MENTAL HEALTH AND QUALITY OF LIFE OF GRADUATE LEVEL THERAPY STUDENTS: A LOOK AT THE ROLE OF COPING

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Abstract

Graduate students in therapist training programs have been found to struggle with high rates of mental health distress such as depression, anxiety and stress impacting their mental health and their quality of life. Despite these challenges, some graduate therapy students have reported high levels of wellness and quality of life. This study explores the mental health, quality of life, and coping patterns and strategies in 165 Canadian graduate level therapist trainees. Results indicate that graduate students overall reported lower mental health and quality of life than the general population. When comparing level of training, both master's and doctoral students reported experiencing similar levels of quality of life, however, master's students reported experiencing significantly more mental health distress. In terms of coping, both groups of students reported significant correlations between avoidant emotional coping patterns and each of the outcome measures. Self-blame significantly predicted mental health outcomes and quality of life for master's level students, while substance use was significantly associated to outcomes for doctoral level students. In terms of spiritual coping, for master's students, but not doctoral students, negative spiritual coping was associated to lower mental health and lower quality of life while forgiveness was significantly positively associated to mental health and quality of life. After controlling for other coping strategies however, only forgiveness significantly predicted mental health, possibly acting as a buffer for the effects of negative spiritual coping. Implications of these findings and recommendations for therapists in training and training programs are discussed.

Keywords: mental health, quality of life, therapists in training, coping, religious/spiritual coping

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Introduction

Alarmingly high rates of depression and anxiety have been documented amongst post-secondary students and the rates continue to increase (ACHA-NCHA II, 2008; 2017; Erdur-Baker, Aberson, Barrow, & Draper, 2006; Gallagher, 2010; Hunt & Eisenberg, 2010). Graduate students in particular (Hyun, Quinn, Madon, & Lustig, 2006) and even more so, graduate students in therapist training programs (Rummell, 2015; White & Franzoni, 1990) have been found to struggle with high rates of mental health distress such as depression, anxiety and stress impacting their mental health well-being, their quality of life as well as their academic performance. Graduate students face particular stressors, such as less formal training requirements than undergraduate studies and more life stressors, familial, and financial obligations, among other challenges (Heins, Fahey, & Leiden, 1984; Hyun et al., 2006; Nogueira-Martins, Fagnani Neto, Macedo, Citero, & Mari, 2004; Toews et al., 1997). These stressors make graduate students more vulnerable to mental health distress such as depression, anxiety and stress. Graduate students in counselling programs encounter even further stressors during their studies related to their clinical work, supervision, vicarious traumatization and others. Researchers have shown that this demographic has struggled with increased physical and mental health problems at higher rates than other graduate students, diminished quality of life, academic difficulty, burn-out, school drop-out, feelings of incompetence, and hampered clinical work (Hipple, & Beamish, 2007; Rønnestad & Skovholt, 2003; Thériault, Gazzola, & Richardson, 2009; White & Franzonoi, 1990). Despite these documented challenges and struggles, some graduate therapy students have reported high levels of wellness and quality of life (Myers, Mobley, & Booth, 2003; Myers, Sweeney, & Witmer, 2000; White

& Franzoni, 1990). Gaining further knowledge into the mental health and quality of life of therapists-in-training and identifying the mechanisms by which some graduate counselling students rise above their myriad of challenges and successfully cope during clinical graduate training will serve to inform training programs and university support programs as they develop best practices for student support.

The way in which one copes with life stressors can have a significant impact on one's mental health and quality of life. In exploring the mental health of populations facing a particular stressor, researchers often also evaluate quality of life (Eisen et al., 2015; Fellinger, Holzinger, Sattel, & Laucht, 2008). With regards to student mental health, The World Health Organization (WHO, 2005) has defined mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2005, p. 2). The present study focuses on depression, anxiety, and stress as markers of mental health distress. Flanagan (1978) defined quality of life as having 15 categories, which fall under the five following components: Physical and material quality of life; relations with other people; social, community, and civic activities; personal development and fulfillment; creativity and personal expression, and recreation. While there is overlap in these two constructs, they remain conceptually separate. By exploring both mental health and subjective quality of life, an individual's own satisfaction with their functioning in each of these life domains can be explored alongside mental health.

Research has demonstrated that therapists-in-training are particularly vulnerable to higher levels of stress, which can have a negative impact on their personal and

professional functioning (Pakenham & Stafford-Brown, 2012). Researchers have identified factors that compound the high levels of anxiety and stress that has been reported by therapists-in-training. Some of these factors include: ambiguity (Pica, 1998), self-doubt and professional competency (including work with clients) (Hipple, & Beamish, 2007; Rønnestad & Skovholt, 2003; Thériault et al., 2009), and academic evaluation (Glogowska, Young, & Lockyer, 2007). Glogowska et al. (2007) and Rønnestad and Skovholt (2003) identified that as students, therapists-in-training must navigate the demands and challenges facing the student population, while at the same time gaining experience and competency in assessing and treating clients in a therapy setting. Professional development and clinical work are added stressors facing this particular demographic and each phase of student development carries with it distinct challenges. Students in the beginning phase of therapist training, such as master's students, are consistently enthusiastic; however, Rønnestad and Skovholt, have shown that that excitement is tempered by the intense challenges inherent in learning the counselling profession. During this beginning phase of therapist development, students are faced with the question of their suitability for the profession, often feeling a "chasm between theory and practice" (Rønnestad & Skovholt, 2003, p.12). Striving for professional capability, students find it difficult to effectively unite theoretical concepts with practical implementation (Glogowska et al., 2007; Rønnestad & Skovholt, 2003). This can lead to both professional doubts and self-doubts, which in turn may have significant negative consequences in their work with clients (Hipple, & Beamish, 2007; Rønnestad & Skovholt, 2003; Thériault et al., 2009).

In their review of the literature, Pakenham and Stafford-Brown (2012) reported

that the younger a therapist is, the higher their tendency to experience burnout. Because of this, they suggest that therapists-in-training "may be particularly susceptible to stress-related problems" (Pakenham & Stafford-Brown, 2012, p. 150). This suggests that the training phase may be an important factor in the stress experienced. Beginning level students such as master's students tend to question their fit with the chosen profession and struggle in the role of both student and therapist (Rønnestad & Skovholt, 2003). It has been suggested that students in a more advanced phase of therapist development, such as doctoral students, are faced with different challenges, related to "feel[ing] pressure to do things more perfectly than ever before" when working with clients (Rønnestad & Skovholt, 2003, p. 14). Students in this phase of training may feel vulnerable and insecure, with a tendency toward "excessive and misunderstood responsibility…for everything" (Rønnestad & Skovholt, 2003, p. 15). Thus, master's and doctoral level therapists-in-training seem to experience different struggles. For this reason, Pakenham and Stafford-Brown (2012) called for further research into the role of stress over the course of therapist training.

With regards to student well-being, research has also explored links between mental health distress and quality of life however, the findings have been conflicting. While some research has linked low levels of self-reported quality of life to low levels of mental health in the student population (Elliot, Thrash, & Murayama, 2011; Michalos & Orlando, 2006), other research has found that this is not necessarily the case for therapists-in-training. For example, Myers et al. (2003) found that therapists-in-training reported high levels of well-being. They also noted that doctoral level students reported higher levels of well-being than students entering a clinical master's program. The

researchers reported that these findings were surprising as they "expected to find low levels of wellness within the student population" (Myers et al., 2003, p. 270). In discussing their results, these researchers attributed their findings to the possibility of a pre-existing wellness amongst program admissions selecting committees, or counselling students self-selecting for a program such as counselling. They also attributed their finding to the possibility that counselling program staff may positively influence the wellness of their students, or that therapist preparation may impact "students in processes of self-exploration, learning, and personal growth" (Myers et al., 2003, p. 271). In this way, students may learn, and make use of, effective coping strategies during their training, thereby acting as a buffer for their quality of life during a time of mental health distress. Further research is needed to explore these links in counselling student populations in order to gain insight into how therapists-in-training are coping, particularly in different phases of their training.

Depression, Anxiety, Stress, and Quality of Life of Post-Secondary and Graduate Students

As previously noted, a large body of research has documented overall increases in mental health issues in post-secondary student populations (ACHA-NCHA II, 2008; 2017; Erdur-Baker et al., 2006; Gallagher, 2010; Hunt & Eisenberg, 2010), with few exceptions (Furr, Westefeld, McConnell, & Jenkins, 2001). The demand for counselling services in the post-secondary student demographic and the number of students being diagnosed with severe psychological problems is growing at a rapid rate and this far exceeds the general population. Studies have found dramatic increases in frequency of mental illness diagnoses (Hunt & Eisenberg, 2010), severity and chronicity of mental

illnesses like major depression (Erdur-Baker et al., 2006; Kitzrow, 2003), and in students seeking campus counselling services for these issues (Benton, Robertson, Tseng, Newton, & Benton, 2003; Kitzrow, 2003; Mackenzie et al., 2011). This has been a catalyst for an influx of research exploring the nature of these mental health concerns in the post-secondary student population (Beiter et al., 2015; Eisenberg, Golberstein, Hunt, 2009; Erdur-Baker et al., 2006; Gallagher, 2010; Kitzrow, 2003).

According to the World Health Organization's report on prevention of mental health disorders (WHO, 2004), vulnerability can be increased by the presence of multiple risk factors and a lack of protective factors. According to the report, "both risk and protective factors can be individual, family-related, social, economic and environmental in nature" (WHO, 2004, p. 20). Post-secondary students are therefore especially at risk, often moving to a new city, away from protective family and social support. They also often encounter financial instability and new academic environmental stressors rendering them particularly vulnerable to depression, anxiety and stress (Beiter et al., 2015).

Furthermore, researchers have also been exploring risk factors to better understand the stressors that augment students' vulnerability to certain mental health concerns. Beiter et al. (2015) surveyed 374 undergraduate students between the ages of 18 and 24 attending Franciscan University in Ohio in order to identify the sources of concern that are most correlated with depression, anxiety, and stress. They found that the four sources of concern most strongly correlated with depression and anxiety were: academic performance, pressure to succeed, post-graduate plans, and financial concerns. Aligned with the WHO (2004) report, these findings demonstrated that factors related to student life experiences (ie. academic performance, pressure to succeed, post-graduate

plans, financial concerns) have great potential to impact their mental health. Thus, the student experience seems to implicitly carry with it risk for mental health distress in the form of depression, anxiety, and stress.

While the literature has reported significant increases in students making use of campus counselling services (Erdur-Baker et al., 2006), those numbers are still low compared to the number of students reporting mental health problems (Hyun et al., 2006). Left untreated, mental health issues in students can lead to dropping out of university (Turner & Berry, 2000; Wilson, Mason, & Ewing, 1997) and to the use of negative coping strategies such as amotivation, alcohol and substance, and self-harm amongst others. These negative coping strategies in in turn may negatively impact quality of life and perpetuate depression, anxiety, and stress (Baker, 2004; Cook, 2007).

Stress and anxiety have been the topic of many studies relating to student mental health problems, often investigated alongside depression (Beiter et al., 2015; Eisenberg et al., 2009; Eisenberg, Gollust, Golberstein, & Hefner, 2007; Shields, 2001). Benton et al. (2003) collected data over 13 years (between 1988 and 2001) from campus therapists at the termination of their therapy with clients who were seen for one or more sessions (with data collected from 13,257 participants). During this time, their data indicated steady increases in 14 of the 19 problem areas that were studied, which included depression, anxiety and stress, amongst others. Most importantly, however, they also noticed a shift from relationship problems to stress/anxiety as the most frequently reported student client problem. Further studies have identified these three mental health problems (depression, anxiety, and stress) as the foremost problems that are either being self-reported by students, diagnosed, and/or treated in the student population (Beiter et al., 2015; Hyun et

al., 2006; Nogueira-Martins et al., 2004).

This trend of increasing student mental health distress – specifically, the rise of depression, anxiety, and stress – has also been observed in data collected from the American College Health Association, which has surveyed the post-secondary student population across America using their health assessment tool (NCHA II) (2008; 2017) each Fall and Spring since 1999. The data from this widely-used questionnaire fall in line with those reported by other researchers: there has been a rise in student mental illness and distress including depression, anxiety, and stress. For example, in 2008 (n = 26,685), 19.3% of students reported being diagnosed or treated for one or more mental illness within the last 12 months. This rose to 31.2% in 2017 (n = 63,497) – a 12% increase. Further, the 2008 data reported: within the last 12 months 47% of students felt that things were hopeless; 49.1% felt overwhelming anxiety; 30.6% felt so depressed that it was difficult to function; and 6.4% seriously considered suicide. In 2017, students reported higher levels in each one of these categories: within the last 12 months 51.1% felt that things were hopeless; 60.8% felt overwhelming anxiety; 39.1% felt so depressed it was difficult to function; and 10.3% seriously considered suicide (ACHA-NCHA II 2008; 2017).

The NCHA II has twice reported (Spring 2013 and Spring 2016) data specific to the Canadian student population concurrent with the United States data reports. These results showed that Canadian students reported the same trend of increasing levels of depression, anxiety, and stress. In 2013, 34,039 students from 34 post-secondary institutions participated in the study, and 19.9% reported having been diagnosed or treated for one or more mental illness within the last 12 months. In the same category in

2016, 43,780 students participated from 41 post-secondary institutions, and 28.2% reported having been diagnosed or treated for one or more mental illness – nearly a 10% increase. The percentage of the overall student body who reported feeling that things were hopeless within the last 12 months jumped from 53.8% in 2013 to 59.6% in 2016. Likewise, between 2013 and 2016, students reported an increase of overwhelming anxiety from 56.5% to 64.5%; feeling so depressed that it was difficult to function from 37.5% to 44.4%; and of seriously considering suicide from 9.5% to 13% (ACHA-NCHA II 2013; 2016). These findings highlight the trend of rising rates of depression, anxiety, and stress in the student population spans North America.

While post-secondary students as a whole have been found to experience higher rates of mental health distress impacting their quality of life, graduate students in particular have been found to face added challenges that potentially put them at even greater risk of depression, anxiety, and stress. For instance, several studies have found that graduate students are especially vulnerable to life stressors such as familial and financial obligations, etc. (Hyun, et al., 2006; MIT mental health task force, 2001; Toews et al., 1997), pressure to succeed, and post-graduate plans (Beiter et al., 2015) that may impact their susceptibility to depression, anxiety, and stress. According to Hyun, et al. (2006), these stressors are a direct cause for the observed high levels of depression, stress-related problems, exhaustion, and feeling overwhelmed in the graduate student population.

Studies have found that transition years (the first year of a new program) tend to be the most difficult for undergraduate and graduate students alike (Nogueira-Martins et al., 2004; Paura, & Arhipova, 2014). Dropout rates tend to peak in the first year or two of

study in a new program (Gerdes, & Mallinckrodt, 1994; Paura, & Arhipova, 2014). They have been linked to risk factors related to adjustment, integration and mental health, which have been linked to navigating these transition years successfully (Baker, & Robnett, 2012; Gerdes, & Mallinckrodt, 1994; Eisenberg et al., 2009; Paura, & Arhipova, 2014). Indeed, Nogueira-Martins et al. (2004) found that graduate students in their first year of a master's or doctoral program reported the highest rate of referrals to campus mental health centres.

In terms of prevalence, graduate students have been found to experience much higher levels of depression, anxiety, and stress than the general population. A recent large-scale survey conducted by Evans, Bira, Beltran Gastelum, Weiss, and Vanderford (2018), on 2,279 graduate students from 26 countries, found that "graduate students are more than six times as likely to experience depression and anxiety as compared to the general population" (2018, p. 282). Furthermore, graduate students have been found to experience higher levels of depression, anxiety, and stress than other students (Toews et al., 1997; Wyatt & Oswalt, 2013). For example, a study comparing stress levels among medical students, residents, and graduate students was conducted by Toews et al., (1997), who found that graduate students reported the highest levels of stress, anxiety, and depression between these three groups. Indeed, depression, anxiety, and stress related problems are the main mental health concerns facing the graduate student population. Nogueira-Martins et al. (2004) surveyed 146 graduate students and found that depression and anxiety disorders were the most frequently diagnosed mental health problems amongst the graduate student population at the Federal University of São Paulo. Given

these findings, researchers concluded that there is a "mental health crisis in the graduate student population" (Evans et al., 2018, p. 282).

Many studies have explored the mental health of graduate students as a whole (Nogueira-Martins et al., 2004); however, there is less within-group research and much of existing the within-group research has focused on specific programs of study (Toews et al., 1997) or gender/race differences (Oswalt & Riddock, 2007). Researchers have highlighted the importance of gaining understanding in terms of how graduate students and undergraduates are impacted differently by mental health distress (Nogueira-Martins et al., 2004; Wyatt & Oswalt, 2013). However, few studies have examined differences in graduate student mental health between master's and doctoral levels. Some studies however, that have looked at these differences have found that doctoral level students and master's level students encounter many of the same stressful situations, and report similar stress levels (Mazzola, Walker, Shockley, & Spector 2011). In contrast however, they found that there was a difference in workload with doctoral students reporting higher levels of workload. This suggests the possibility that doctoral students maybe coping more effectively given that they report similar stress levels while experiencing a higher workload. Furthermore, in their exploration of graduate students' mental health needs and use of counselling services, Hyun et al. (2006) reported that doctoral level students were significantly less likely to report mental health needs such as depression, anxiety, and stress than their master's level counterparts. These findings suggest that there may be differences in coping between the two groups, with doctoral students seemingly faring better. Further research is needed to explore these differences and gain greater understanding of the underlying coping mechanisms.

Unsurprisingly, the rise in depression, anxiety, and stress in the post-secondary student population as a whole seems to correspond to low reported levels of quality of life. Michalos and Orlando (2006) conducted a study at the University of Northern British Columbia during a 7-year period during which they explored the well-being and subjective quality of life of 3,407 students. The researchers compared their results to a general adult population (n = 387) surveyed in the same city and found that each of the scores in the general adult population were higher than the student counterparts (these measures included satisfaction in areas such as happiness, overall quality of life, standard of living, and life satisfaction). Thus, students reported lower well-being and lower subjective quality of life than adults over 18 in the same city. They also found a negative correlation between the amount of credits earned and a student's university-related satisfaction. The longer a student had been in school, the less satisfied they seemed to be with their quality of life at school. Elliot et al. (2011) obtained similar results in their study of 159 students enrolled in an undergraduate psychology course. They found a significant relationship between life stressors and subjective quality of life. The more life stressors a student faced, the lower their level of subjective quality of life. Given these trends, it would seem intuitive that therapists-in-training would also report lower levels of quality of life because they are facing more life stressors than many undergraduate students and have been in school longer. However, studies have found that these trends are not necessarily consistent with what has been reported by therapists-in-training.

Depression, Anxiety, Stress, and Quality of Life in Graduate Student Therapists-in-Training: Added Challenges

For student therapists-in-training in both master's and doctoral graduate training

programs, the stress they are already facing as graduate students may be compounded by several added pressures. Based on a survey of American Association of Marriage and Family Therapy (AAMFT) student members, Polson and Nida (1998) found that 27% of student therapists-in-training reported that they had considered dropping out due to stress related to the high demands of their program. Further, 11.2% reported actually dropping out. Indeed, within the graduate student population, researchers have found that student therapists-in-training experience higher rates of mental health distress, in particular depression, anxiety, and stress, than the general population (Rummell, 2015; White & Franzoni, 1990).

Another study of 119 doctoral students in clinical and counselling psychology programs in the United States and Canada found that "doctoral students in clinical and counseling psychology programs experience a significant amount of somatic and psychological symptoms— both at rates higher than what is observed in the general population" (Rummell, 2015, p. 395). Nearly half of their respondents (49.11%) reported experiencing "three or more symptoms of anxiety…occurring multiple times per week" (Rummell, 2015, p. 395). Additionally, they found that 39.3% of their student participants were experiencing five or more symptoms of depression multiple times per week, and 34.8% were experiencing both depression and anxiety.

Beginning clinical work. Therapist trainees are facing pressure as they begin to work with clients. Researchers have identified clinical work as a stressor that adds to mental health problems in clinical training programs as a whole, such as medical school, nursing, psychiatry, and counselling (Rønnestad & Skovholt, 2003; Toews et al., 1997; Truell, 2001). In their cross-sectional and longitudinal qualitative study of counsellor and

therapist development, Rønnestad and Skovholt (2003) identified meeting clients for the first time as one of the main anxiety-provoking incidents for student therapists-in-training beginning their training. They wrote, "meeting clients for the first time can be a critical incident for the student.…often with an anxiety at a level that makes it difficult for students to concentrate, focus attention, cognitively process and remember what happened during the hour" (Rønnestad & Skovholt, 2003, p. 12). This intense 'Beginning Student Phase' of development is fraught with anxiety and can lead students to question their aptitude and capability for the counselling profession and erode their confidence and self-efficacy (Rønnestad & Skovholt, 2003). This added stress on student therapists-in-training as they begin to counsel clients may increase their risk for mental health distress and lower quality of life, also putting them at further risk for dropping out.

Vicarious traumatization of working with traumatized clients. Another potential stressor that is unique to the counselling trainee experience is what researchers refer to as 'vicarious traumatization.' According to Adams and Riggs (2008), "vicarious trauma [is] a process involving a transformation in the inner experience of the therapist resulting from empathetic engagement with clients' traumatic material" (Adams & Riggs, 2008, p. 26). They described vicarious traumatization as an accumulative process that is not attached to any specific client, that can be long-lasting, and that can have multiple implications in the therapist's personal and professional life.

The bidirectional relationship between client and therapist is collaborative, and it is the relationship itself ('therapeutic alliance') that most impacts the shared efforts to heal the client's suffering (Ardito & Rabellino, 2011). Adams and Riggs (2008) conducted a study to examine the variables that influence graduate therapist trainees'

vicarious traumatization. First, they found that a therapist's own trauma history (a category in which 50 of their 134 participants self-identified) could potentially have a re-traumatizing effect on the student working with traumatized clients. Further, having a self-sacrificing defense style, which was reported by over half of participants, left students with an "increased potential for vicarious trauma symptoms" (Adams & Riggs, 2008, p. 31). Finally, the study also found that the level of training a student had undergone at the point of clinical trauma work also impacted their vulnerability to vicarious traumatization. Beginning students with 0-2 semesters of training self-reported significantly higher levels of impairment than more experienced trainees, perhaps partly due to the profound anxiety they experienced as a result of just meeting their client for the first time (Rønnestad & Skovholt, 2003).

It must be noted, however, that the effects of trauma work are not always harmful. In their qualitative study interviewing 21 psychotherapists, Arnold, Calhoun, Tedeschi, and Cann (2005) found that therapists reported, "that trauma work heightened their sense of personal vulnerability…and heightened awareness of humanity's dark side, [causing] deep existential shame at what our species is capable of" (Arnold et al., 2005, p. 257-258). Their participants followed up on this discussion of the harmful and negative effects of trauma work, however, by saying "this change in self-perception had made life seem more precious and inspired them to live fuller, richer lives" (Arnold et al., 2005, p. 257).

Arnold et al.'s (2005) findings suggest a sense of optimism for future therapists working with trauma survivors; however, with an average of 16.9 years of clinical practice, their findings may not fit with the trainee population, especially given Adams

and Riggs' (2008) finding that trainees with less experience struggle more with vicarious traumatization. Thus, therapist trainees face a high level of difficulty in their clinical practice, especially when working with clients experiencing the effects of trauma, which may add to their stress, anxiety, and may even cause possible mental health problems.

Supervision. While supervision can act as a helpful and encouraging positive support for therapist trainees, a difficult supervisor-student relationship can add intense stress and pressure to the trainee's clinical and professional experience. Because of this, researchers have paid ample attention to the supervisor-student relationship. Several studies have demonstrated that supervision within counselling training has the potential to be an intensely threatening experience and has even been shown to be counter-productive to a trainee's clinical development if the supervisory relationship is hampered by frequent conflict (Gray, Ladany, Walker, & Ancis, 2001; Ladany, Hill, Corbett, & Nutt, 1996; Nelson & Friedlander, 2001). In contrast, research has also found that a strong supervisory relationship can facilitate professional learning, improvement, and confidence (Hipple & Beamish, 2007; Ladany, Mori, & Mehr, 2013; Worthington & Roehlke, 1979). While positive supervisory relationships are to be pursued, such ideal relationships may not be as ubiquitous as training program coordinators may assume.

Taking into account the powerful influence of supervision on students beginning a practicum, supervision dynamics often "increase the tension and constant self-evaluation reported" (Rønnestad & Skovholt, 2003, p. 15) by therapist trainees. Student therapists-in-training under scrutiny, then, typically cannot fully relax, take risks, nor bring humour into their practicum work, leading to "excessive and misunderstood responsibility" (2003, p. 15). Furthermore, performance anxiety in supervision can lead therapists-in-training to

hide, or deliberately choose not to share, feelings of self-doubt or incompetence in order to avoid negative evaluations (Thériault et al., 2009). Research has found that therapists-in-training have identified that validation and normalization of these feelings would be helpful in supervision because open discussion in a safe supervision atmosphere would offer the possibility for discussion of self-care strategies and connection. Instead, therapists-in-training are left feeling isolated, vulnerable and incompetent (Thériault et al., 2009). Not only is this harmful to the student's quality of life, it is also linked to clinical competency and outcomes of clinical work (Lockman, et al., 2009). The supervisory relationship has the potential to be extremely helpful and supportive; however, unfortunately this is often not the case. Rather, this relationship often exacerbates a trainee's anxiety and stress, and can inhibit clinical development. These factors may all negatively impact a trainee's mental health and quality of life.

The relationship between personal development and clinical competency. Alongside professional development, researchers have highlighted personal development as equally important for a therapist-in-training's competency with clients (Hensley, Smith, & Waller Thompson, 2003). For therapist trainees, there is a bidirectional relationship between a therapist's development of a secure sense of self and quality of life, and their professional competency. This developmental process requires a trainee to hone their ability to look inward and to grow in self-awareness – a skill directly linked to what the profession calls 'counter-transference.' The ability to understand and work with one's counter-transference then has a direct effect on a trainee's clinical competence. It is this skill that also cultivates a secure sense of self and quality of life (Norcross, 2000; Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2003; Rybak, 2013; Thériault et al.,

2009). Indeed, assessment models of therapist trainee competence include skills such as openness, flexibility, willingness to use and accept feedback, and ability to self-reflect and to demonstrate empathy, amongst others (Hensley, et al., 2003). Given the pressure on student therapists-in-training to succeed in professional development, personal development, and mental health become stressors that add to a student's feelings of anxiety (Krohne, 1989; Schwarzer, 1984).

Watson (1993) addressed the challenges and dilemmas involved in assessing what clinical training refers to as 'the person of the therapist.' She explains the intention of training the person of the therapist, saying, "this structured work should assist the trainee in identifying and examining her or his own personal cultural lens, blindspots, and prejudices. Further, it should assist the trainee in minimizing or eradicating the effects that these factors have in her or his interactions with others" (Watson, 1993, p. 24). Such areas of personal development can be difficult to cultivate and to demonstrate successfully in an academic setting. In addition, it can be confusing and stressful for students to be evaluated on such personal aspects of their development. Furthermore, they also blur the boundary between personal and professional (Watson, 1993), adding to the unique stress of the therapist-in-training's experience.

Quality of life. With the research attention that has been paid to the high levels of student therapist mental health distress such as depression, anxiety, and their stressors, Myers and Sweeney (2008) pointed out that there has been surprisingly little research into student therapist wellness. However, the limited studies that have been conducted on this topic demonstrate surprising findings: quality of life and mental health distress (such

as depression, anxiety, and stress) are not necessarily correlated in the therapist trainee population.

In their study of master's level counselling education students, White and Franzoni (1990) did find that therapists-in-training scored significantly higher for mental health distress, including depression, anxiety, and stress-related psychopathologies than the general population. Furthermore, they found that as psychopathology scores increased to severe levels, mental health was found to decline. Unexpectedly, however, the researchers also found that with the exception of severe levels of psychopathology, therapists-in-training did not report significantly lower levels of what they referred to as 'mental health' (measured by locus of control and social interest) than the general population. Another study, conducted by Myers et al. (2003) found that therapists-in-training experienced higher levels of well-being than the general population. Graduate students in counselling programs (n = 263, part of a 3,043 participant database, which acted as a general population control group) across several states in the US filled out a survey measuring 5 life tasks: spirituality, self-direction, work and leisure, friendship, and love, with several subscales also being measured. Myers et al. found that therapists-in-training scored equal to, or higher than, the average population on all subscales measured. These findings suggest that alongside the problematic levels of mental health distress such as depression, anxiety, and stress, therapists-in-training are also reporting high levels of well-being and quality of life.

Drawing clear conclusions concerning the research on therapists-in-training is challenging due to methodological differences in research designs and differences in operationalization of terms. Wellness, well-being, and mental health all seem to explore

aspects of quality of life. For example, Myers et al. (2003) used the Wheel of Wellness to measure student 'well-being,' in which well-being included: spirituality, self-direction, work and leisure, friendship, and love. White and Franzoni (1990), however, used the Adult Nowicki-Strickland Internal-External Control Scale and the Life Style Personality Inventory measuring one's level of internal locus of control and social interest, respectively, to measure mental health. The measures used in both of these studies to explore mental health bring forward aspects of wellness that relate to Flanagan's (1978) more over-arching concept of quality of life, which has proposed the following 5 components: physical and material quality of life; relations with other people; social, community, and civic activities; personal development and fulfillment; creativity and personal expression, and recreation. Taking into account these two studies in terms of quality of life, the data indicate that while therapists-in-training are experiencing mental health distress, this does not necessarily predict lower quality of life.

Research has been conflicted, but has hinted at a possible difference in quality of life between master's and doctoral level therapists-in-training. Roach and Young (2007) conducted a study in which they examined whether counselling programs promoted wellness for their students. They found that therapists-in-training reported higher levels of quality of life than the general population, even at the beginning of their training (Roach & Young, 2007). They also explored differences in counselling student wellness at the beginning, middle, and end of training, however did not find statistical differences. This may have been due to the fact that all of their participants were in the beginning, middle, or end of a master's program and that no doctoral level students participated. Myers et al. (2003), however, found that doctoral-level students reported higher levels of

total quality of life than entry-level students. These findings suggest that therapist trainees begin their training with a high level of quality of life and that this may increase when a student moves from master's level program to a doctoral level program.

In sum, there is a growing body of research that has identified the rise in student mental health distress as a crisis that must be taken seriously. Data have demonstrated an alarming rise in the amount, severity, and chronicity of post-secondary students suffering from depression, anxiety, and stress. Graduate students have also reported a rise in mental illness as they face more life stressors than undergraduates. As graduate students, therapists-in-training are facing additional challenges such as: clinical work, vicarious traumatization, conflict in supervisory relationships, and the conflation of personal and professional development, which may be contributing to their high levels of depression, anxiety, and stress. However, therapist trainees undergo training at either (or both) the master's or the doctoral level. Given the significant difference in the impact of depression, anxiety and stress in undergraduate and graduate students, there may also be a difference between master's and doctoral therapist trainees. Furthermore, therapists-in-training seem to be reporting high levels of quality of life alongside mental health distress. Due to the importance of student retention, therapist professional development and competency, and the personal mental health and quality of life of this student population, it is important to gain deeper insight into the experience of this population by exploring components that may contribute to students' ability to adapt successfully during the difficulty of a graduate training program.

Student Religion/Spirituality, Mental Health, and Quality of Life

Religion/spiritualty is one component that may be related to a student's ability to manage the stress of a graduate therapy-training program. There is a trend in the populations of most Western countries, including Canada, in which people have reported a move away from religiosity (Marger, 2013). In following this trend, researchers have begun to study the link between mental health and varying levels of religion/spirituality in order to explore its impact (Dilmaghani, 2018). While people have reported lower levels of religiousness, those who identify themselves as non-religious often still report that spirituality is important in their lives (Pew Research Centre, 2013). Because of this, researchers have begun to articulate the difference between religiousness and spirituality and include both religiousness and spirituality in research.

In their review of the literature on religiousness and mental health, Moreira - Almeida, Neto, and Koenig (2006) defined religion as "an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent God, higher power, or ultimate truth/reality" (p. 243). In contrast, spirituality was defined as "the personal quest for understanding answers to the ultimate questions about life, about meaning, and about relationship with the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of a community" (p. 243). While religion and spirituality are two separate paradigms, the current shift toward spirituality makes it important to study both. In his review of the literature, Keonig (2009) proposed that "spirituality be defined in terms of religion, where religion is a multidimensional construct not limited to institutional forms of religion" (p. 285). For this reason, measures have been developed, such as the Fetzer Institute's Multidimensional Measurement of

Religiousness/Spirituality, that include efforts geared toward measuring both religion and spirituality together (Fetzer Institute and National Institute on Aging Working Group, 1999).

Researchers have found a significant link between religion/spirituality domains and mental health in many different population samples, such as women adjusting to cancer (Gall & Bilodeau, 2017), soldiers (Ganocy et al., 2016), the general population (Rasic, Robinson, Bolton, Bienvenu, & Sareen, 2011), and in particular, in post-secondary student populations (Bonab, Hakimirad, & Babibi, 2010; Nemati, Habibi, Vargahan, Mohamadloo, & Ghanbari, 2017). Research has indicated that religious/spiritual affiliation is linked to aspects of quality of life such as satisfaction with living environment, family relationships, school, self, and friends (Yuen, 2013). Findings have been mixed, however, on the role that religion/spirituality plays in relation to mental health, with studies finding either/both a positive and/or a negative link between these two factors (Bonab et al., 2010; Deb, McGirr, & Sun, 2016).

Many studies have found that there is a link between religion/spirituality and mental health and research seems to be clear that this relationship can be either positive or negative. Silton, Flannelly, Galek, and Ellison (2013) found a significant link between belief about God and mental health. In their study of 1,426 Americans, they reported a positive association between psychiatric symptoms and belief in a punitive God and a negative association between psychiatric symptoms and belief in a benevolent God. Along the same lines, Pargament, Koenig, Tarakeshwar, and Hahn (2004) conducted a longitudinal study of 268 medically ill, elderly patients and found that spiritual discontent and feeling punished by God were linked to more feelings of depression both at initial

measurement and two years later. These findings illustrate that it is one's appraisal of religious/spiritual beliefs (e.g., belief in a punitive or punishing God or belief in a benevolent or loving God) that seem to be predictive of mental health outcomes.

This trend has been replicated in relation to quality of life. Pargament et al. (2004) found that both depression and quality of life were significantly linked to spiritual discontent and interpersonal religious discontent. Moreover, they found that "poorer quality of life was also tied to significantly greater punishing God reappraisal, demonic reappraisal, reappraisal of God's power and religious forgiveness" (Pargament et al., 2004, p. 720). The link between both quality of life and mental health and religion/spirituality seems to be influenced by one's own appraisal, or relationship with, religion/spirituality.

Particularly in student populations, studies have demonstrated that better mental health is linked to greater spiritual belief and a sense of purpose (Adams, Bezner, Drabbs, Zambarano, & Steinhardt, 2000; Deb et al., 2016; Yeun, 2013). Indeed, the more spiritual purpose or meaning one finds, the less distress one reports. This can have implications for students in their clinical training. In studying a sample of nursing students (n = 1,276) Hsiao, Chien, Wu, Chiang, and Huang (2010) found that "spiritual health was an important predictive factor for clinical practice stress, depressive tendency and health-promoting behaviours" (p. 1619). They found a negative association between spiritual health and both clinical practice stress and depression. These data clearly indicate that religion/spirituality is an important component to consider in relation to mental health and quality of life.

In their review of existing literature on the relationship between religion and mental health, Moreira-Almeida et al. (2006) suggest that participation in religion/spirituality may act as a buffer for psychological well-being, with greater well-being implications for those who are experiencing an environmental stressor. As therapists-in-training undergo the stress of their training program, religion/spirituality should be considered as a factor relating to mental health distress and quality of life. Furthermore, in studying mental health and quality of life, researchers have explored how coping patterns – including spiritual coping – interact with mental health and quality of life, especially amongst a population that has faced a particular stressor (Guillamon et al., 2013; Koenig, 2009; Montel, Albertini, Desnuelle, & Spitz, 2012). No studies have been conducted to explore how coping (including spiritual coping) interacts with mental health and quality of life of student therapists-in-training.

Coping

The Transactional Model of Stress and Coping

Lazarus and Folkman (1984) proposed a theoretical model called the Transactional Model of Stress and Coping. This model underwent several revisions over the next several decades. To set the groundwork, Lazarus and Folkman (1984) proposed a widely used definition of psychological stress, stating, "psychological stress is a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her quality of life" (p. 19). Folkman and Lazarus (1980) defined coping as "cognitive and behavioural efforts to manage psychological stress" (p. 237).

After reviewing the historical progression of coping research, Folkman and

Lazarus (1988) noticed that researchers had focused primarily on the ways in which emotion impacts coping. Folkman and Lazarus instead viewed the relationship between coping and emotion as bidirectional, opening up the discourse to include coping as a mediator of emotion.

The Transactional Model of Stress and Coping thus proposes that coping strategies carry two primary functions which allow the 'coper' to address an environmental stressor: making efforts to manage the problem itself and to make efforts to manage one's emotional relationship with the stressor (Folkman & Lazarus, 1988; Lazarus, 1991; Lazarus & Folkman, 1984). People undertake two types of appraisals when faced with an environmental situation. Primary appraisals consist of an individual's assessment of how their personal quality of life may be impacted by the environmental encounter (Lazarus, 1991). Secondary appraisals consist of evaluative judgements of the efficacy of possible coping options (Lazarus, 1991; Lazarus & Folkman, 1987). In keeping in line with these two types of appraisals, the theory posits that a particular person's emotional reaction to an encounter in their environment informs their primary appraisal of whether it is 'taxing or exceeding' their resources or 'endangering' their quality of life. This is the relationship or 'transaction' between the person and their environment. This, in turn, influences the person's secondary appraisal of the coping options available to them. In this way, three types of psychological stress may be generated: threat, harm, or challenge. Actual coping efforts (which had been brought to mind during the secondary appraisal) are made to manage this psychological stress. These coping efforts are delineated into two categories: problem-focused and emotion-focused. The process of undergoing these two types of appraisals alters the person's

relationship to the original environmental stressor, which causes them to reappraise the encounter, creating a fluid and ongoing loop (Lazarus, 1991).

Types of coping. Problem-focused coping efforts consist of actions intended to correct or modify the source of the stress, generally when a person believes that a constructive action has the potential to change the problematic situation. Emotion-focused coping usually occurs when a person believes they must bear with the situation. It consists of cognitive strategies aimed at re-evaluating the emotional distress attached to the situation. Carver, Scheier, and Weintraub (1989) argued that this dyadic distinction is too simple. In their development of a tool to assess coping strategies – the COPE, later the Brief COPE (Carver, 1997) – they instead proposed 14 conceptually separate coping processes, with several falling under the umbrellas of emotion-focused and problem-focused coping, and which included coping responses that are "potentially dysfunctional as well as adaptive responses" (1997, p. 93). These 14 processes are: active coping, planning, seeking social support for instrumental reasons, seeking social support for emotional reasons, humour, positive reframing, venting, behavioural disengagement, self-blame, substance use, self-distraction, turning to religion, denial and acceptance.

The transactional model of stress and coping as it relates to therapists-in-training. Based on Lazarus and Folkman's (1984; 1988) model, it would be expected that students who appraise their environment as exceeding their resources and threatening their quality of life experience high levels of psychological stress, anxiety, and/or mental illness. According to the transactional model of stress and coping, one's appraisal of the stressor (counselling program) in relation to one's quality of life and one's subsequent coping efforts lead to a re-appraisal of one's state of quality of life in relationship to the

original environmental stressor. In the case of student therapists-in-training, this would be the experience of those who appraise themselves as lacking the coping strategies to manage the demands of their graduate counselling program (such as academic work, client work, vicarious traumatization, etc.) and their ability to continue to pursue their training. For student therapists-in-training, these challenges (environmental stressors) include: clinical work, the possibility of vicarious traumatization, possible difficulties relating to supervision, professional pressure to demonstrate personal development, clinical competency, financial strain, familial expectations, academic performance, pressure to succeed, post-graduate plans, financial concerns, transitioning to a new program, etc. In this way, coping may have an effect on a person in two very important ways. First, on one's level of mental health and second, on one's quality of life.

In line with this model, several studies have found evidence supporting the notion that positive (adaptive) coping has a positive impact on mental health (Frydenberg, Care, Freeman, & Chan, 2009; Linley & Joseph, 2007; Sasaki & Yamasaki, 2005; Turner et al., 2005). For example, in their validation of a coping style inventory, studying distress and coping styles of 305 Hong Kong university students, Siu and Chang (2011) found that positive coping strategies (in the case of their study the use of social supports and problem solving) were correlated with fewer symptoms of anxiety and depression, while negative coping (such as avoidance) was linked to more stress. Thus, the use of positive coping efforts impacted mental health for the better and the use of negative coping efforts impacted mental health negatively.

Religious/Spiritual Coping

In their work on spirituality in the therapist preparation, Myers and Williard (2003) stated, "it is the integrating force that motivates and shapes the physical, psychological, and emotional functioning of all human beings" (p. 150). Gall et al. (2005) offered a spiritual framework of coping that falls in line with Lazarus' (1984) Transactional Model of Stress and Coping and heeds the gravity with which Myers and Williard (2003) treat the spiritual component's effect on functioning. They wrote "spiritual appraisals and coping behaviours operate as mediating factors in the process of coping with stress" (Gall et al., 2005, p. 90). Operating in the same way as non-religious or spiritual coping strategies, individual spiritual appraisals and coping mediate the effect of life stressors through meaning-making. In addition, this model takes into account spiritual person factors, which "orient an individual in his or her interpretation, comprehension, and reaction to life experiences" (Gall et al., 2005, p. 90), and situational meaning, which functions as spiritual reappraisal of meaning, in a specific person-environment circumstance (Gall et al., 2005).

Studies have found that in particular, spiritual coping plays a central role in effectively dealing with life stressors (Pargament, Smith, Koenig, & Perez, 1998; Myers et al., 2003; Myers & Sweeney, 2008). As Gall and Guirguis-Younger (2013) identified, studies have shown that religious or spiritual coping correlates with lower distress, depression, and anxiety (Baider, et al., 1999; Lee, 2007; Tix & Frazier, 1998), and greater qualities of mental health such as happiness, quality of life, and psychosocial quality of life (Lee, 2007). Indeed, in their review of one widely used theoretical model of wellness (the Wheel of Wellness), Myers and Sweeney (2008) pointed out "spirituality is depicted

as the center of the wheel and the most important characteristic of wellbeing" (2008, p. 483). Furthermore, studies have connected religion and spirituality to physical health (George, Ellison, & Larson, 2002; Powell, Shahabi, & Thoresen, 2003). As these findings demonstrated, "religion and spirituality are distinctive dimensions that add unique explanatory power to the prediction of physical and mental health" (Hill & Pargament, 2003, p.72). An individual's use of spiritual or religious coping may offer additional, and more far-reaching implications when one is faced with psychological stress.

Myers et al.'s (2003) study of the wellness of counselling students found a correlation between those who reported high 'total wellbeing' scores and those who reported high spiritual quality of life, which "includes an orientation to meaning and purpose in life as well as religious or spiritual beliefs and practices" (p. 270). Likewise, Sui and Chang (2011), in their exploration of the coping styles and psychological distress of Hong Kong University students, found that their results demonstrated a "positive association between the use of religious or spiritual strategies for coping and the level of overall life satisfaction" (p. 98). Similarly, therapists identified 'participating in spiritually-oriented activities' as being particularly effective, when surveyed on strategies used to cope with especially taxing work with survivors of sexual violence (Schauben & Frazier, 1995). Thus, spirituality may be an important factor when studying therapist quality of life and may impact quality of life.

How Coping Relates to Mental Health Distress and Quality of Life

Researchers have examined the role coping plays in mediating symptoms of depression, anxiety and stress in the student population (Abdollahi, Hosseinian, &

Asmundson, 2018; Chou, Chao, Yang, Yeh, & Lee, 2011; Meyer, 2001; Nelson, Dell'Oliver, Koch, & Buckler, 2001; Schnider, Elhai, & Gray, 2007). In their study of 123 college students, Schnider et al. (2007) studied how coping style was linked to significant life stress. They delineated Carver, et al. (1989) and Carver's (1997) Brief COPE subscales into the following three coping categories: problem-focused coping (including: active coping, planning, instrumental support, and religion scales); active emotional coping (including: venting, positive reframing, humor, acceptance, and emotional support scales); and avoidant emotional coping (including: self-distraction, denial, behavioral disengagement, self-blame, and substance use scales). Schnider et al. (2007) then found that all three coping categories positively correlated with stress severity. However, with further exploration they found that "only avoidant emotional coping remained as a significant and substantial predictor" (Schnider et al., 2007, p. 347). Alongside other researchers, this study has suggested that those suffering more severe symptoms of mental health distress are using any and every coping resource available to them (Abdollahi et al., 2018; Meyer, 2001; Schnider et al., 2007). Further, their finding that avoidant emotional coping is significantly related to symptom severity has suggested that the use of avoidant emotional coping (also referred to as maladaptive or negative coping) may act as a negative predictor of quality of life. Indeed, there seems to be a trend in regards to the pervasive and especially influential impact of avoidant coping on mental health distress. Negative coping has been linked to several negative outcomes including depression, anxiety, and stress (Baker, 2004; Cook, 2007; Tamboly & Gauvin, 2013).

Specifically in terms of the effect of coping on depression, Abdollahi et al. (2018), have explored how coping mediates perfectionism and depression. The researchers reported that task-focused coping was found to contribute positively to depressive outcomes (less depression). While the study concentrated on perfectionism and its relationship with depression and coping, the definition of 'evaluative concerns perfectionism' as a continuous stressor means that their findings also speak to the mediating effect of coping between one's stress appraisal and one's level of depression. Thus, in a high-stress, long-term situation, students' use of task-focused coping has been found to have a positive effect on their level of depression.

Furthermore, in their review of the literature, Dyrbye, Thomas, and Shanafelt (2005) reported that student coping "strategies that centre on disengagement, such as problem avoidance, wishful thinking social withdrawal, and self-criticism, have negative consequences and correlate with depression, anxiety, and poor mental health" (p. 1613-1614). They also found that coping strategies that are engaging (for example: problem solving, positive reframing, relying on social supports, expressing emotion, etc.) help students adapt, which decreases feelings of depression, anxiety, and stress.

While there has been significant study of coping within the student population as a whole, there has not been adequate study specific to counselling students. Some comparisons can be made to the medical student population as they also undergo clinical training in which they are responsible for the well-being of clients. Research has found that students who are experiencing high levels of mental health distress were more likely than non-distressed students to use self-blame and denial to cope (Yusoff et al., 2011). In fact, self-blame and self-criticism have been found to be the most frequently used coping

strategies by post-secondary students (Bamuhair et al., 2015). These results may indicate a trend in which self-blame, denial, and self-criticism are frequently used, and seem to be related to distress. However, another study of 225 medical graduate students found that active coping, planning, positive reframing and acceptance were most often used in their sample of graduate students. (Goyal, Upadhyah, Pandit, Sharma, & Howale, 2016). This suggests a trend from use of avoidant emotional coping in beginning years of study in a clinical training program, to more adaptive problem-focused and active emotional coping in more advanced years of study.

In terms of spiritual coping, Anye, Gallien, Bian, and Moulton (2013) found that their sample of 225 college students reported a positive relationship between spirituality (including spiritual quality of life and behavioural expressions of spirituality) and quality of life. Specifically in regards to therapists-in-training, Graham, Furr, Flowers, and Burke (2001) found that in their sample of 115 master's level counselling students, religion and spirituality were positively correlated with one's ability to cope during times of stress. In addition, Calicchia and Graham (2006) found that spirituality could be both positively and negatively associated with stress in their sample of 56 master's level counselling students. These findings pointed to some ambiguity in regards to what effect the use of spiritual coping has on mental health and quality of life. Myers et al. (2003) found that doctoral level therapists-in-training reported greater spiritual well-being than their lower level counterparts. The authors expand on this finding in terms of their scale's "orientation to meaning and purpose in life as well as religious or spiritual beliefs and practices" (p. 272). They report that this finding could be attributed to greater self-awareness among doctoral students in regards to their personal spiritual needs, greater

attention paid to spiritual growth, and/or the effects of training in their counselling program. However, it may also be attributed to effective use of positive religious/spiritual coping.

Therapists-in-training have been found to use positive coping strategies. One study of 295 master's level counselling students in Australia found that problem solving and seeking social support were the most utilized coping strategies (Furlonger & Gencic, 2014). Another study of 53 doctoral level counselling students found that these students reported using positive reinterpretation and growth most frequently (Nelson et al., 2001). These findings suggest that active emotional and problem-focused coping patterns are commonly used by therapists-in-training. Furthermore, these findings suggest that therapists-in-training are using adaptive and engaging coping strategies. It is important to gain deeper understanding into how these coping efforts impact mental health and quality of life in this population.

Purpose & Research Question/Hypothesis

Current data reveal significant program-related stressors as well as high levels of depression, anxiety, and stress among graduate students in general and graduate therapy students particularly, with greater distress seemingly being experienced at the earlier stages of training (Adams & Riggs, 2008; Hyun et al., 2006; Rønnestad & Skovholt, 2003). Distress, in turn, may negatively impact their work with clients (Hensley et al., 2003; Lockman, et al., 2009; Rønnestad & Skovholt, 2003). In contrast, therapist trainees have also been found to report high levels of quality of life (Myers et al., 2003). Further research is needed to understand how counselling students cope at different levels of training to understand the mechanisms, which help or hinder their mental health and

quality of life. Indeed, counselling students who report high levels of quality of life may be coping differently than those who report low levels of quality of life. This study aims to gain further knowledge on the relationship between coping behavior and student mental health and quality of life. The findings from this current research may have significant implications for training programs and student support services alike.

This research addresses the following questions:

1) What are therapist trainees' self-reported levels of mental health and quality of life? Is there a significant difference between master's and doctoral level students?
2) What coping strategies correlate with mental health and quality of life, namely: active coping, planning, seeking social support for instrumental reasons, seeking social support for emotional reasons, humour, positive reframing, venting, behavioural disengagement, self-blame, substance use, self-distraction, turning to religion, denial and acceptance?
3) What role does religious/spiritual coping play? Does coping and religious/spiritual coping differ between master's and doctoral level students?

Based on the literature review and these research questions, the researcher puts forward the following hypotheses:

1) Therapist trainees' self-reported levels of mental health will be significantly lower than the general population while their quality of life will be higher than the general adult population.
2) A significant difference will be found between master's level and doctoral level therapists-in-training in terms of coping, mental health and quality of life; with

master's level students reporting more mental health distress.

3) The use of avoidant emotional coping patterns will be associated with lower levels of mental health and quality of life, while the use of active emotional coping and problem focused coping will be associated with higher levels of mental health and quality of life.
4) The use of negative religious/spiritual coping will correlate with lower levels of mental health and quality of life, while the use of positive religious/spiritual coping will be associated with higher levels of mental health and quality of life.

Method

Ethics

The study received approval from the Saint Paul University Research Ethics Board (Appendix A; REB file number 1360.11/17). The voluntary nature of participation in the study was clearly articulated in a recruitment email, which was sent to a contact person with each counselling and therapy graduate training program (Appendix B), as well as the email that was attached for the program contact person to disseminate to the students in their graduate program (Appendix C). Participants were informed of their rights of participants, limits to confidentiality, and the contact information of the researchers at the introduction to the survey before beginning participation. Furthermore, implied consent was obtained in the introduction to the survey (Appendix D).

Recruitment and Data Collection Procedures

Recruitment took place in collaboration with each graduate program. A participation recruitment email was sent out to all masters-level programs in counselling identified on the Canadian Counselling and Psychotherapy Association's website (51 programs) and to all of the accredited English clinical PhD programs (including Clinical Psychology, Counselling Psychology, School Psychology, and Neuropsychology) identified on the Canadian Psychological Association's website (31 programs). Taken together, 82 programs were emailed from 42 different post-secondary schools (located in nine of Canada's 10 provinces) with the intention of gaining a broad range of responses from across Canada and from various counselling and therapy graduate training programs. Each graduate program contact person was asked to disseminate a recruitment email to his or her graduate students. The recruitment invitation described the purpose of

the survey and provided a URL link to the limesurvey.org questionnaire. The survey was launched on January 31, 2018 and remained open to participants until March 30, 2018. Participants were informed that their participation was anonymous, voluntary, and that participants would not be compensated for their time. Given that it was unknown how many programs followed through and sent the invitation email to their students – therefore how many students received the invitation to participate – it was not possible to calculate participation rates.

All questionnaires were attached to a participant number in order to ensure anonymity. Participants began by filling in socio-demographic information including gender, age, program of study, level of study, and school. Following this, participants were asked to fill in five measures of assessment: the Brief COPE, the Brief Multidimensional Measure of Religiousness/Spirituality: 1999 (BMMRS), the Depression, Anxiety, and Stress Scale (DASS 21), the SF36 mental health composite, and the Flanagan Quality of Life Scale (QOLS).

Measures

Mental health. The Depression, Anxiety, and Stress Scale (DASS) 21 (Appendix E), is a self-report measure used to assess the emotional states of depression, anxiety, and stress. Each of these three subscales contains seven items which participants are asked to rate on a scale from 0-4 (0 = Did not apply to me at all, 1 = Applied to me to some degree or for some of the time, 2 = Applied to me to a considerable degree or for a good part of the time 4 = Applied to me very much or most of the time). Each subscale was situated in the participants' experience during the last seven days. The depression scale evaluated dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest /

involvement, anhedonia and inertia (Lovibond & Lovibond, 1995). The anxiety scale evaluated autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect (Lovibond & Lovibond, 1995). The stress scale evaluated levels of chronic non-specific arousal, difficulty relaxing, nervous arousal, and being easily upset / agitated, irritable / over-reactive and impatient (Lovibond & Lovibond, 1995). In other research, the DASS 21 has demonstrated excellent internal consistency: Depression (range $\alpha = .91$ to $\alpha = .97$); Anxiety (range $\alpha = .81$ to $\alpha = .92$); and Stress (range $\alpha = .88$ to $\alpha = .95$) (Gloster et al., 2008). In our study, chronbach's alpha scores also showed good internal consistency: Depression $\alpha = .89$; Anxiety $\alpha = .81$; and Stress $\alpha = .85$.

The Medical Outcome Short Form 36 health study (SF36) (Appendix F) was created by the Rand Corporation in the United States of America (Ware, Davies-Avery, & Donald, 1978; Ware, Manning, Duan, Wells, & Newhouse, 1984). This shortened version consists of 36 items instead of the original 108, which was too long for general use. This study utilized the four-dimension mental component summary – a mental health composite of the SF-36. This measure was situated in the participant's experience of their program of study during the past four weeks. This four-dimension mental health composite of the SF-36 is a self-report questionnaire that included four dimensions, which were scored according to the SF-36 coding scheme (Ware, 2006): social functioning (two questions), role limitation due to emotional problems (which explored the impact of a student's perceived stress and anxiety on their ability to accomplish tasks) (three questions), mental health (emotional well-being) (five questions), energy/vitality (four questions) (Kopjar, 1996). Based on the Rand scoring instructions, each item was

recoded on a scale from 0 (worst possible health state) – 100 (best possible health state) and averaged out to provide a score for each subscale. The SF-36 four-item composite has demonstrated excellent internal consistency in other studies, with each variable as follows: Social Functioning α = .76; Role Limitations due to Emotional Problems α = .80; Mental Health (Emotional Well-being) α = .83; Energy/Vitality α = .85 (Jenkinson, Coulter, Wright, 1993). In our study, chronbach's alpha scores showed good internal consistency: Social Functioning α = .87; Role Limitation due to Emotional Problems α = .77; Mental Health α = .83; Energy/Vitality, α = .87. The four-item mental component summary has been utilized in many studies with acceptable internal consistency (Farivar, Cunningham, & Hays, 2007; Ware et al., 1995) and in our study showed good internal consistency α = .89.

Quality of life. The Flanagan Quality of Life Scale (QOLS) (Appendix G) contains 16 items, which measure aspects of quality of life including: physical and material well-being, relations with other people, social, community and civic activities, personal development and fulfillment, recreation, and independence (Flanagan, 1978). The QOLS was situated in the participants' level of satisfaction in each area of their quality of life during their time spent in their program of study using a 7-point rating scale. The rating scale was as follows: 1 = "Delighted;" 2 = "Pleased;" 3 = "Mostly Satisfied;" 4 = "Mixed;" 5 = "Mostly Dissatisfied;" 6 = "Unhappy;" 7 = "Terrible." Scores were reversed after data collection so that a higher score reflected a higher quality of life. While no psychometric data was reported on this measure when it was constructed, internally consistency was measured to be excellent (α = .82 to α = .92) and demonstrated high test-retest reliability (r = .78 to r = .84) in a study done in 1989

(Burckhardt, Woods, Schultz, & Ziebarth, 1989). Furthermore, researchers using translations of the QOLS have reported similar reliability estimates (Burckhardt, Anderson, Archenholtz, & Hagg, 2003). In our study, the QOLS demonstrated excellent internal consistency at $\alpha = .89$.

Coping. To measure coping, the Brief COPE (Appendix H) was used. The Brief COPE contains the following subscales: self-distraction; active coping; denial; substance use; use of emotional support; use of instrumental support; behavioral disengagement; venting; positive reframing; planning; humor; acceptance; religion; self-blame (Carver, 1997). Participants were asked to respond to the Brief COPE in the context of the participant's experience of coping with the demands of their program of study. Each subscale consisted of two questions, which were rated on a scale from 1-4 (1 = "I haven't been doing this at all;" 2 = "I've been doing this a little bit;" 3 = "I've been doing this a medium amount;" 4 = "I've been doing this a lot"). Other research has demonstrated that internal consistency of reliability of the Brief COPE (measured by subscale) ranged from $\alpha = .5$ to $\alpha = .9$ (Carver, 1997). In our study, chronbach's alpha scores also showed good internal consistency and the subscales were categorized into three coping patterns previously identified by Schnider et al., (2007): Problem-Focused Coping included: active coping $\alpha = .62$, planning $\alpha = .74$, instrumental support $\alpha = .83$, and religion $\alpha = .89$, with a total subscale reliability of $\alpha = .75$; Active Emotional Coping included: venting $\alpha = .53$, positive reframing .74, humor $\alpha = .81$, acceptance $\alpha = .52$, and emotional support $\alpha = .80$, with a total subscale reliability of $\alpha = .80$; and Avoidant Emotional Coping included: self-distraction $\alpha = .41$, denial $\alpha = .41$, behavioral disengagement $\alpha = .54$, self-blame $\alpha = .80$, and substance use $\alpha = .91$,with a total

subscale reliability of α = .75.

Religious/spiritual coping. Religious and spiritual coping were measured using the Brief Multidimensional Measure of Religiousness/Spirituality: 1999 (BMMRS) (Appendix I), which was developed by the Fetzer Institute and National Institute on Aging Working Group (1999). Of the 10 subscales in the BMMRS, only the following four subscales were used in the data analysis: positive religious/spiritual coping (three questions), negative religious/spiritual coping (three questions), meaning (two questions), and forgiveness (three questions). Participants were asked to respond to the BMMRS within their experience of coping with the demands of their program of study. In line with other researchers, (Bodling, Heneghan, Walsh, Yoon, & Johnstone; 2013; Johnstone & Yoon, 2009), this study standardized the range of scoring so that each subscale was scored equivalently using a 1-4 rating scale with regards to a participant's experience with religion or spirituality during their time spent in their program of study (1 = "A great deal;" 2 = "Quite a bit;" 3 = "Somewhat;" 4 = "Not at all"). Scores were reversed after data collection so that a higher score reflected a higher use of each coping subscale. Each of the subscales used have demonstrated good internal consistency in other studies: Positive Religious/Spiritual Coping (α = .81); Negative Religious/Spiritual Coping (α = .54); Forgiveness (α = .66); Meaning (α = .70) (Fetzer Institute and National Institute on Aging Working Group, 1999; Bodling et al, 2013). In our study, chronbach's alpha scores mostly demonstrated good internal consistency: Positive Religious/Spiritual Coping (α = .88); Negative Religious/Spiritual Coping (α = .15); Forgiveness (α = .56); Meaning (α = .84).

Participants

A total of 187 graduate level therapist trainees were recruited. Twenty-two of these participants filled out less than half of the survey, which lead the researchers to exclude their data, thus reducing the amount of participants who completed the survey to 165. Out of the 42 schools that were sent recruitment emails, participants responded from 18 different schools (42.86%), with one participant reporting 'no answer' as to which school they attended. This sample consisted of participants from every province across Canada with the exception of Prince Edward Island (which does not offer any clinical graduate programs). The cross Canada distribution of participants is demonstrated in Table 1. Participants as a group ranged in age from 21 - 60, with a mean age of 31.48 (*SD* 7.74). MA participants ranged in age from 21-60 with a mean age of 32.11 (*SD* 8.45). PhD participants ranged in age from 24-45 with a mean age of 29.21 (*SD* 4.55). Participants included 145 females (87.9%) and 20 males (12.1%). Of these participants, 42 (25.5%) were in a PhD program and 123 (74.5%) were in a master's program.

When asked the question **'**to what extent do you consider yourself a religious person?' 16 (13%) of master's students responded 'a great deal,' 15 (12.2%) responded 'quite a bit,' 26 (21.2%) responded 'somewhat,' and 63 (51.2%) responded 'not at all.' When asked the same question, 2 (4.8%) of doctoral students responded 'a great deal,' 3 (7.1%) responded 'quite a bit,' 5 (11.9%) responded 'somewhat,' and 30 (71.4%) responded 'not at all.' When asked 'to what extent do you consider yourself a spiritual person?' 39 (31.7%) of master's students responded 'a great deal,' 37 (30.1%) responded 'quite a bit,' 31 (25.2%) responded 'somewhat,' and 13 (10.6%) responded 'not at all.'

Table 1

Frequency of Participation by Geographic Area

Geographic Area	School	Province	Frequency	Percentage
Eastern Canada	Acadia University	Nova Scotia	2	1.2
	University of New Brunswick	New Brunswick	2	1.2
	Concordia University	Quebec	19	11.5
	Dalhousie University	Nova Scotia	7	4.2
	Memorial University of Newfoundland	Newfoundland	4	2.4
	Total		34	20.5
Central Canada	OISE University of Toronto	Ontario	8	4.8
	Ryerson University	Ontario	7	4.2
	Saint Paul University	Ontario	25	15.2
	University of Western Ontario	Ontario	3	1.8
	York University	Ontario	9	5.5
	University of Winnipeg	Manitoba	9	5.5
	University of Manitoba	Manitoba	9	5.5
	Total		70	42.5
Western Canada	Athabasca University	Alberta	24	14.5
	Briercrest College and Seminary	Saskatchewan	11	6.7
	Simon Fraser University	British Columbia	6	3.6
	Trinity Western University	British Columbia	6	3.6
	University of Calgary	Alberta	5	3.0
	University of Lethbridge	Alberta	8	4.8
	Total		60	36.2
	Missing		1	.6
	Total		165	100

When asked the same question, 9 (21.4%) doctoral students responded, "a great deal,' 7 (16.7%) responded 'quite a bit,' 14 (33.3%) responded 'somewhat,' and 10 (23.8%) responded 'not at all.' Three (2.4%) master's students and 2 (4.8%) doctoral students did not provide an answer to either question.

Overall, the participant sample reported being more spiritual than religious. This is in line with a trend amongst Canadians moving away from religious affiliation. Research has found that within the rising percentage of Canadians identifying themselves as having no religious affiliation (4% in 1971 – 24% in 2011) many (33%) reported that spiritual beliefs are important to their daily living and nearly one fifth (18%) reported that prayer, meditation, or engaging in other forms of worship are practiced at least once a month (Pew Research Centre, 2013).

Data Analysis

All data analyses were conducted using SPSS v23.0. Missing data was handled through listwise deletion. One-sample t-tests were conducted in order to determine if a statistically significant difference existed between each of the outcome variables from the master's level therapists-in-training and the general population. Normative data for the general population was used for the SF-36 (Hopman et al., 2000), the DASS 21 (Crawford & Henry, 2003) and the QOLS (Burkhardt & Anderson, 2003). One-sample t-tests were also conducted in order to determine if a statistically significant difference existed between each of the outcome variables from the doctoral level therapists-in-training and the general population. These one-sample t-tests used normative data for comparison with the QOLS (Burckhardt & Anderson, 2003), the DASS21 (Crawford &

Henry, 2003), and the SF36 (Hopman et al., 2000). Normative data for the SF36 used the sum of the norm means for each of the 4 subscales of the mental composite summary.

Independent t-tests were conducted to compare each of the outcome variables (mental health, depression, anxiety, stress, quality of life) between the master's and doctoral populations in order to determine if there was a significant difference between groups.

In order to determine the degree and pattern of relationship amongst each outcome variable and each group of coping style for both the master's and the doctoral student samples, Pearson correlations were conducted. When groups of coping styles were found to significantly correlate with outcome variables, multiple linear regression analyses were conducted in order to determine which particular coping strategies significantly predicted the outcome measure.

In order to explore whether or not religious/spiritual coping significantly predicted the outcomes after having controlled for coping styles alone, hierarchical linear regressions were conducted on outcomes that were found to correlate significantly with both a coping style (input in Block 1) and a religious/spiritual coping strategy (input in Block 2).

Results

Comparing Therapists-in-Training to the General Population: Mental Health and Quality of Life

Master's level therapists-in-training reported lower scores on the mental health composite (M = 211.845, SD = 84.471) than the general population, $t(117) = -9.755$, $p <$ .001 and lower quality of life (M = 74.946, SD = 13.045) than the general population,

$t(92) = -11.129$, $p < .001$. Master's level therapists-in-training reported higher depression ($M = 10.423$, $SD = 9.007$) than the general population, $t(122) = 6.000$, $p < .001$; higher anxiety ($M = 8.081$, $SD = 7.524$) than the general population, $t(122) = 6.664$, $p < .001$; and higher stress ($M = 16.260$, $SD = 8.206$) than the general population, $t(122) = 9.447$, $p < .001$. These results indicate that our sample of master's level therapists-in-training experienced significantly lower levels of mental health and lower quality of life than the general population.

Similarly, doctoral level therapists-in-training reported lower levels of mental health on the mental health composite ($M = 258.514$, $SD = 78.743$) than the general population, $t(36) = -2.255$, $p = .030$ and lower quality of life ($M = 80.033$, $SD = 13.718$) than the general population, $t(29) = -3.980$, $p < .001$. However, no significant difference was found between doctoral level therapists-in-training's level of depression ($M = 6.524$, $SD = 6.656$), anxiety ($M = 4.238$, $SD = 4.721$), and stress ($M = 10.714$, $SD = 7.494$) than the general population, $t(41) = .948$, $p = .349$, $t(122) = .934$, $p = .357$, $t(122) = 1.249$, $p = .219$, respectively. In line with their master's student counterparts, these results demonstrate that our sample of doctoral level therapists-in-training reported lower quality of life and lower mental health than the general population, however, unlike their master's-level counterparts, they did not report higher levels of depression, anxiety, and stress than the general population in the measures used.

Comparing Master's and Doctoral Level Therapists-in-Training: Mental Health and Quality of Life

A significant difference between master's and doctoral students was found in the independent-samples t-tests comparing the mental health composite, depression, anxiety,

and stress. Master's students reported lower levels of mental health (M = 211.84, SD = 84.47) than doctoral students (M = 258.51, SD = 78.74), [$t(153) = -2.98$, $p = .003$]. Master's students also reported higher levels of depression (M = 10.42, SD = 9.01) than doctoral student (M = 6.52, SD = 6.66), [$t(163) = 2.57$, $p = .005$]; higher anxiety (M = 8.08, SD = 7.52) than doctoral students (M = 4.24, SD = 4.72), [$t(163) = 3.11$, $p = .002$]; and higher stress (M = 16.26, SD = 8.21) than doctoral students (M = 10.71, SD = 7.49), [$t(163) = 3.86$, $p < .001$]. Thus, master's students report significantly higher levels of mental health distress in all domains than their doctoral level counterparts.

However, in the independent-samples t-test comparing quality of life, no significant difference was found in the scores for master's students (M = 74.95, SD = 13.04) and doctoral students (M = 80.03, SD = 13.72), [$t(121) = -1.83$, $p = .069$]. These results suggest that master's and doctoral students are experiencing comparable levels of quality of life in our sample.

The Coping Patterns of Therapists-in-Training

The correlations between mental health and quality of life and coping patterns of therapists-in-training are presented in Table 2. Avoidant emotional coping was consistently associated with the mental health composite and quality of life. There was a significant positive correlation between avoidant emotional coping and depression, anxiety, and stress, and a significant negative correlation between the mental health composite and quality of life. These results suggest that the more depressed, anxious, and stressed master's level students feel and the lower their reported level of mental health and quality of life, the more they are using avoidant emotional coping. Alternatively, the more master's students use avoidant emotional coping, the lower their

self-reported level of mental health and quality of life. A significant positive correlation between stress and active emotional coping was found, however, active emotional coping was not significantly correlated with any other outcome. Similarly, no significant problem-focused coping was associated with any of the outcomes. Increased self-reported stress is significantly correlated with increased coping strategies.

Table 2

Correlation of Coping Patterns with Quality of Life and Mental Health of Master's and Doctoral Students

Outcome Variables	Level of Study	Problem Focused Coping	Active Emotional Coping	Avoidant Emotional Coping
Mental Health Composite	MA	.043	-.017	-.569**
	PhD	.088	-.090	-.831**
Quality of Life	MA	.047	-.009	-.408**
	PhD	-.040	.059	-.526**
Depression	MA	-.027	.037	.591**
	PhD	-.192	.044	.733**
Anxiety	MA	.071	.150	.538**
	PhD	.021	.180	.570**
Stress	MA	.106	.179*	.574**
	PhD	-.069	.134	.561**

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

Correlations of doctoral level therapists-in-training mental health and quality of life with their coping patterns are also presented in Table 2. Like master's students, avoidant emotional coping was related to each of the outcomes for doctoral students as

well. The results demonstrate a negative relationship between avoidant emotional coping and both the mental health composite and quality of life as well as a positive relationship between avoidant emotional coping and depression, anxiety, and stress.

In summary, greater use of avoidant emotional coping was negatively correlated with the mental health composite and quality of life, and positively correlated with depression, anxiety, and stress in both the master's and the doctoral level therapists-in-training.

The Coping Strategies of Therapists-in-Training

Based on the correlations of the coping subscales that were found to be significantly associated with each outcome, multiple regression analyses were conducted to identify which coping strategies within each coping style were independently predictive of both mental health and quality of life outcomes in both the master's and doctoral student populations. Table 3 displays the results of the multiple regressions on components of avoidant coping for master's students. Table 4 displays the results of the multiple regressions on components of avoidant coping for doctoral students. Table 5 displays the results of the multiple regression on components of active emotional coping.

For the master's level students, self-blame consistently predicted each of the outcomes. Mental health, depression, anxiety, stress, and quality of life are significantly predicted by the use of self-blame coping. That is, use of self-blame coping significantly predicts lower mental health and quality of life. Furthermore, scores on depression and the mental composite were significantly predicted by the use of behavioural disengagement coping strategies, suggesting that the more students disengage from their coping efforts, the more depressed they report themselves being and the lower their

mental health composite scores.

Table 3

Regression analysis of Mental Health, Quality of Life, Depression, Anxiety, and Stress on components of Avoidant Coping in Master's Level Student Therapists-in-Training

	Predictor Variables	β	Std. Error	R^2	*F*	Sig.
Mental Health Composite				.39	14.57	
	SD	-.046	5.36			.586
	Denial	.067	9.71			.447
	BD	-.215	7.95			.018*
	Self-Blame	-.467	4.11			.000**
	Substance Use	-.154	4.50			.045*
Quality of Life				.37	10.32	
	SD	.165	.996			.108
	Denial	.230	1.72			.032*
	BD	-.208	1.48			.061
	Self-Blame	-.520	.752			.000**
	Substance Use	-.211	.789			.019*
Depression				.43	17.75	
	SD	.134	.55			.096
	Denial	-.065	.99			.438
	BD	.417	.80			.000**
	Self-Blame	.305	.41			.000**
	Substance Use	.105	.42			.146
Anxiety				.32	11.00	
	SD	.126	.50			.152
	Denial	.081	.91			.380
	BD	.080	.73			.386
	Self-Blame	.405	.38			.000**
	Substance Use	.077	.42			.326
Stress				.36	14.61	
	SD	.173	.52			.039*
	Denial	.039	.94			.654
	BD	.068	.76			.435
	Self-Blame	.466	.39			.000**
	Substance Use	.054	.44			.474

* $p < .05$; ** $p < .001$. Note: SD = Self-Distraction; BD = Behavioural Disengagement

Table 4

Regression analysis of Mental Health, Quality of Life, Depression, Anxiety, and Stress on components of Avoidant Coping in Doctoral Level Student Therapists-in-Training

	Predictor Variables	β	Std. Error	R^2	*F*	Sig.
Mental Health Composite				.50	4.84	
	SD	-.350	5.27			.003*
	Denial	-.199	19.80			.150
	BD	-.095	11.87			.438
	Self-Blame	-.214	5.06			.055*
	Substance Use	-.350	7.69			.010*
Quality of Life				.50	4.84	
	SD	-.153	1.42			.364
	Denial	-.763	5.13			.003*
	BD	.132	4.49			.553
	Self-Blame	-.149	1.34			393
	Substance Use	.105	1.90			.590
Depression				.64	12.79	
	SD	.037	.47			.739
	Denial	-.002	1.48			.988
	BD	.265	1.01			.043*
	Self-Blame	.215	.48			.069
	Substance Use	.504	.55			.000**
Anxiety				.47	6.32	
	SD	.227	.41			.046*
	Denial	.114	1.28			.424
	BD	-.225	.87			.153
	Self-Blame	.101	.41			.475
	Substance Use	.569	.48			.001*
Stress				.36	4.01	
	SD	.241	.71			.110
	Denial	.033	2.23			.833
	BD	-.001	1.52			.997
	Self-Blame	.104	.72			.503
	Substance Use	.424	.83			.014*

* $p < .05$; ** $p < .001$. Note: SD = Self-Distraction; BD = Behavioural Disengagement

Stress was significantly predicted by self-distraction and venting coping efforts,

suggesting that master's students who are reporting increased stress, are also reporting increased use of venting and self-distraction. Quality of life was significantly predicted by denial, suggesting that the lower the quality of life master's students reported, the more they used denial coping. Finally, scores on quality of life and the mental health composite were significantly predicted by the use of substance use to coping, suggesting that the lower quality of life and mental health master's students reported, the more they coped by substance use.

Unlike their master's level counterparts, in doctoral level students, only the scores on the mental health composite were significantly linked to the use of self-blame as a coping strategy. In the doctoral level students, scores on the mental health composite, depression, anxiety, and stress were each significantly predicted by substance use coping. In doctoral level students, scores on the mental health composite were significantly predicted by the use of self-distraction. As well, depression was significantly predicted by behavioural disengagement coping and anxiety was significantly predicted by distraction coping. Finally, for doctoral students, quality of life was significantly predicted by denial coping.

In summary, the primary coping strategy that predicted measures of mental health and quality of life of master's level students, was self-blame coping. The primary coping strategy that predicted measures of mental health in doctoral students was substance use coping. Quality of life in doctoral level students, however, was not predicted by substance use coping. These data distinguish differences between master's and doctoral level therapists-in-training in terms of the coping strategies were found to be predictive of mental health and quality of life.

Table 5

Regression analysis of Stress on components of Active Emotional Coping in Master's Student Therapists-in-Training

Predictor Variables	β	Std. Error	R^2	*F*	Sig.
			.13	3.52	
Venting	.40	.63			.000**
Positive Reframing	-.12	.58			.311
Humour	.01	.47			.954
Acceptance	-.01	.60			.937
Emotional Support	-.01	.54			.893

N = 122
* $p < .05$; ** $p < .001$

The Religious/Spiritual Coping Patterns of Therapists-in-Training

Pearson correlations of master's level therapists-in-training mental health and quality of life with their religious/spiritual coping patterns are presented in Table 6. The use of negative religious/spiritual coping strategies was negatively related to quality of life and mental health and positively related to depression and stress. The use of forgiveness was also significantly positively related to mental health and negatively related to levels of depression. Neither positive religious/spiritual coping nor meaning significantly related to any of the outcomes.

Correlations of doctoral level therapists-in-training mental health and quality of life with their religious/spiritual coping patterns are also presented in Table 6. No significant relationship between religious/spiritual coping and quality of life or mental health variables was found.

Table 6

Correlation of Religion/Spiritual Coping Patterns with Quality of Life and Mental Health of Master's and Doctoral Students

	Level of Study	Negative Religious/Spiritual Coping	Positive Religious/Spiritual Coping	BMMRS Meaning	BMMRS Forgiveness
Mental Health Composite	MA	-.281*	.011	-.067	.284*
	PhD	.016	-.179	-.094	.062
Quality of Life	MA	-.247*	-.105	-.146	.164
	PhD	-.083	.104	-.014	.237
Depression	MA	.276*	-.047	-.047	-.232*
	PhD	.129	-.135	-.138	-.198
Anxiety	MA	.157	.003	.068	-.178
	PhD	.002	.081	.010	-.077
Stress	MA	.239*	-.016	.037	-.168
	PhD	-.137	-.046	-.107	-.156

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

After conducting a visual review of the correlations, for each of the outcome variables that correlated with both a coping style and religious/spiritual coping, hierarchical regressions were conducted (Table 7) to investigate whether the spiritual coping significantly predicted outcomes after controlling for the other coping strategies that were significantly associated. Religious/spiritual coping was not found to significantly predict quality of life, depression or stress for master's students after controlling for general coping strategies. However, forgiveness coping was found to significantly predict mental health, after controlling for other coping strategies, accounting for an additional 5% of the variance in their level of mental health.

Table 7

Results from Hierarchical Regression Analyses Showing Religious/Spiritual Coping as an Additional Contributor to Master's Student Mental Health and Quality of Life

Regression Models	β	R^2	R^2 Change	$F(df)$, p level R^2 change
Criterion:				
Mental Health Composite				
$F(3,110) = 22.528$, $p < .001$				
Predictors:				
Step 1				
Avoidant Emotional Coping	-.513*	.330	.330	$F(1,112) = 55.05$, $p < .001$
Step 2				
Negative R/S Coping	-.115	.381	.051	$F(2,110) = 4.53$, $p = .013$
Forgiveness	.190*			
Criterion:				
Quality of Life				
$F(2,88) = 9.873$, $p < .001$				
Predictors:				
Step 1				
Avoidant Emotional Coping	-.370*	.169	.169	$F(1,89) = 18.097$, $p < .001$
Step 2				
Negative R/S Coping	-.126	.183	.014	$F(1,88) = 1.540$, $p = .218$
Criterion:				
Depression				
$F(3,112) = 25.367$, $p < .001$				
Predictors:				
Step 1				
Avoidant Emotional Coping	.566*	.377	.377	$F(1,114) = 69.067$, $p < .001$
Step 2				
Negative R/S Coping	.103	.405	.027	$F(2,112) = 2.567$, $p = .081$
Forgiveness	-.126			
Criterion:				
Stress				
$F(3,114) = 20.285$, $p < .001$				
Predictors:				
Step 1				
Avoidant Emotional Coping	.530*	.342	.342	$F(2,115) = 29.908$, $p < .001$
Active Emotional Coping	.096			
Step 2				
Negative R/S Coping	.081	.348	.006	$F(1,114) = 1.025$, $p = .313$

* $p < .05$; ** $p < .001$. Note: R/S = Religious/Spiritual

Discussion

Using a cross-sectional pan-Canada sample of graduate students, the present study investigated the mental health, quality of life, and coping patterns of therapists-in-training. Aligned with our prediction, we found that our sample of students reported overall significantly higher levels of mental health distress and lower quality of life than the general population. Specifically, both master's and doctoral students reported significantly more mental health distress than the general population, and master's level students (but not doctoral students) reported higher levels of depression, anxiety, and stress than the general population. These findings align with previous research indicating a rise in reported severity and chronicity of mental health distress in the graduate student population as a whole (Evans et al., 2018) as well as with research indicating that therapists-in-training specifically, report experiencing high levels of mental health distress (Rummell, 2015; White & Franzoni, 1990). These high levels of reported distress may be compounded by the particularities of graduate training in psychotherapy, which include beginning work with clients (Rønnestad & Skovholt, 2003), vicarious traumatization (Adams & Riggs, 2008), supervision (Gray et al., 2001; Ladany et al., 1996; Nelson & Friedlander, 2001) and personal and professional development (Krohne, 1989; Schwarzer, 1984). Indeed, Rummel (2015) found that 60% of their clinical and counselling psychology graduate student sample reported that the most stressful facet of their lives was their graduate training program. Other research has also linked clinical training experiences (psychotherapy, clinical psychology, or medical school) to mental health distress such as depression, anxiety, and stress (Dyrbye, Thomas, & Shanafelt, 2006; Rummel, 2015).

Regarding quality of life, both master's and doctoral level students reported significantly lower levels of quality of life than the general population. These findings do not align with our prediction and conflict with previous research, which have found that therapists-in-training report higher wellness than the general population (Myers et al., 2003; White & Franzoni, 1990). These conflicting findings may be due to methodological differences in measures used. While we used an overarching measure of quality of life, other researchers used differing and narrower measures of well-being (Myers et al., 2003), locus of control and social interest (White & Franzoni, 1990). It may be that therapists-in-training experience high levels of some aspects of quality of life and/or that there are some aspects of quality of life that are particularly low for this population. Further study on specific sub-categories of quality of life may help improve awareness of specifically how therapists-in-training are struggling in order to better inform strategies that may help them improve.

The finding that doctoral level students (unlike their master's level counterparts) did not report significantly lower levels of depression, anxiety, and stress than the general population, is noteworthy. Even with lower reported quality of life, doctoral students seemed to be managing well emotionally. When we compared master's level and doctoral level students, master's level students reported significantly more mental health distress in every category. However, there was no significant difference found between the groups in quality of life. Length of time spent in a psychotherapy training program may influence how students cope with their mental health. As Lazarus and Folkman's (1987) Transactional Model of Stress and Coping indicates, it is the appraisal of one's available resources and one's ability manage an environmental stressor that establishes

one's emotional relationship to that stressor. In light of this model, it may be that doctoral level students appraise their own ability to cope effectively with the stress of therapy training program with stronger assurance. As other researchers have suggested, a high level of healthy coping among counsellors in training may be due to time spent in a program of study (Adams & Riggs, 2008). Adams and Riggs also suggested that spending more time in a therapy training program may allow a student to begin to integrate healthy means of adaptation. Furthermore, therapy programs often encourage students to attend personal counselling, which may also increase a student's self-awareness and mental health (Adams & Riggs, 2008). The cross-sectional design of this study, however, does not allow us to conclude if there is indeed a progression in mental health; however future longitudinal research would be important for exploring these findings further. It may also be that there is an existing wellness among students who choose (and are selected) to pursue a higher level of study. Similarly, these data may be attributed to a good occupational good fit. Students who choose to pursue a doctoral level degree may find their training particularly fulfilling and find themselves well-suited to the work. Linley and Joseph (2007), in their study on positive and negative well-being among a sample of 156 practicing therapists, found that the more hours of therapy their sample of therapists practiced, the greater the reported positive change and personal growth. They credit this phenomenon to the likelihood that therapists who are oriented toward benefitting from their work may then choose to take on an increased workload because of the benefits they experience through their practice. The same may be true for our sample of doctoral students: those who chose to pursue a doctoral degree may have done so because they were already benefitting from their work as therapists. This could

also explain why they tolerate low reported levels of quality of life (as students) without necessarily suffering from heightened depression, anxiety, and stress.

It must be noted that doctoral levels students did, however, report a significantly higher level of mental health distress on the mental health composite measure than the general population. The mental health composite measured emotional well-being, energy/fatigue, social functioning, and role limitation due to emotional problems (which explored the impact of a student's perceived stress and anxiety on their ability to accomplish tasks). On these measures, doctoral students, like master's students, did report experiencing more distress than the general population. This finding may be due to the possibility that the subscales of the SF-36 mental health composite measure we used relate differently to the experiences of students. In fact, it may be possible that baseline scores for students on two of the four subscales in particular: energy/fatigue and emotional problems that affect one's ability to accomplish tasks might have (e.g., attending classes, client work, and assignment/paper writing) may be different than the general population, which may skew this finding.

Coping Patterns, Mental Health, and Quality of Life

Avoidant coping was found to correlate with each mental health outcome as well as quality of life. The widespread use of avoidant coping among post-secondary students has been well-documented (Brougham Zail, Mendoza, & Miller, 2009; Chao, 2011) and its link to increased depression and anxiety has been found in college populations. (Romero, Riggs, & Ruggero, 2015). When we conducted multiple regression analyses to explore which particular coping strategies were significant within the larger pattern of avoidant emotional coping, we found self-blame was more predictive of distress in

master's students, while substance use was more predictive of distress in doctoral students. Self-blame significantly predicted all of the mental health and quality of life outcomes in the master's level student sample. Spataro, Tilstra, Rubio, and McNeil (2016) caution educators to be particularly attentive to the use of self-blame as a coping strategy as it was found to be predictive of distress in their sample of 198 medical residents. The authors concluded that greater use of self-blame coping may act as a considerable factor in precipitating burnout and emotional exhaustion. They also stated that, "more frequent use of self-blame appears to cancel out the benefits of other more adaptive coping mechanisms" (p. 1150). Given these findings, the use of self-blame as a coping strategy may contribute to impairments in master's level therapists-in-training's quality of life and mental health. It may also be undermining the outcome of possible attempts to utilize other, more adaptive, coping strategies.

In terms of substance use, doctoral level therapists-in-training' use of substances significantly predicted lower mental health on the mental health composite, as well as higher depression, anxiety, and stress. For master's level students, substance use was only found to significantly predict lower quality of life and lower scores on the mental health composite. Some researchers have also found a link between substance use and mental health distress such as depression, anxiety, and stress (Cranford, Eisenberg, & Serras, 2009; Prosek, Giordano, Woehler, Price, & McCullough, 2018). Other research however, has found conflicting findings, reporting no significant associations between substance use and mental health distress in post-secondary student populations. For example, Cranford et al. (2009) found that while frequent binge drinking was associated with higher anxiety, it was also associated with lower levels of major depression in

college populations. The researchers suggested social norms and expectations may play a role in the use of alcohol among college populations, particularly for undergraduate students (Cranford et al., 2009; Serras, Saules, Cranford, & Eisenburg, 2010). Indeed, post-secondary undergraduate students have been found to abuse substances more frequently than graduate students (Cranford et al., 2009). Our finding that doctoral students who reported greater use of substances also reported higher levels of mental health distress is especially relevant in that it may be indicative of maladaptive coping. In this way, the relationship between mental health and using substances to cope may be the same for doctoral students and the general population alike, as research has found a link between substance use and mental health distress (Cramer, Colbourn, Gemerling, Graham, & Stroud, 2015; Newcomb, Scheier, & Bentler, 1993). Whereas master's level students, however, may not be reporting a link between substance use and depression, anxiety, and stress because they may still be considering alcohol/drug use as a socially acceptable way of life, rather than using substances to cope. In light of our finding that master's level students who reported low levels on the mental health composite and low quality of life also reported greater use of substances, the deleterious effects of substance use remains apparent. In line with the findings of Prosek et al. (2018) in their sample of college students, we found that in our sample of both master's level and doctoral level students, using substances as a coping strategy was linked to students who reported struggling (either with mental health distress, or low quality of life).

Religious/Spiritual Coping

In terms of our exploration of religious/spiritual coping, we found that for master's level students, negative religious/spiritual coping and forgiveness was

significantly linked to mental health and quality of life. No relationship was found in doctoral students. In our sample, doctoral level students reported lower religious saliency, which may explain the differences observed between the groups. We found that the use of negative religious/spiritual coping had a positive correlation with depression, anxiety, and stress, and a negative correlation with the mental health composite and quality of life. As other researchers have noted, negative beliefs about God (e.g., belief that God is vindictive, cruel, or punishing) are associated with high psychological distress (McConnell, Pargament, Ellison, & Flannelly, 2006 Silton et al., 2013). Furthermore, McConnell et al. (2006) found that people dealing with a difficult environmental stressor report a stronger relationship between spiritual struggles and mental health distress. It seems that when students use more negative religious/spiritual coping, they may 'spiral' down into greater mental health distress. This finding aligns with Gall and Bilodeau (2017) who refer to a 'downward spiral effect' in which negative religious/spiritual coping is especially salient in the long-term. In their study of women coping with breast cancer, the authors found that use of negative religious/spiritual coping predicted greater distress at follow-up, which in turn again predicted greater distress at the next follow-up, etc. In this way, when master's students use negative religious/spiritual coping, they may get caught in a downward spiral, experiencing heightened mental health distress, which compounds and intensifies, leading to even more mental health distress, and so on.

Within the religious/spiritual forgiveness subscale, our participants were asked to respond to questions about forgiving themselves for things they had done wrong, forgiving others who had hurt them, and knowing that God forgives them. In our sample of master's students, the use of forgiveness had a positive correlation with the mental

health composite and a negative association with depression. These findings are similar to previous research, which has found that forgiveness is related to lower levels of depression (Yoon & Lee, 2007) and more life satisfaction (Bono, McCullough, and Root, 2008). We also looked into whether the religious/spiritual coping strategies significantly predicted outcomes beyond the other coping patterns. For master's students, forgiveness was the only spiritual coping strategy found to significantly predict higher scores on the mental health composite after controlling for other coping strategies. This may be because of the way in which forgiveness coping functions. In describing their Spiritual Framework of Coping, Gall et al. (2005) acknowledge the recursive nature of spiritual coping and meaning-making. Primary appraisal of one's relationship to a stressor leads to spiritual appraisal and spiritual coping, which leads to meaning-making. This cycle then re-occurs as one re-appraises their new relationship to the stressor. Spiritual forgiveness coping may be especially valuable for the master's students in our sample. Taking into account the strong correlation reported by master's students between each of the outcomes and self-blame, the finding that religious/spiritual forgiveness demonstrated significance is especially important. The more master's students reported using forgiveness, the better they reported being on the mental health composite. In this way, religious/spiritual forgiveness seems to act as a buffer for mental health. Furthermore, while forgiveness was found to significantly impact mental health after controlling for other coping strategies, negative religious/spiritual coping did not. Therefore, it is possible that forgiveness may also act as a buffer for mental health distress.

Conclusions, Limitations, and Future Directions

In summary, this study begins to address the gap in the literature of mental health, coping, and quality of life in graduate level therapists-in-training. Overall, our cross-sectional sample of Canadian graduate level therapists-in-training reported lower mental health and quality of life than the general population. Both master's and doctoral students reported experiencing similar levels of quality of life, however, master's students reported experiencing significantly more mental health distress, which may be explained by the coping strategies they utilize. While both groups of students reported significant correlations between avoidant emotional coping patterns and each of the outcome measures, master's students reported greater use of self-blame while doctoral students reported greater substance use. Finally, master's students, but not doctoral students, reported that negative religious/spiritual coping was related to mental health and quality of life, with religious/spiritual forgiveness seeming to act as a buffer for their reported mental health.

Education/Training Program Implications

Firstly, it would potentially be beneficial for clinical programs to provide personal therapy resources to their students as they encounter the stresses of their graduate program. Another way to respond to the high levels of depression, anxiety, and stress in this population may be through Mindfulness training. Research has found that one particular model of Mindfulness, called Mindfulness-Based Stress Reduction, may precipitate many benefits for therapists-in-training, both for their clinical work and for therapists personally and may address positive religious/spiritual coping at the same time (Shapiro, Brown, & Biegel, 2007). This approach to self-care has been found to aid in

reducing stress, negative affect, rumination, anxiety, and has demonstrated a positive relationship with positive affect and self-compassion (2007). Self-compassion seems to be particularly needed among master's level therapists-in-training. The Transforming Lives Through Resilience Education intervention may also be a good tool to effectively address doctoral level students' substance use and master's level students' use of self-blame. Researchers have found that it promotes greater resilience as well as greater use of effective coping strategies, lower use of avoidant coping, and students reported better mental health post-intervention (Steinhardt & Dolbier, 2008).

Furthermore, clinical therapy training programs in Canada may do well to educate their students on the downward spiral effect of using negative religious/spiritual coping and encourage them to access more adaptive and positive coping strategies that may be available to them. Our results indicate that fostering forgiveness may temper the negative effects of using negative religious/spiritual coping. One strategy that may be used by training programs, and individuals alike, is implementing a growth mindset program, or even a single session intervention (such as the one presented by Schleider & Weisz, 2016). Basically, growth mindset follows the premise that when one believes in the potential for change of global attributes (growth mindset), one is more resilient in times of distress (Schroder et al., 2017). Empirical evidence has supported the theory behind growth mindset and its link to resiliency and lower mental health distress, which would be especially helpful for master's levels students who are using self-blame coping (Schleider & Weisz, 2016; Schroder et al., 2017). It may also be a cost-effective and easy to implement addition to clinical training programs.

Limitations, Strengths, and Future Research Directions

The primary limitation of this study is its cross-sectional design. Future longitudinal studies would be beneficial. Longitudinal research would aid in gaining deeper understanding into the mental health and/or quality of life changes that may occur as therapists-in-training progress through their clinical program. The low internal consistency reliability of the negative religious/spiritual coping scale was also a limiting factor. It would be beneficial for future studies to use more reliable measures of religious/spiritual coping to gain a better understanding of the impact of religious/spiritual coping on mental health and quality of life. Furthermore, there is potential that sampling bias may limit the generalizability of the results. Also, the predominantly female response may also impact the generalizability of the findings. This field of study would benefit from future studies with a more equal male-female ratio. It would be beneficial for future studies to also survey both French and English speaking clinical graduate programs to ensure that the findings are indeed generalizable to the entire Canadian population.

The strengths of this study include its pan-Canada sample of participants, which may aid in providing a deeper understanding of how graduate students across Canada are coping during their studies. This study is also the first of its kind to explore how spiritual coping strategies interact with mental health and quality of life in this population. Further studies exploring graduate students' use of religious/spiritual coping during clinical training programs will help bolster scientific understanding of its effects on mental health and quality of life.

Conclusion

As training programs move toward a bio-psycho-social-spiritual model of training, these data may aid educators as they guide students to more adaptable spiritual coping. Indeed, as this population struggles with mental health distress and low quality of life, our findings expose the particularly harmful use of avoidant emotional coping and negative religious/spiritual coping. With this knowledge, therapists-in-training and program administrators can take steps toward fostering more adaptable coping and better mental health during clinical therapy graduate school.

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Appendix A

Saint Paul University Research Ethics Board Approval

UNIVERSITÉ SAINT-PAUL UNIVERSITY

31-01-2018
dd-mm-yyyy

Bureau de la recherche et de la déontologie
Office of Research and Ethics

Ethics Certificate
Research Ethics Board (REB)

REB File Number **1360.11/17**

Principal Investigator / Thesis supervisor / Co-investigators / Student

Last name	Name	Affiliation	Role
Whitley	Michaela	Faculty of Human Sciences	Student-Principal Investigator
Bilodeau	Cynthia	Faculty of Human Sciences	Thesis Supervisor

Type of project Master Thesis

Title Coping in the Student Therapist.

Approval date	Expiry Date	Decision
31-01-2018 *(dd-mm-yyyy)*	**30-01-2019** *(dd-mm-yyyy)*	**1 (approved)**

Committee comments:
The Research Ethics Board (REB) approved the project.
The researcher is invited to use the reference number 1360.11/17 when recruiting participants.

In accordance with the Tri-Council Policy Statement, the Saint Paul University Research Ethics Board has examined and approved the application for an ethics certificate for this project for the period indicated and subject to the conditions listed above.

The research protocol may not be modified without prior written approval from the REB. This includes, among others, the extension of the research, additional recruitment for the inclusion of new participants, changes in location of the fieldwork, any stage where a research permit is required, such as work in schools. Minor administrative changes are allowed.

The REB must be notified of all changes or unanticipated circumstances that have a serious impact on the conduct of the research, that relate to the risk to participants and their safety.
Modifications to the project, information, consent and recruitment documentation must be submitted to the Office of Research and Ethics for approval by the REB.

The investigator must submit a report four weeks prior to the expiry date of the certificate stated above requesting an extension or that the file be closed.

Documents relating to publicity, recruitment and consent of participants should bear the file number of the certificate. They must also indicate the coordinates of the investigator should participants have questions related to the research project. In which case, the documents will refer to the Chair of the REB and provide the coordinates of the Office of Research and Ethics.

Signature

Louis Perron
Chair
Research Ethics Board (REB)

1/1

Appendix B

Recruitment Email Send to Contact Person at Each Training Program

Hello,

I am conducting research as part of my Masters Thesis at Saint Paul University in the Counselling, Psychotherapy, and Spirituality program. My research will look at graduate student therapists' wellbeing and the coping strategies they are using. Researchers are finding rising levels of mental illness among students, in particular among graduate students. The growing rate of student mental illness is of concern due to the personal toll it takes on students and the possible effects it has their ability to successfully complete their programs. As coping can be a mediator of emotion, this study will explore the coping strategies – including spiritual coping – of student therapists.

This research will have wider ramifications for the wellbeing of therapists in training and provide insight into the role of student well-being in relation to student retention in order to develop strategies for assisting students in their post-secondary studies

I am requesting that you share the following email with the students in your graduate program(s) in therapy/counselling/clinical fields of study. Participation is voluntary in nature, if at any time during the survey a participant wishes to stop participation, they are free to do so. Participation will take approximately 20 - 30 minutes to complete.

Sincerely,

Michaela Whitley (M.A. Candidate)
Master of Arts in Counselling and Spirituality
Saint Paul University
223 Main Street
Ottawa, Ontario
K1S 1C4
e-mail: mwhit140@uottawa.ca

UNIVERSITÉ SAINT-PAUL UNIVERSITY

Appendix C

Recruitment Email Disseminated to Student Therapists

The Coping Strategies of Therapists in Training

Dear students,

I am conducting research as part of my Masters Thesis at Saint Paul University in the Counselling, Psychotherapy, and Spirituality program. My research will look at graduate student therapists' well-being and the coping strategies they are using. Researchers are finding rising levels of mental illness among students, in particular among graduate students. The growing rate of student mental illness is of concern due to the personal toll it takes on students and the possible effects it has their ability to successfully complete their programs. As coping can be a mediator of emotion, this study will explore the coping strategies – including spiritual coping – of student therapists.

This research will have wider ramifications for the well-being of therapists in training and provide insight into the role of student well-being in relation to student retention in order to develop strategies for assisting students in their post-secondary studies

I am requesting that you participate in this study by filling out the survey below. Participation is voluntary in nature, if at any time during the survey you wish to stop participation, you are free to do so. Participation will take approximately 20 - 30 minutes to complete. Please click on the following to complete the survey:

studenttherapistcoping.limequery.com

Sincerely,
Michaela Whitley (M.A. Candidate)
Master of Arts in Counselling and Spirituality
Saint Paul University
223 Main Street, Ottawa, Ontario, K1S 1C4
e-mail: mwhit140@uottawa.ca

Appendix D

Introduction to the Survey

Rights of Participants and Limits of Confidentiality: Participation in this study will take approximately 20 - 30 minutes. Participants are free to withdraw from the study at any time and are also permitted to refrain from answering any question without reason. Your participation in the study is fully voluntary. All information collected will remain completely confidential, will be stored in a locked filing cabinet at Saint Paul University, and will be used for research purposes only. Information collected will be analysed as grouped data and questionnaires will be number-coded so that your name will not appear in publication.

Contact Information:
The Saint Paul University Ethical Review Board has reviewed and approved this research proposal. For questions or concerns regarding participants' rights in research studies, please contact the Office of Research and Ethics Services at recherche-research@ustpaul.ca or 613-236-1393.
For questions or concerns directly related to the present study, please contact us:
Michaela Whitley MA Candidate at mwhit140@uottawa.ca
Dr. Cynthia Bilodeau at cbilodeau@ustpaul.ca

Signed Consent:
By clicking "Next" you are you are agreeing to the above information and providing consent to participate in this study.

Appendix E

Depression, Anxiety, and Stress Scale 21

Please read each statement and select a number 0, 1, 2 or 3 which indicates how much the statement applied to you during the last 7 days. There are no right or wrong answers. Do not spend too much time on any one statement. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a qualified health professional.

Please choose the appropriate response for each item:

	0 = Did not apply to me at all	1 = Applied to me to some degree or for some of the time	2 = Applied to me to a considerable degree or for a good part of time	3 = Applied to me very much or most of the time
I found it hard to 'wind down'	○	○	○	○
I was aware of dryness of my mouth	○	○	○	○
I couldn't seem to experience any positive feelings at all	○	○	○	○
I experienced breathing difficulty (e.g. breathlessness or excessively rapid breathing in the absence of physical exertion)	○	○	○	○
I found it difficult to work up the initiative to do things	○	○	○	○
I tended to over-react to situations	○	○	○	○
I experienced trembling (e.g. in the hands)	○	○	○	○
I felt that I was using a lot of nervous energy	○	○	○	○

	0 = Did not apply to me at all	1 = Applied to me to some degree or for some of the time	2 = Applied to me to a considerable degree or for a good part of time	3 = Applied to me very much or most of the time
I was worried about situations in which I might panic and make a fool of myself	○	○	○	○
I felt that I had nothing to look forward to	○	○	○	○
I found myself getting agitated	○	○	○	○
I found it difficult to relax	○	○	○	○
I felt down-hearted and blue	○	○	○	○
I was intolerant of anything that kept me from getting on with what I was doing	○	○	○	○
I felt I was close to panic	○	○	○	○
I was unable to become enthusiastic about anything	○	○	○	○
I felt I wasn't worth much as a person	○	○	○	○
I felt that I was rather touchy	○	○	○	○
I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart 'missing a beat')	○	○	○	○
I felt scared without any good reason	○	○	○	○

	0 = Did not apply to me at all	1 = Applied to me to some degree or for some of the time	2 = Applied to me to a considerable degree or for a good part of time	3 = Applied to me very much or most of the time
I felt that life was meaningless	○	○	○	○

Appendix F

Short-Form 36

Please respond to each of the following questions relating to your experience of your time spent in your program of study compared to before you began the program.

Please choose the appropriate response for each item:

	1 - Excellent	2 - Very good	3 - Good	4 - Fair	5 - Poor
In general, would you say your health is:	○	○	○	○	○

Please choose the appropriate response for each item:

	1 - Much better now than one year ago	2 - Somewhat better now than one year ago	3 - About the same	4 - Somewhat worse now than one year ago	5 - Much worse now than one year ago
Compared to one year ago, how would you rate your health in general now?	○	○	○	○	○

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

Please choose the appropriate response for each item:

	Yes	No
Cut down the amount of time you spent on work or other activities	○	○
Accomplished less than you would like	○	○
Didn't do work or other activities as carefully as usual	○	○

Please choose the appropriate response for each item:

	1 - Not at all	2 - Slightly	3 - Moderately	4 - Quite a bit	5 - Extremely
During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?	○	○	○	○	○

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks**...

Please choose the appropriate response for each item:

	1 - All of the time	2 - Most of the time	3 - A good bit of the time	4 - Some of the time	5 - A little of the time	6 - None of the time
Did you feel full of pep?	○	○	○	○	○	○
Have you been a very nervous person?	○	○	○	○	○	○
Have you felt so down in the dumps that nothing could cheer you up?	○	○	○	○	○	○
Have you felt calm and	○	○	○	○	○	○

	1 - All of the time	2 - Most of the time	3 - A good bit of the time	4 - Some of the time	5 - A little of the time	6 - None of the time
peaceful?						
Did you have a lot of energy?	○	○	○	○	○	○
Have you felt downhearted and blue?	○	○	○	○	○	○
Did you feel worn out?	○	○	○	○	○	○
Have you been a happy person?	○	○	○	○	○	○
Did you feel tired?	○	○	○	○	○	○

Please choose the appropriate response for each item:

	1 - All of the time	2 - Most of the time	3 - Some of the time	4 - A little of the time	5 - None of the time
During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?	○	○	○	○	○

How TRUE or FALSE is **each** of the following statements for you.

Please choose the appropriate response for each item:

	1 - Definitely true	2 - Mostly true	3 - Don't know	4 - Mostly false	5 - Definitely false
I am as healthy as anybody I know	○	○	○	○	○
I expect my health to get worse	○	○	○	○	○
My health is excellent	○	○	○	○	○

Appendix G

Flanagan Quality of Life Scale

Please rate your present level of satisfaction during your time spent in your program of study, in the following areas:

Please choose the appropriate response for each item:

	1 - Delighted	2 - Pleased	3 - Mostly satisfied	4 - Mixed	5 - Mostly dissatisfied	6- Unhappy	7 - Terrible
Material comforts: Home, food, modern conveniences, financial security	○	○	○	○	○	○	○
Health: Being physically fit and vigorous	○	○	○	○	○	○	○
Relationships with parents, sibling and other relatives: Communicating, visiting, helping	○	○	○	○	○	○	○
Having and rearing children	○	○	○	○	○	○	○
Close relationship with spouse	○	○	○	○	○	○	○

	1 - Delighted	2 - Pleased	3 - Mostly satisfied	4 - Mixed	5 - Mostly dissatisfied	6- Unhappy	7 - Terrible
or other significant other							
Close friends	○	○	○	○	○	○	○
Helping and encouraging others, participating in organizations, volunteering	○	○	○	○	○	○	○
Participating in political organizations or public affairs	○	○	○	○	○	○	○
Learning: attending school, improving knowledge	○	○	○	○	○	○	○
Understanding yourself: knowing what life is about	○	○	○	○	○	○	○
Work: job or home	○	○	○	○	○	○	○
Expressing yourself	○	○	○	○	○	○	○

	1 - Delighted	2 - Pleased	3 - Mostly satisfied	4 - Mixed	5 - Mostly dissatisfied	6- Unhappy	7 - Terrible
creatively							
Socializing: meeting other people, doing things	○	○	○	○	○	○	○
Reading, music or watching entertainment	○	○	○	○	○	○	○
Participating in active recreation	○	○	○	○	○	○	○
Independence, being able to do things yourself	○	○	○	○	○	○	○

Appendix H

Brief COPE

These items deal with ways you've been coping with the stress in your life since you began your graduate training. I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

Please choose the appropriate response for each item:

	1 = I haven't been doing this at all	2 = I've been doing this a little bit	3 = I've been doing this a medium amount	4 = I've been doing this a lot
I've been turning to work or other activities to take my mind off things.	○	○	○	○
I've been concentrating my efforts on doing something about the situation I'm in.	○	○	○	○
I've been saying to myself "this isn't real."	○	○	○	○
I've been using alcohol or other drugs to make myself feel better.	○	○	○	○
I've been getting emotional support from others.	○	○	○	○
I've been giving up trying to deal with it.	○	○	○	○
I've been taking action to try to make the situation better.	○	○	○	○
I've been refusing to believe that it has happened.	○	○	○	○
I've been saying things to let my	○	○	○	○

	1 = I haven't been doing this at all	2 = I've been doing this a little bit	3 = I've been doing this a medium amount	4 = I've been doing this a lot
unpleasant feelings escape.				
I've been getting help and advice from other people.	○	○	○	○
I've been using alcohol or other drugs to help me get through it.	○	○	○	○
I've been trying to see it in a different light, to make it seem more positive.	○	○	○	○
I've been criticizing myself.	○	○	○	○
I've been trying to come up with a strategy about what to do.	○	○	○	○
I've been getting comfort and understanding from someone.	○	○	○	○
I've been giving up the attempt to cope.	○	○	○	○
I've been looking for something good in what is happening.	○	○	○	○
I've been making jokes about it.	○	○	○	○
I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	○	○	○	○
I've been accepting the reality of the fact that it has happened.	○	○	○	○
I've been expressing my negative feelings.	○	○	○	○

	1 = I haven't been doing this at all	2 = I've been doing this a little bit	3 = I've been doing this a medium amount	4 = I've been doing this a lot
I've been trying to find comfort in my religion or spiritual beliefs.	○	○	○	○
I've been trying to get advice or help from other people about what to do.	○	○	○	○
I've been learning to live with it.	○	○	○	○
I've been thinking hard about what steps to take.	○	○	○	○
I've been blaming myself for things that happened.	○	○	○	○
I've been praying or meditating.	○	○	○	○
I've been making fun of the situation.	○	○	○	○

Appendix I

BMMRS

Please answer the following questions based on your experience with religion or spirituality during the time you have spent in your program of study.

Please choose the appropriate response for each item:

	1 - A great deal	2 - Quite a bit	3 - Somewhat	4 - Not at all
I feel God's presence.	○	○	○	○
I find strength and comfort in my religion.	○	○	○	○
I feel deep inner peace or harmony.	○	○	○	○
I desire to be closer to or in union with God.	○	○	○	○
I feel God's love for me, directly or through others.	○	○	○	○
I am spiritually touched by the beauty of creation.	○	○	○	○
I believe in a God who watches over me.	○	○	○	○
I feel a deep sense of responsibility for reducing pain and suffering in the world.	○	○	○	○
I have forgiven myself for things that I have done wrong.	○	○	○	○
I have forgiven those who hurt me.	○	○	○	○
I know that God forgives me.	○	○	○	○
How often do you pray privately in places other than at church or	○	○	○	○

	1 - A great deal	2 - Quite a bit	3 - Somewhat	4 - Not at all
synagogue?				
Within your religious or spiritual tradition, how often do you meditate?	○	○	○	○
How often do you watch or listen to religious programs on TV or radio?	○	○	○	○
How often do you read the Bible or other religious literature?	○	○	○	○
How often are prayers or grace said before or after meals in your home?	○	○	○	○
I think about how my life is part of a larger spiritual force.	○	○	○	○
I work together with God as partners.	○	○	○	○
I look to God for strength, support, and guidance.	○	○	○	○
I feel God is punishing me for my sins or lack of spirituality.	○	○	○	○
I wonder whether God has abandoned me.	○	○	○	○
I try to make sense of the situation and decide what to do without relying on God.	○	○	○	○
To what extent is your religion involved in understanding or dealing with stressful situations in any way?	○	○	○	○

	1 - A great deal	2 - Quite a bit	3 - Somewhat	4 - Not at all
If you were ill, how much would the people in your congregation help you out?	○	○	○	○
If you had a problem or were faced with a difficult situation, how much comfort would the people in your congregation be willing to give you?	○	○	○	○
How often do the people in your congregation make too many demands on you?	○	○	○	○
How often are the people in your congregation critical of you and the things you do?	○	○	○	○
How often have you had a religious or spiritual experience that changed your life?	○	○	○	○
How often have you had a significant gain in your faith?	○	○	○	○
How often have you had a significant loss in your faith?	○	○	○	○
I try hard to carry my religious beliefs over into all my other dealings in life.	○	○	○	○
How often do you contributed to your congregation or to religious causes?	○	○	○	○
How often do you spend time participating in activities on behalf of your church or activities that you do for religious or spiritual reasons?	○	○	○	○

	1 - A great deal	2 - Quite a bit	3 - Somewhat	4 - Not at all
How often do you go to religious services?	○	○	○	○
Besides religious services, how often do you take part in other activities at a place of worship?	○	○	○	○
To what extent do you consider yourself a religious person?	○	○	○	○
To what extent do you consider yourself a spiritual person?	○	○	○	○
How often do you believe that the events in your life unfold according to a divine or greater plan?	○	○	○	○
How often do you believe that you have a sense of mission or calling in your own life?	○	○	○	○