a dilemma in our everyday lives. Emotional intelligence training will be beneficial to victims of crime and HIV/AIDS. This would prepare individuals to facilitate their ability to manage stressors and increase their ability to function and succeed in life.

Very little literature is available regarding the relationship between emotional intelligence, coping and health. Both emotional intelligence and coping have been established as contributing to well-being and/or health, but the dynamics between them remains inadequately researched and therefore unknown. It is therefore recommended that future research further explore the theoretical relationship between emotional intelligence and coping and how it is manifested in behaviour. It is also recommended that further research should be conducted on preferred coping strategies and coping behaviour in different provinces amongst different cultures and language groups, as well as different genders.

Supervisors and counsellors should become aware of the causes and symptoms of stress, as well as certain management actions that could alleviate the effects on non-professional counsellors. This could help them to become aware of their own coping strategies, health and emotions, so that interventions could be taken before the effects of stress become too serious. More research should be conducted on preferred coping strategies and coping behaviour in different provinces amongst different cultures and language groups, as well as different genders to address specific needs.

A limitation of this study is that the design is cross-sectional. As a result, no causal inferences could be drawn. Therefore the causal relationships between variables were interpreted rather than established, and more complex forms of non-recursive linkages could not be examined.

Another limitation is the accessibility of non-professional counsellors. This limitation is the result of the size of the sample group and the poorly represented language groups. A recommendation for future research will be to conduct the study in more provinces. The low education levels may be a risk in the sense that participants could not read properly or understand the questions. The language matter also becomes evident in this regard.

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CHAPTER 3

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

This chapter comprises conclusions regarding the literature review and results obtained in the empirical studies. Conclusions are drawn with regard to the specific research objectives. Furthermore, limitations that have been identified throughout the course of the study are discussed, followed by recommendations for the research problem.

3.1 CONCLUSIONS

The general objective of this research was to determine the relationship between emotional intelligence, coping and health of non-professional counsellors. The following conclusions can be drawn:

The first objective of the study was to conceptualise emotional intelligence, coping strategies and health from the literature. Emotional intelligence were conceptualised as the ability to perceive accurately, appraise, and express emotions; the ability to access and generate feelings when they facilitate thought; the ability to understand emotion and emotional knowledge; and the ability to regulate emotions to promote emotional and intellectual growth (Salovey & Mayer, 1995). Four branches of emotional intelligence are identified by Mayer, Caruso and Salovey (2000) namely emotional perception, emotional integration, emotional understanding and emotional management. *Emotional perception* is the ability to register, attend to and decipher emotional messages as they are expressed in a variety of contexts (e.g. facial expressions, tone of voice and acting). *Emotional integration* refers to the ability to access and generate feelings which facilitate thought by giving information about their mood state. *Emotional understanding* is the ability to comprehend the implications of emotions, by understanding how one emotion leads to another, how emotions change over time, and how the temporal patterning of emotions can affect relationships. *Emotional management* is the ability to regulate one's emotions, to choose to be open to experiencing emotions and to control the way in which these are expressed.

Coping according to Lazarus (1993) were conceptualised as the thoughts and behaviours one will use to manage the internal and external demands of situations that are appraised as

stressful (Folkman & Moskowitz, 2004). Lazarus and Folkman (1984) identified two forms of coping namely problem-focused coping and emotion-focused coping. Problem-focused coping is the attempt to understand and define a problem and to work out possible solutions. Emotional focused coping strategy refers to managing emotional distress. These strategies include physical exercise, mediation, expressing feelings, and seeking support (Kleinke, 1991).

Health was defined as a feeling of well-being, an ability to cope with the demands of life, physical and mental fitness, and freedom from disease and disability (Love, Gardner, & Legion, 1997). Different dimensions of health include the physical or nutritional dimension; intellectual well-being; interpersonal or social wellness; emotional wellness; spiritual wellness; occupational wellness and environmental wellness (Love et al., 1997).

The second objective of this study was to determine the relationship between emotional intelligence, coping strategies and health according to the literature. Mayer and Salovey (1995) indicate that the regulation of disturbed feelings and emotions can lead to poorer health if an individual does not process the relevant emotional information. In demanding and challenging environments, such as those of non-professional counsellors, emotional intelligence influences the selection and control of coping strategies for use within the immediate situation (Matthews & Zeidner, 2000). Law (2004) found in her study that emotional intelligence is a better predictor of active coping and problem solving than sense of coherence. Research has also indicated that emotional intelligence has an influence on stress that affects mental health such as depression, hopelessness and suicide ideation (Ciarrochi, Deane, & Anderson, 2002).

According to Figley (1995) negative consequences of not being able to cope effectively with stress can result in the following: physical health (e.g. high blood pressure, headaches, indigestion, fatigue, insomnia, etc), psychosocial health (e.g. anxiety, irritability, anger, depression, mood swings, hypersensitivity, etc) and behavioural health (e.g. smoking, overeating, loss of appetite, increased use of alcohol or drugs, isolation, impatience, etc.). Individuals employing coping efforts characterised by problem-focused coping suffered from less psychological distress at lower to moderate stress levels (Wang & Yeh, 2005). On the other hand, the greater the perceived stress, the more emotion-focused coping behaviours may be needed (Wang & Yeh, 2005). Results also indicate that the use of avoidance and

emotional disturbance behaviour might reduce individual ability to reduce distress therefore making the subject more vulnerable to its negative consequences (Wang & Yeh, 2005).

Research has indicated that emotional intelligence has an influence on stress that affects mental health such as depression, hopelessness and suicide ideation (Ciarrochi et al., 2002). Oginska-Bulik (2005) also found in her study that employees reporting high emotional intelligence perceived lower levels of occupational stress and suffered less from negative health outcomes. It seems that emotional intelligence plays the buffering role in preventing workers from negative health outcomes, especially from depression symptoms.

The third objective of this study was to determine the validity and reliability of the measuring instruments of emotional intelligence, coping strategies and health for non-professional counsellors in North West and Gauteng provinces. The factor structures of the measuring instruments were determined via principle axis factoring. A direct oblimen rotation was used when there was more than one factor and when the factors were found to be correlated. Two factors could be extracted on the EIS, explaining 27,67% of the total variance. These factors were labelled emotion expression and appraisal and emotion utilisation. Law (2004) found in her study, by using the varimax rotation method, eight factors that could be extracted which explained 61.4% of the variance. Four factors could be extracted on the COPE, explaining 33,26% of the total variance. These factors were labelled approach coping, avoidance, turning to religion and emotional support. Law (2004) found 15 factors for the COPE scale where these factors explained 72,8% of the variance. Two factors could be extracted on the Health Subscale, explaining 40,75% of the total variance. These factors were labelled psychological health and physical health.

Acceptable Cronbach alpha coefficients varying from 0,78 to 0,83 were obtained. These alpha coefficients compare reasonably well with the guideline of 0,70 (0,55 in basic research), demonstrating that a large proportion of the variance is explained by the dimensions (internal consistency of the dimensions) (Nunnally & Bernstein, 1994). Most of the scales of the measuring instruments had relatively normal distributions, with low skewness and kurtosis, except for turning to religion. Research done by Vosloo (2005) within South African groups found acceptable validity for the Emotional Intelligence scale. Research done by Du Toit (1999) specifically with South African groups found acceptable

validity for the COPE scale. Coetzer (2004) also obtained acceptable validity measures for the Health Scale among a sample of 613 employees in an insurance company in South Africa

The fourth objective of the study was to determine the relationship between emotional intelligence, coping strategies and health in a sample of non-professional counsellors. Pearson product-moment correlation showed a statistically significant positive correlation between emotion expression and appraisal and emotion utilisation, approach coping and seeking emotional support. This implies that when a person expresses emotions such as compliment others when they have done something well etc. and appraise emotions such as recalling times when faced with similar obstacles and re-evaluate what is important, such a person will tend to use emotions i.e. using good moods to help overcoming obstacles, being able to solve problems etc.

When expressing and appraising emotions, the tendency to apply an approach coping strategy and seeking for emotional support exists. The fact that emotion utilisation was statistically significant positive correlated with seeking emotional support, imply that when using emotions to help overcome obstacles and to help solve problems, one will more than likely seek for emotional support in times of need. Approach coping is statistically significant positive correlated with seeking emotional support, and implies that by seeking emotional support one is approaching the problem, redefining it as something positive or a learning experience, and accepting that it has happened.

Avoidance is statistically significant positive correlated with physical health. This implies that avoidance as a coping strategy will result in higher levels of physical (ill) health. Turning to religion is statistically significant positive correlated with seeking emotional support. This implies that one seeks emotional support by finding comfort in religion, praying more than usual and putting one's trust in. Psychological health is statistically significant positive correlated with physical health.

In Law's (2004) study emotional intelligence had a stronger correlational relationship with coping than sense of coherence. It was concluded that individuals with a high emotional intelligence have developed more effective coping strategies than individuals who do not have well-developed emotional abilities (Law, 2004). In a study conducted on protection services members, Van der Linde (2004) found that high levels of burnout may lead to either

physical or psychological health problems. This study also confirmed that physical health is related to psychological health (Van der Linde, 2004). Very little literature is available regarding the relationship between emotional intelligence, coping and health. Both emotional intelligence and coping have been established as contributing to wellbeing or health but the dynamics between them remains mostly inadequately researched and therefore unknown.

The fifth objective of this study was to determine whether higher levels of emotional intelligence and positive coping strategies will result in lower levels of psychological and physical (ill) health in a sample of non-professional counsellors. The results of a multiple regression analysis with psychological health as dependent variable and emotion expression and appraisal, emotion utilisation, approach coping, avoidance, turning to religion and seeking emotional support as independent variables showed that when participants experienced higher levels of emotion utilisation that the experience of psychological health will be lessen, whilst the use of avoidance as a coping strategy will result in psychological health problems. The only significant predictor of physical health is avoidance. Avoidance as a coping strategy will result in higher levels of physical (ill) health.

The sixth objective of this study was to determine the differences in emotional intelligence, coping strategies and health experienced, based on certain demographic factors. No statistical significant differences regarding emotional intelligence levels and coping strategies could be found between the gender groups, language groups, and the education levels of individuals and the province in which they side. However, statistically significant differences were found for language groups and the provinces in which the participants sited.

The relationship between coping strategies and these demographic variable levels that showed statistical significant differences were further analysed showed that there are statistically significant differences between the uses of avoidance and seeking emotional support as coping strategies based on language groups. It seems that African language groups use more avoidance and seeking emotional support as coping strategies than Afrikaans language groups. There were also statistically significant differences between the uses of avoidance as a coping strategies based on the province where the participants were sited. It seems that participants in the North-West province use avoidance more as a coping strategy than the participants in the Gauteng province. No statistical significant differences regarding health could be found between gender groups, education levels and provinces in which

participants' site. Very little literature is available regarding the demographics of coping in the South African context and specifically in the North West and Gauteng provinces.

3.2 LIMITATIONS

The first limitation of this study was the use of a cross-sectional survey design. To deal with the limitation of the use of a cross-sectional design, prospective longitudinal and quasi-experimental research designs are needed to further validate the hypothesised causal relationships within the study.

The second limitation was the size of the sample. The fact that the study was conducted on non-professional counsellors in only the North-West and Gauteng provinces, the results obtained is not valid for the whole South African population. Thus non-professional counsellors in other provinces might not share the same emotional difficulty than counsellors used in this study.

The third limitation was the fact that the non-professional counsellors that were targeted were not accessible in the sense that they did not have facilities such as personal computers or telephones. Four hundred non-professional counsellors were targeted while only 181 (45%) responded of which 172 (95%) were utilised. Low education levels that were obtained might also be a risk. Some of the respondents might not have been able to read and understand questions that were asked.

Some of the counsellors that completed the questionnaires might have doubted the ensured confidentiality and feared that their identity would become known somehow. That could have influence them to answer the questionnaire inaccurately and untruthfully which might have impacted negatively on the results.

Another limitation was that the questionnaire was only available in English. The risk in this regard is that respondents' level of English skills could have influenced the results negatively. Taken the multi-cultural differences in South Africa it is important that every culture's needs be met, to obtain valid and reliable data from respondents, since some participants might not understand some questions and interpret it wrongly.

3.3 RECOMMENDATIONS

The following recommendations are made to the profession, as well as for future research in South Africa.

3.3.1 Recommendations for the profession

Given the serious effects of secondary exposure to traumatic events for counsellors it is important that prevention and management of this phenomenon is taken seriously by all concerned. Compassion fatigue or secondary traumatic stress disorder is preventable and the process can be interrupted in the early stages. Managers and supervisors should be trained and educated in identifying symptoms and to prevent compassion fatigue/ secondary traumatic stress disorder. Supervisors and counsellors should therefore become aware of the causes and symptoms of stress, as well as certain management actions that could alleviate the effects on non-professional counsellors. This could help them to become aware of their own coping strategies, health and emotions, so that interventions could be taken before the effects of stress become too serious.

Emotional intelligence training programmes which includes enhanced coping abilities, improved interpersonal skills and higher levels of wellness will be beneficial towards the counselling environment. Such emotional intelligence enhancement or training could be integrated into the existing curricula of schools, since peers can also function as non-professional counsellors while HIV/AIDS is still a dilemma in our everyday life. Emotional intelligence will be beneficial to victims of crime and HIV/AIDS. This would prepare individuals to facilitate their ability to manage stressors and increase their ability to function and succeed in life.

It is recommended that specific coping strategies or personality traits that promote compassion satisfaction and prevent compassion fatigue and burnout must be researched and developed to help counsellors protect and maintain their mental health and well-being. Apparently, most professionals engaged in helping roles have managed to design and implement "self-made" support systems based mainly on social networks and professional colleagues in order to avoid emotional burnout. Nevertheless, the need for some kind of structured prevention, support and strengthening processes is evident. One-on-one

debriefings, group defusing and processing, and training on self-care are essential. Flight attendants remind us on every trip: Place the oxygen mask on yourself first, and then help others.

It is recommended to provide non-professional counsellors with well deserved benefits and resources to motivate and support them, and therefore eliminate unnecessary distress. Remuneration, paid leave, acceptable facilities to provide counselling services in etc. are only a few examples of benefits.

3.3.2 Recommendations for future research

Counselling in South Africa is a growing profession in South Africa, since the crime and HIV/ AIDS rate are high and victims need support to overcome and deal with their situation. Future research must focus more on secondary traumatic stress disorder amongst non-professional counsellors. Non-professional counsellors are also not well researched and it is recommended that research must be conducted on specific determinants that may cause ill health amongst these counsellors. Very little literature is available regarding the relationship between emotional intelligence, coping and health. Both emotional intelligence and coping have been established as contributing to wellbeing and/or health but the dynamics between them remains mostly inadequately researched and therefore unknown. It is therefore recommended that future research further explore the theoretical relationship between emotional intelligence and coping and how it is manifested in behaviour. It is also recommended that further research should be done on preferred coping strategies and coping behaviour in different provinces amongst different cultures and language groups, as well as different genders.

Another recommendation is that a larger sample must be obtained with a more powerful sampling method to enable generalisation of the findings to other similar groups. One way of conducting this is by including more provinces in South Africa in a similar study.

Different language groups were used in this study and it therefore becomes a requirement to translate the questionnaires in other official languages so that the participants have more understanding and knowledge about the content of the questions.

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