Professional Quality of Life: Compassion Fatigue, Compassion Satisfaction and Professional Burnout in lay trauma counsellors in Cape Town

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A thesis submitted in partial fulfilment of the requirements for the degree of Master of Clinical Psychology in the Department of Psychology, Faculty of Community and Health Sciences, University of the Western Cape

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August 2020

Declaration

I declare that *Professional Quality of Life: Compassion Fatigue, Compassion Satisfaction and Professional Burnout in lay trauma counsellors in Cape Town* is my own work. It has not been submitted before for any other degree or examination at another university, and all the sources I have used or quoted have been indicated and acknowledged as comprehensive references.

Kirsten L Rice August 2020

Abstract

This study explored Professional Quality of Life (ProQOL) among lay trauma counsellors in Cape Town, South Africa, with a secondary focus on the implications for task shifting. The study supplemented a broader project, which sought to determine correlates between age, gender, and the constructs of ProQOL, using a triangulation design to combine nomothetic and idiographic methods. The current study acted to supplement the primary study with qualitative data, but can be treated as a stand-alone qualitative study. The findings of the initial quantitative study suggested that younger, less experienced, or male lay counsellors are at risk for Compassion Fatigue (CF). It also indicated that 37% of lay counsellors fell into an at-risk category, and 37% reported being traumatised at work. The current study expanded on this information using semi-structured qualitative interviews. In the current study, trauma lay counsellors were interviewed (N=20). The data was analysed using Thematic Analysis (TA) and the findings were discussed in relation to Constructivist Self-Development Theory (CSDT) as well as ProQOL. Emergent themes included the construction of a lay counsellor identity, feelings of anxiety and uncertainty, frustrations with a lack of recognition from regulatory bodies, experiences of Secondary Traumatic Stress (STS), and positive personal transformations. Implications for task shifting, which refers to the redistribution of mental healthcare treatment amongst existing team members or extends to include lay counsellors, includes recommendations for organisational change, such as careful selection of trauma lay counsellors, standardised training, increased supervision, psychoeducation regarding ProQOL, and the promotion of Vicarious Post-Traumatic Growth (VPTG). Ethical clearance was obtained by the Humanities and Social Science Research Ethics Committee of the University of the Western Cape.

Keywords: compassion fatigue, compassion satisfaction, lay counsellors, mental health, post-traumatic growth, professional quality of life, task-shifting, trauma, Cape Town, South Africa

Acknowledgements

I would like to acknowledge Prof Anita Padmanabhanunni, who has been with me from the start and who has gone beyond what is expected of an academic supervisor. Thank you for your care and your guidance. To my family and friends, thank you for your continuous support. To the lay counsellors who participated, I hope that I have accurately captured and have done justice to your experiences. Finally, thank you to Natalie Donaldson, for editorial support.

To the reader, I hope you can find hope within the words written here.

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List of Abbreviations

BO	Professional Burn Out
CF	Compassion Fatigue
CMDs	Common Mental Disorders
CS	Compassion Satisfaction
DSM-5	Diagnostic and Statistical Manual of mental disorders, Fifth Edition
HICs	High Income Countries
HIV	Human Immuno-deficiency Virus
HPCSA	Health Professions Council of South Africa
IPV	Intimate Partner Violence
LMICs	Low-and-Middle Income Countries
ProQOL	Professional Quality of Life
PTG	Post-Traumatic Growth
PTSD	Post-Traumatic Stress Disorder
SA	South Africa/n
SADAG	South African Depression and Anxiety Group
SAPS	South African Police Service
STATSSA	Statistics South Africa
STS	Secondary Traumatic Stress
UNHCR	United Nations High Commissioner for Refugees
WCP	Western Cape Province
WHO	World Health Organization
VPTG	Vicarious Post-Traumatic Growth
VR	Vicarious Resilience
VT	Vicarious Trauma
VTR	Vicarious Traumatic Resilience

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Chapter One: Background and Rationale

Exposure to trauma via violence and crime in South Africa (SA) is rife. The ill effects of trauma on the mental wellbeing of individuals is well documented (Benjet et al., 2016; Bromet et al., 2018), with Common Mental Disorders (CMDs) and particularly Post-Traumatic Stress Disorder (PTSD) often being the result.

Cape Town, a prominent South African city, is an environment where exposure to trauma is inordinately high. For example, 33% of the police stations where contact crimes are reported, occur in the Cape Town metropole and the surrounds (South Africa Police Service, 2020). The prevalence of exposure to violent crime increases the risk of Common Mental Disorders, especially PTSD, in the local population, which in turn increases the burden of mental health on the greater provincial public health system. Task shifting for low-and-middle income countries is becoming increasingly relevant to the field of mental health and includes the introduction of lay counsellors to existing mental health multi-disciplinary teams. However, research exploring Professional Quality of Life (ProQOL) in lay counsellors are limited, with fewer studies situated in a South African context (Padmanabhanunni, 2019). ProQOL is a well-studied phenomenon, which quantitatively and qualitatively measures the impact of trauma work on mental healthcare providers (Stamm, 2010). Results consistently show that prolonged exposure to clients or patients who are traumatised impacts on the physical, mental, emotional, and behavioural wellbeing of healthcare providers (Adams & Riggs, 2008; Austin et al., 2017; Baum, 2016; Cohen & Collens, 2013; Craig & Sprang, 2010; Stamm, 2010; Turgoose & Maddox, 2017). Particularly, those who engage in interpersonal work such as counselling, are more likely to experience positive and/or negative effects of trauma work (Manning-Jones et al., 2016). If evidence that ProQOL in healthcare providers suggests that there are deleterious effects of trauma work for healthcare professionals, it is likely that it would occur in lay counsellors.

When lay counsellors are introduced to the public healthcare system in the Western Cape Province (WCP), it would be important to ensure quality, consistency, and safety of both the public and lay counsellors themselves (Kagee, 2020). In addition, retention and sustainability would be important.

Literature suggests that certain demographic variables are correlated with the risk of developing compassion fatigue (CF), specifically age and sex (Turgoose & Maddox, 2017). This study seeks to ascertain which of these variables are associated with CF and related constructs. The initial results of the broader project found that up to 47% of existing lay counsellors in the WCP fall into a category where they are at risk of experiencing CF (Padmanabhanunni, 2019). An additional 37% reported that they were traumatised by their work. Understanding the negative experiences of lay counsellors will be helpful in informing future research aims.

This study aims to supplement quantitative data to provide an idiographic account of the lived experience of lay counsellors, in order to better understand their challenges and strengths, and how those manifest within their counselling work. The findings of such an investigation would be helpful in informing how best to implement lay counselling interventions within the WCP, and how best to support and retain lay counsellors. This in turn would help in ensuring effective mental health service provision in a province in which trauma-related mental health complications potentially make up a significant burden on social, economic, educational, and health related outcomes (Atwoli et al., 2015; Koen et al., 2017).

Chapter Two: Literature Review

This chapter outlines recent literature relevant to this study in four detailed sections. The first section provides the grounding statistics of the prevalence of trauma globally, focusing on SA and, specifically, the WCP as well as the Cape Town metropole, where this study is situated. Furthermore, the link between trauma and mental health is described and it is argued that trauma-related mental health challenges constitute a major public health concern. The second section explores the secondary effects of trauma on mental healthcare providers and includes delineating the framework of Professional Quality of Life (ProQOL), which includes Compassion Fatigue (CF), Professional Burnout (BO), and Compassion Satisfaction (CS). After addressing conceptual issues, the review then looks at factors associated with ProQOL. The third section examines the current public health system in SA and the potential role of lay counsellors, sometimes referred to as 'task shifting', where several studies suggest that this method of expanding mental health services holds great potential. However, there are several concerns that have been articulated and these are also discussed. The final section considers the limited international literature regarding ProQOL for lay counsellors, suggesting that this may be an important area of exploration in SA.

2.1. Trauma: A Psychologically Harmful Phenomenon

While there are multiple definitions of trauma, this study makes use of the term as delineated in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (APA, 2013). The DSM-5 (APA, 2013) states that PTSD is the most common psychological outcome associated with exposure to trauma, where criteria for PTSD includes: a) exposure to or witnessing of a traumatic event, b) intrusion symptoms, c) avoidance, d) negative alterations in cognition and mood, and e) hyperarousal. The symptoms must last more than one month and cause clinical distress or impairment. According to the DSM-5, for

PTSD to occur, there should be direct exposure to one of the following traumas: "exposure to war as a combatant or civilian, threatened or actual physical assault, threatened or actual sexual violence … natural or human-made disasters, and severe motor accidents" (DSM-5, 2013, p. 274). It is important to note that, according to the DSM-5 (2013), 'trauma' is not limited to this definition and may include other events.

Across the globe, approximately 70.4% of individuals experience a lifetime trauma, with an average exposure of 3.2 traumas per person (Kessler et al., 2017). This is a devastating statistic when the deleterious effects of trauma are considered. While individual trauma rates are captured by the World Health Mental Survey, cumulative comparative data between High Income Countries (HICs) and Low-to-Middle Income Countries (LMICs) is yet to be established (Koenen et al., 2017). Koenen and colleagues (2017) note that treatment for trauma-related disorders is related to country income level, and Atwoli et. al. (2015) suggest that trauma exposure is higher in LMICs. Help-seeking behaviours in HICs are almost double than that of LMICs (Koenen et. al., 2017). Kessler et al.'s (2017) paper goes on to note that, in SA, exposure to trauma increases to approximately 73%.

During the financial year of March 2019 to March 2020, the South African Police Service (SAPS) recorded 621 282 contact crimes (e.g. murder and attempted murder, assault with grievous bodily harm, and armed robbery) across the country, with an 18% increase in contact crimes in the WCP over the last decade (SAPF, 2020). The SAPS statistics do not capture other transitional sites of violence, such as protests around service delivery, xenophobic attacks, or student uprisings, nor do they cover sexual offences, which sit at 53 293 nationally. According to the SAPS statistics, 42 829 of these crimes are recorded as rape, which translates to approximately five *recorded* rapes per day. Wyatt and colleagues (2017) state that violence, and the traumatic physical and the psychological sequelae that follow, constitutes one of the top four public health priorities in SA. In addition to this, they

suggest that trauma is grossly underreported. This is evidenced by the 28.1% increased rate of which trauma was reported when using a culturally sensitive screening tool (Madigoe et al., 2017).

The World Health Organisation (WHO) includes family and Intimate Partner Violence (IPV) as well as community violence in its definition of interpersonal violence (Krug et al., 2002). Kessler et. al. (2017) note that interpersonal violence is the traumatic phenomenon associated with the highest risk of the development of PTSD, a statement that demands concern and attention when considering the number of contact crimes in SA, in accordance with Krug and colleagues' (2002) definition. This observation holds even more significance when considering that 30.4% of individuals worldwide have experienced four or more (multiple) traumatic events in their lifetimes, a major risk factor for the development of PTSD (Benjet et al., 2016; Bromet et al., 2018). Due to the high prevalence of contact crimes, coupled with more commonplace traumas such as transportation accidents, or the unexpected death of a loved one, it is hypothesized that Benjet et al.'s (2016) statistic increases substantially in SA.

Post-apartheid SA society is recognised as being 'post-conflict' and yet simultaneously one of the most violent in the world (Kaminer et al., 2018). It is a country in which in 2009, 3.5 million people sought care for injuries caused by violence, and it is likely that this statistic has increased with the rise in contact crimes (Seedat et al., 2009). As this study is located in the WCP, the following data are of particular relevance: the SAPS (2020) data showed that 60% of the top ten police stations recording the highest number of reported murders fall within the WCP metropole, with a further one third (33.3%) of the top 30 stations for this crime also located in the WCP(SAPF, 2020). Padmanabhanunni (2020a) describes a 'trauma nation', recording that 97.6% of 914 students at a WCP university report trauma exposure. In addition to this, Kaminer et al. (2018) argue that, in SA, complex-PTSD

is a common psychological state, due to neighbourhoods where continued and daily community violence occurs. The authors make a case for the recognition of *continuous traumatic stress*, a concept born during the context of protracted political violence and state repression during apartheid. They point to a legacy of violence and oppression in the country, which contributes to a collectively traumatised national psyche.

Kaminer and colleagues' (2018) theory fits with the recent findings of Sui et al. (2018), who found that SA adolescents experience chronic feelings of anxiety and hopelessness simply from *hearing* about apartheid-related victimisation of others and the authors note that transgenerational trauma has an adverse outcome on the psychological health of younger generations. In addition to transgenerational trauma, Sui et al.'s (2018) results indicate that victimisation or trauma experienced in the community was associated with increased scores on measures of hopelessness, depression, anxiety, perceived stress, and suicidal ideation. These findings were mirrored in Visser et al.'s (2016) study, which also found that exposure to interpersonal violence led to differences in personality expression – a more enduring and, perhaps, chronic effect. These adverse outcomes give an initial indication of the extent of the impact of trauma on the psyche.

Critical risk factors for PTSD or other psychological outcomes that are pertinent to SA include being socially disadvantaged, having fewer years of schooling, experiencing trauma in childhood, witnessing four or more traumatic events, or having a history of exposure to interpersonal violence (Shalev et al., 2017; Wyatt et al., 2017). Researchers (cf. Shalev et al., 2017; Wyatt et al., 2017) add that the intensity (i.e. the more severe the trauma is that is experienced, as well as whether the trauma is protracted or acute) of the traumatic exposure is another critical predictor of the severity of psychological and other health outcomes.

At least five recent studies conducted in Cape Town, WCP, have shown that trauma and exposure to violence are associated with negative psychological sequelae, such as emotional disorders, poor behavioural and social outcomes, and overall mental health (Cluver et al., 2015; Gibbs et al., 2018; Hinsberger et al., 2016; Koen et al., 2017; Shalev et al., 2017; Stansfeld, 2017; Watt et al., 2017). While each study uses specific terms, they are comparable in that all capture the outcome of either generalised or specific trauma which fit with the definition operationalised in this literature review.

One study (Stansfeld et. al., 2017) surveyed 1034 early-adolescents at seven different governmental co-educational schools, to determine the association between exposure to violence and mental health disorders, using the Harvard Trauma Questionnaire (HTQ). The study recorded that 84.1% of learners had been exposed to violence, with 41.2% of the learners meeting the threshold for clinical depression, 15.6% for anxiety, and 21.5% for clinical level PTSD symptoms. In addition, 13.4% of the sample had attempted suicide. Social support, although present, was not a mitigating factor. Stansfeld and colleagues (2017) state that exposure to violence is so prevalent among young people and should, therefore, be of concern. They also note that facing adversity, which is inclusive of trauma but also systematic socio-economic factors, is associated with re-victimisation. Cluver and colleagues' (2015) study of 3515 adolescents found that childhood adverse events, specifically trauma, were associated with a greater risk of suicidality during adolescence, and Gibbs et al. (2018) found that childhood trauma resulted in an increased likelihood of Human Immuno-deficiency Virus (HIV) risk behaviours, as well as perpetration of interpersonal violence. In this way, adversity may be linked to the perpetuation of trauma, leading to a never-ending public health burden.

A Cape Town study suggests that women who have trauma histories experience psychological hindrances in their attempts to engage in HIV care (Watt et. al., 2017). In

addition, there is much evidence that women are generally more susceptible to developing PTSD (Kessler et al., 2017; Koenen et al., 2017; Shalev et al., 2017). In Watt and colleagues' (2017) study, HIV care engagement was particularly poor among women with complex histories of sexual trauma. This was posited to be the result of avoidance, a key psychological mechanism in PTSD and a hallmark of traumatic cognition. The impact of PTSD and trauma on pregnant women is also of concern. Koen et al. (2017) documented that, in addition to higher rates of maternal depression, infants suffered from poorer developmental outcomes, specifically on fine motor and adaptive motor behaviours, as measured on the Bayley III Scales of Infant Development. Associations between anxiety during pregnancy and poorer infant emotional regulation were also found (cf. Koen et al., 2017). While women may be more susceptible to PTSD, another Cape Town study showed that young men who have either witnessed or experienced trauma may often develop appetitive aggression, which in turn leads to not only increased perpetration of violence but also heightens the severity of their own experiences of PTSD (Hinsberger et al., 2016). In this way, a violent and traumatic society continues.

The social environment impacts not only the South African born population, but also those who have come to seek refuge and asylum in SA. At the end of 2019, the United Nations Higher Commissioner for Refugees (UNHCR) recorded 277 581 'persons of concern', which includes refugees, asylum-seekers, internally displaced persons, and stateless persons (UNHCR, 2020). Whilst the Constitution of SA affords refugees and asylum-seekers equal access to health services, Zihindula et al.'s (2017) qualitative study of 31 Congolese refugees in SA revealed incidences of medical xenophobia. The respondents of the study reported difficulties not only with language barriers and confusion regarding their documentation, but also pervasive xenophobia in the form of ethnic slurs and discriminatory practices, often resulting in denial of treatment. This is concerning considering that, in

addition to risks associated with the 'normal' exposure to violence and trauma that colours the lived SA experience, refugees and asylum seekers are vulnerable to historically entrenched Afrophobia and xenophobia (Thela et al., 2017; Zihindula et al., 2017).

Hall and Olff (2016) write that transition (either internal or international) is a critical and heightened time of risk and exposure to traumatic events. Trauma exposure may occur across all three phases of a transition: pre-migration, transit, and post-migration. The opportunity to address difficult mental health outcomes associated with transition comes at the point of resettlement, and yet, as noted above, there are significant barriers to accessing treatment within SA. In addition, it could be argued that many communities in SA are sites of heightened risk of trauma exposure themselves. In a further qualitative study in which 18 refugees residing in Durban were interviewed, major themes suggest significant difficulties with xenophobia and racism, consequent mental health, physical safety, and quality of life (Labys et al., 2017). Respondents reported feelings of worry, fear, emotional pain, powerless, worthlessness and at times, suicidal ideation.

In terms of prevalence, Thela et al. (2017) conducted a quantitative survey of 335 African help-seeking refugees in the Durban metropole. Prevalence of mental distress was high, with nearly a quarter of the sample meeting the criteria for PTSD (24.9%), half (49.9%) meeting the clinical criteria for anxiety, and over half (54.6%) for depression. As argued by the authors, mental health interventions targeted for refugee members of the population should be a priority.

This section has provided evidence that points to the high prevalence of crime-related trauma in Cape Town, the WCP Province, as well as across SA. Specifically, vulnerable groups include young people, women, and refugees, but all SA residents are likely to experience at least one trauma in their lifetime and experience its aftermath. These factors show that the SA population, both local and international, is vulnerable and at risk of

experiencing traumatic events, chronic stress, and the associated outcomes on their mental health. Therefore, a psychological vulnerability is present and demands the attention of the public health system. This constitutes a significant burden on the public health system, and yet, comparatively little attention is paid to those who work within it. The next section focuses on the impact of working with trauma on healthcare professionals.

2.2. The Secondary Impact of Trauma

This review has noted that the impact of trauma on those who experience it may lead to several adverse outcomes in terms of physical and psychological health and wellbeing, as well as on the public health system itself. Historically, less recognition has been afforded to those who *work with* traumatised individuals within the public health system, with the original emphasis being on understanding the primary impact of trauma, rather than the secondary impacts of trauma.

An expanding literature on this topic over the last few decades has suggested that working with traumatised individuals comes with its own psychological carcinogenic risks, often referred to as 'The Cost of Caring' (Figley, 1995; Padmanabhanunni, 2019). Professionals, including but not limited to researchers, healthcare workers such as emergency care workers and first responders, nurses, midwives, psychologists, and social workers, as well as law enforcement officers, are vulnerable to the negative effects that secondary trauma might engender (Austin et al., 2017; Manning-Jones et al., 2016). The work is often also highly rewarding.

In an article, which delineates the differences between the various terms used to describe clinician responses to client traumas, Newell et al. (2016) identify a linguistic milieu: professional burnout, compassion fatigue, secondary traumatic stress, and vicarious trauma. The authors state that, within the research canon of these phenomena, the terms have at times been used ambiguously and interchangeably. For clarity, this thesis is focussed on

ProQOL and additional concepts related and useful for this thesis are addressed within this section.

The ProQOL measure was designed to assess three constructs: compassion fatigue (CF), burnout (BO), and compassion satisfaction (CS). CF is conceptualised as both the symptom of secondary traumatic stress (STS) and professional burnout (BO) (Stamm, 2010). The most obvious distinction between Compassion Fatigue and Secondary Traumatic Stress is that Compassion Fatigue is an outcome, a consequence of Secondary Traumatic Stress (Figley & Ludick, 2017). The symptoms of Secondary Traumatic Stress mirror those of post-traumatic stress disorder (PTSD) and include: (1) intrusive re-experiencing of the client's trauma, (2) cognitive and behavioural attempts to avoid reminders of the client's trauma, (3) emotional numbing, and (4) symptoms of physiological hyper-arousal (APA, 2013; Stamm, 2010.) The term Secondary Traumatic Stress captures the experience of the healthcare provider, and their symptomatic afflictions (Stamm, 2010).

Burn Out is described by Stamm (2010) as the dissatisfaction that results from a cumulative build-up of perceived challenges within the work environment. The construct conjures up a simple narrative: something has gone wrong in people's relationship to their work, and they begin to feel a sense of exhaustion, feelings of frustration, cynicism, and a sense of ineffectiveness (Maslach & Leiter, 2017). Burn Out is elsewhere argued to be caused by solely organisational factors, such as high caseloads, lack of control of procedures, low peer and supervisory support, and poor training (Newell et al., 2016).

Compassion Fatigue and Burn Out are phenomena which significantly impact the individual counsellor and their ProQOL. However, it is also recognised that individuals may gain a sense of fulfilment from their work, termed compassion satisfaction (CS), another construct defined within the ProQOL. Theoretically, Stamm (2010) conceptualises Compassion Satisfaction as a counter to Compassion Fatigue, where Compassion Satisfaction

refers to the ability of counsellors to find meaning and fulfilment from their empathy-related work, thereby promoting resilience. Unlike Burn Out, which is caused by organisational factors, Compassion Fatigue and Compassion Satisfaction result through empathic engagement with the individual.

Within the broader literature, there exist conceptual idiosyncrasies as well as construct overlaps that need be accounted for. For example, the origin of Compassion Fatigue was influenced by the early work of Pearlman and Saakvitne (1995), who named the phenomenon Vicarious Trauma (VT). Pearlman and Saakvitne (1995) understood the impact of Vicarious Trauma through constructivist self-development theory (CSDT), which essentially posits that Vicarious Trauma, through empathic engagement, influences a healthcare providers' cognitive schemas, including their concepts of self, others, and perceptions of the safety of the environment. The counter to this is Vicarious Resilience (VR), which refers to a positive psychological transformation as a result of direct exposure to a client's growth and recovery, and a sense of professional satisfaction as the client overcomes the psychological impact of the adversity experienced (Pearlman and Saakvitne, 1995).

Newell and colleagues (2016) as well as Turgoose and Maddox (2017) state that Compassion Fatigue is a more 'user-friendly' term, which captures the overall experience of cognitive, behavioural, and psychological outcomes. This term, as delineated in the ProQOL manual, posits that healthcare providers may or may not experience Secondary Traumatic Stress symptoms when experiencing Compassion Fatigue. Those who do experience Secondary Traumatic Stress may experience Post-Traumatic Growth (PTG), where their empathy has not only brought on PTSD-like symptoms, but simultaneously and perhaps paradoxically, further feelings of emotional strength and fulfilment. In the broader literature, Compassion Satisfaction refers to the positive interactions with patients and clients and does

not necessarily convey a counsellor's sense of personal growth that they experience through the counselling experience.

Tedeschi and Calhoun (2004) distinguish Post Traumatic Growth as an experience of positive change that occurs as a result of highly challenging life crises. These changes tend to happen across five domains within the individual: appreciation for life, more positive relationships, a sense of personal strength, changed priorities, and a richer existential orientation to life (Tedeschi & Calhoun, 2004). The authors cite a body of literature which evidences that these changes come after experiences of assault, refugee experiences, sexual assaults, as well as other adverse life circumstances. The key marker of Post Traumatic Growth is that there is a movement beyond pre-trauma levels of adaption and there is a qualitative improvement in functioning. Cohen and Collens (2013) assert that this process may also happen vicariously, most noticeably in mental health trauma workers. They term this Vicarious Post Traumatic Growth (VPTG), noting that growth and distress are not mutually exclusive.

The majority of studies in recent years have made use of the ProQOL (Sinclair et al., 2017). What is clear, however, is that regardless of the terms used, there exists two counterpoints: (1) deleterious and (2) healing effects, either of which (or both) may occur when working with traumatised individuals and in trauma settings.

In a review of 90 papers, it was found that more than forty different symptoms of Compassion Fatigue are described across the literature (Sinclair et al., 2017). Collectively, symptoms are most noticeably characterized by a general sense of fatigue as well as diminished compassion (Figley & Ludick, 2017). Killian (2008) notes that symptoms of work stress alone can include sleep disturbances, becoming easily distracted, difficulties concentrating, and changes in mood, evidenced by feeling on-edge, being less patient, and feeling anxious and panicky. If work stress alone can cause this kind of deterioration in functioning, it becomes essential that the impact of working with trauma and severe mental illness be taken seriously.

A study of mental healthcare professionals identified that neither nurses, social workers, psychologists, psychiatrists, nor case managers are immune to the impact of Compassion Fatigue (Ray et al., 2013). The risk of this goes beyond the general mental and physical health of these much needed healthcare providers: it diminishes healthcare workers' abilities to effectively deliver mental healthcare services, and also creates a double burden of trauma and potential mental distress which then requires intervention.

2.3. Risk and Resilience: Factors Associated with ProQOL

2.3.1. Established factors. The literature on ProQOL has often focused on, and subsequently discovered, differences in the associated factors regarding Compassion Fatigue, Compassion Satisfaction, and Burn Out. The aim of the literature has been to establish factors either associated or correlated with constructs in the ProQOL. In their narrative review of the quantitative literature, Turgoose and Maddox (2017) found that the most consistent Compassion Fatigue associate and correlated variables include trauma workers' prior experiences of traumatic events, their level and type of empathy, and their caseloads. Specifically, high caseloads and ones in which there is complex trauma are likely to positively correlate with Compassion Fatigue.

Turgoose and Maddox's (2017) statement that prior exposure to trauma is a risk factor for Compassion Fatigue is supported by relatively recent literature (Lawson & Myers, 2011; Ray et al., 2013; Rossi et al., 2012; Thomas, 2013; Thomas & Otis, 2010). It is also supported by the initial literature on the topic (Adams & Riggs, 2008; Deighton et al., 2007; Killian, 2008). For example, prior trauma experienced by trauma workers was found to have a significant impact on the development of Secondary Traumatic Stress (MacRitchie & Liebowitz, 2010). Recent stressors or exposure to negative events may also have an impact on the development of Compassion Fatigue. Rossi et. al. (2012) found that a single negative event experienced by counsellors within the previous 12 months was positively associated

with Compassion Fatigue. Thomas and Otis (2010) found that experiencing trauma in adulthood, as opposed to childhood, was significantly associated with Compassion Fatigue. This potential 'risk' factor for Compassion Fatigue is particularly relevant in SA, where traumatic events such as assault and rape are commonplace and are likely to be experienced by both patients and trauma workers alike.

Regarding high caseloads, it is not merely the number of cases that result in an association with Compassion Fatigue but also the type of cases. For example, physicians and nurses who carried more than 50% critical care patients were more likely to report moral distress, and a desire to leave the profession (Austin et al., 2017). The authors found that assigning just one additional patient to a nurse's caseload increased the risk of Burn Out by 23%. In a study of 532 trauma therapists, a higher percentage of PTSD cases were associated with higher levels of Compassion Fatigue (Craig & Sprang, 2010a). In this study, this result was found to be consistent regardless of the therapist's age or years of experience. In a study of clinical social workers, when caseloads included a higher percentage of at-risk clients, there was a higher risk of Burn Out (Lawson & Myers, 2011). In another study, a set of home-based therapists (N=225) were surveyed, and it was found that increased workload, and by association, increased number of hours, positively predicted decreased Compassion Satisfaction and increased Compassion Fatigue, with the potential of an eventual need to either leave or break from the profession (Macchi et al., 2014). Ray and colleagues' (2013) study with frontline mental health providers found similar results: full-time workers, as opposed to part-time or casual workers who worked less hours, were more likely to report Compassion Fatigue.

In an important study, MacRitchie and Leibowitz's (2010) findings established a moderate positive relationship between empathy and Secondary Traumatic Stress. The study proposed that the higher the individual's level of empathy is, the more susceptible they are to

developing Secondary Traumatic Stress. In addition, empathy moderated the impact of prior trauma on Compassion Fatigue. The implication of this is particularly relevant in understanding ProQOL, since empathy is not only key to developing any form of therapeutic relationship, but it may also be key to developing Compassion Satisfaction and Post Traumatic Growth for both client and therapist (Newell et al., 2016). MacRitchie and Leibowitz's (2010) study is supported by the work of Duarte et al. (2016). In their quantitative study of 280 nurses, it was found that empathetic engagement and affective empathy were positively associated with both Compassion Fatigue and Compassion Satisfaction, while personal distress was positively associated with Compassion Fatigue. In addition, critical self-judgment, isolation, and over-identification with patients were associated with the presence of both Burn Out and Compassion Fatigue. The study concluded that, in order to retain nurses and also ensure quality patient care, nurses and healthcare professionals need to learn to regulate their capacity to empathise, and build up their self-compassion capacities, as individuals who are harsh and critical of themselves are more likely to experience Burn Out and Compassion Fatigue. It is important to note that a recent study of Counsellors-In-Training found that their level of empathy did not predict Compassion Fatigue (Can & Watson, 2019). As highlighted in the following section, some of the literature has found that age may predict Compassion Fatigue, Compassion Satisfaction, and Burn Out, and this may be due to healthcare professionals' inexperience and limited exposure to trauma.

2.3.2. Inconclusive factors. In comparison to factors more consistently associated with Compassion Fatigue, the following variables have attained divergent results: age, sex, and work experience (Turgoose & Maddox, 2017).

Regarding age, results from studies have often been contradictory. For example, being younger and having less experience has been found to be associated with a higher risk of developing Compassion Fatigue (Lawson & Myers, 2011; Sprang et al., 2011), whereas Rossi

et al. (2012) found that being on a long-term contract and having served more years was positively correlated with Compassion Fatigue in community healthcare workers. They suggest that this is the result of a higher cumulative exposure to trauma than in casual or part-time staff, who may have a more acute experience.

Rossi and colleagues' (2012) findings are directly contradicted by Macchi et al. (2014), who found that years of experience acts as a protective factor for Compassion Fatigue, which they hypothesise may have to do with having a more curated skillset and, therefore, higher feelings of effectiveness. This finding is echoed in the work of Ray et al. (2013), who found that years in the profession is negatively correlated to Burn Out. This would *potentially* include workers who were slightly older. Against these findings, in their study of 491 nurses, Kelly et al. (2015) found that nurses in the 'Millenial Generation' (i.e. younger nurses) had an increased risk of developing Burn Out. Overall, it should be noted that age is sometimes related to years of experience and, as such, it is potentially difficult to separate these two variables, and some studies only measure one or the other.

Studies have posited that being female is more likely to result in Compassion Fatigue (Lawson & Myers, 2010; Thompson et al., 2014), while others have demonstrated that being male may result in higher Burn Out (e.g. Sprang et al., 2011). However, other studies have not found any significant association between gender and Burn Out (Thompson et al., 2014). Additionally, Craig and Sprang's (2010) found that an increase in PTSD cases in overall caseload predicted Compassion Fatigue regardless of age, sex, or years of experience. This potentially suggests that Burn Out, a construct which captures the influence of the nature of the organisational environment, moderates and overrides these individual factors.

Whether these collective results constitute 'risk factors' for Compassion Fatigue is still inconclusive and both Ray and colleagues (2013) and Turgoose and Maddox (2017) suggest that more longitudinal research is needed.

2.3.3. Factors associated with Compassion Satisfaction and VPTG.

Within the model of the ProQOL itself, there exists associations between certain constructs. Overall, the literature reports that Compassion Fatigue and Burn Out are often associated (Turgoose & Maddox, 2017) or correlated (Ray et. al., 2013). The presence of a higher score of Compassion Satisfaction seems to be associated with lower Compassion Fatigue, which intimates that factors associated with Compassion Satisfaction, Vicarious Post Traumatic Growth or Vicarious Traumatic Resilience should be promoted. Overall, guiding literature on what increases experiences of Compassion Satisfaction is limited.

Potentially, mindfulness may have an association with Compassion Satisfaction (Thomas & Otis, 2010; Turgoose & Maddox, 2017). Turgoose and Maddox (2017) argue that this could be a promising protective factor for developing Compassion Satisfaction, which has also been shown to be associated with lower levels of Compassion Fatigue. Thomas and Otis (2010) suggest, based on their sample of 171 licensed clinical social workers, that age, gender, experience, or trauma history have no significant impact on a practitioner's ability to experience Compassion Satisfaction. They suggest that mindfulness alone plays a significant role in promoting Compassion Satisfaction, as well as moderating the variance in Burn Out scores.

In the previous section, it was noted that, in their study of 491 nurses, Kelly et al. (2015) found that younger nurses had an increased risk of developing Burn Out. However, there were no differences between less experienced nurses or older nurses in terms of experiencing Compassion Satisfaction. The older nurses articulated that meaningful recognition from their superiors also enhanced their job satisfaction, which could be a possible contributing factor.

There has been a broader body of studies situated in the field of factors associated with Post Traumatic Growth and Vicarious Post Traumatic Growth. In one of their

foundational papers, Tedeschi and Calhoun (2004) found that certain personality characteristics, such as extraversion and openness to experience, were associated with Post Traumatic Growth. They also outlined that a person's cognitive processes are important in that there is a shift from automatic and intrusive thoughts, to a more meaning-making and integrative process in obtaining Post Traumatic Growth (Tedeschi & Calhoun, 2004). Cognitive processes have been highlighted elsewhere and will be addressed in this study's theoretical framework section.

A more recent study, which surveyed across health providing disciplines, found that self-care and social support negatively predicted Secondary Traumatic Stress (Manning-Jones et al., 2016). Factors including humour, self-care, and peer-support positively predicted Vicarious Post Traumatic Growth. This is mirrored in the work of Samios et al. (2012), who found that therapists who work with sexual trauma experience both high Secondary Traumatic Stress and Vicarious Post Traumatic Growth. Vicarious Post Traumatic Growth moderated the impact of Secondary Traumatic Stress on levels of depression and anxiety, and therapists who experience Vicarious Post Traumatic Growth articulated feelings of personal meaning and increased satisfaction with life. Interestingly, an earlier paper postulated that increased cumulative exposure, the very basis of Compassion Fatigue, was also associated with increased sense of coherence as well as increased feeling of empathy (Brockhouse et al., 2011). The authors suggest that each story the therapist is exposed to contributes to a gradually changing schema. Their study found that, initially, levels of empathy at the beginning of a career increased the potential of a Vicarious Trauma experience, which was further increased by relating to others. However, a process of identification increases the impact of the vicarious experience, which then results in an adjustment of existing schemas: the process of Vicarious Post Traumatic Growth.

Guiding literature on what increases feelings of Compassion Satisfaction is sparse and, this, therefore, is an area which could hopefully be explored in further research, especially since it has been suggested that Compassion Satisfaction protects and moderates the impact of Compassion Fatigue, and perhaps even begins a process which leads to Vicarious Post Traumatic Growth.

2.4. Task Shifting in the Public Health System: The Role of Lay Counsellors

According to the WHO (2016), there were only 1.5 psychiatrists per 100 000 of the SA population at the time. While this number may have increased, the Health Professions Council of South Africa (HPCSA) (2018) records just 8 800 registered psychologists and 2 482 registered counsellors across the country, where the population is estimated to be 58.8 million (Statistics South Africa, 2019). The number of mental health care nurses and social workers is generally unrecorded. Considering the evidence of the prevalence of trauma and the incidences of associated mental health effects, this leaves a deep fissure in mental health service provision. This is additionally significant as 65% of the population accesses healthcare from public clinics (Statistics South Africa, 2018).

These statistics deteriorate when examining the mental health needs of SA's population. The rural population makes up approximately 40% of SA, most who are reliant on public health facilities. Within these health facilities, De Kock and Pillay (2018) found that mental health nurses, clinical psychologists, mental health medical doctors, and psychiatrists practice at a rate of 0.68, 0.47, 0.37, and 0.03 respectively per 100 000 of the population in rural facilities. In addition to this, 69% of facilities have no specialist mental health facilities at all.

Due to the dearth of individuals who may provide effective mental health services, De Kock and Pillay (2018) call for an innovative task shifting approach to mental health service provision, asserting it as a health service development priority. This includes the redistribution

of tasks amongst the existing health workforce teams, as well as the incorporation of volunteer lay counsellors (De Kock & Pillay, 2018; WHO, 2008).

The benefits of this approach are considered multitudinous as it is argued to be practical, effective, and allows for cost-cutting. Evidence from previous task shifting also suggests promise, such as the incorporation of mental health nurses in psychiatric medication prescription. It has been argued that task shifting for mental health may be further expanded, with the initiation of programmes to incorporate lay counsellors, with an aim to promote behavioural change and deliver psychological services within primary health care settings (Petersen et al., 2014).

Although there are different definitions of lay counsellors, several studies show that lay counsellors fulfil a promising and important role in mental health service provision (MacRitchie & Leibowitz, 2010; Peterson et al., 2011). In a paper that reviews a number of lay counselling interventions post the 2004 tsunami in South East Asia, Thara et al. (2014) note that, compared to psychiatric medication driven interventions which yielded limited results, lay counselling led interventions resulted in benefits to health care users. The study asserts that lay counsellors were able to assist with case identification, make appropriate referrals, elementary counselling, family support, and psychosocial interventions. In addition to alleviating mental health difficulties associated with the trauma of a natural disaster, studies reviewed suggest potential promise in assisting with the identification and community rehabilitation of psychoses. A second study by Matsuzaka et al. (2017) trained non-specialist community healthcare workers to provide interpersonal counselling to treat depressive symptoms in Brazil. In this study, 86 patients received 3 to 4 sessions, and it was found to be effective.

A SA study situated in the North-West province yielded similar promising results, where a task shifting approach of 5 to 8 person-centred counselling sessions provided to

patients with depressive symptoms resulted in improved functionality, reduced self-stigma, feelings of resilience, and feeling of being better able to cope (Selohilwe et al., 2019).

Petersen-Williams et al. (2020) piloted a lay-counselling intervention in the WCP for women who abused alcohol, experienced depression, and were HIV positive. The women reported that the intervention helped them learn new coping strategies, manage current life stressors, and regulate negative thoughts and emotions. Importantly, the study expressed an urgent need to extend this type of intervention to include trauma-focussed support, as many of the women reported traumatic experiences that were associated with their current precarious mental state.

Lay counselling interventions specifically for trauma have been perceived to be effective, although the data is limited. Neuner et al. (2008) describe a lay counsellor delivered programme based on Narrative Exposure Therapy principles in an African refugee settlement where, post intervention, 70% of participants no longer met the criteria for PTSD. Similarly, Van der Water et al. (2018) conducted a small qualitative study in Durban on adolescents receiving an exposure-based intervention for PTSD delivered by non-specialist nurses. In the study, the adolescents reported varying effects, which they attributed to the intervention, including symptom relief, better coping mechanisms, decreased aggression, and improved academic performance. Both adolescents and nurses in the study reported the experience as a positive one.

In considering the feasibility of lay counselling interventions, the perceptions of both patients and lay counsellors (or mental health team members) need to be carefully considered. In a feasibility assessment of the transferability of counselling in chronic illness care treatment, Myers and colleagues (2018) discovered that patients preferred to receive counselling from designated lay counsellors as opposed to members of the clinical team. Lay counsellor experiences tended to be more varied. For example, in another paper, Myers and colleagues

(2019) documented that the lay counselling team requested more training, and that their lack of training impacted on their confidence in delivering their service. This echoes a finding in Van der Water et al.'s (2018) study, in which nurses who delivered an exposure-based programme felt that they needed closer supervision and additional support in delivering a more technical intervention. Thara et al. (2014) also recommend that periodic monitoring and support for lay counsellors is critical to the efficacy of their interventions.

Another difficulty for lay counsellors in Myers and colleagues' (2019) study, which took a task shifting and transdisciplinary approach, was that lay counsellors who were already part of the health team found that the additional workload of counselling was simply too much. Although noted to be enthusiastic, some expressed that they felt as if their workload had tripled. Petersen et al. (2016) put forward similar findings in an exploration that looked at barriers to referral for both designated lay counsellor and nurses who had taken on a counselling role. For nurses, high patient loads suggest a structural difficulty in this form of task shifting implementation while, anecdotally, they expressed low self confidence in their diagnostic abilities and a lack of confidence in their counselling abilities. Lay counsellors expressed that their marginalised status and unclear roles were areas of difficulty, as well as feelings of low confidence. It is also noted by Petersen et al. (2016) that an additional barrier to treatment is poor suitability of some counsellors for their role, as well as unattended personal issues.

In a critical review of the encouraging literature on task shifting in mental healthcare with lay counsellors, Kagee (2020) lays out several important considerations regarding selection and training. Kagee (2020) notes that, in the context of a treatment gap, NGOs, faith- and community-based organisations, as well as several areas of health and social governmental services, have needed to assume responsibility for the mental healthcare burden. Although the literature regarding task shifting appears promising, it often assumes adequate training. Yet recruitment, selection, and training of lay counsellors is highly variable, which poses several

difficulties in ensuring quality and consistency of care. Kagee (2020) further notes that often, the selection of lay counsellors is based on budget constraints and the needs of health users, which limits the ability for careful selection and lengthy training.

Given this, Kagee (2020) argues that lay counsellors should be screened carefully for personal suitability, a task that is fraught with uncertainty even in the selection of specialist professionals, such as psychologists. While many counselling micro-skills may be learned, characteristics such as effective affect regulation, emotional coping skills, and inner resilience are more difficult to acquire, yet are critical in protecting and ensuring the health of lay counsellors and mental health users. Without these qualities, not only may the counselling service be compromised, but lay counsellors themselves become a higher risk for vicarious traumatisation and Compassion Fatigue. The likelihood of the secondary effects of trauma occurring are already heightened due many lay counsellors coming from and living in the communities that they serve, meaning they are at risk for the same community traumas and consequent mental health conditions. This is important, as it determines the extent to which they may carry out their work with clients.

There are limited specialist mental health professionals in SA and a task shifting approach, which includes the use of lay counsellors, holds great potential and promise. However, O'Sullivan and Whelan (2011) note that defining the work of trauma counsellors can be difficult since there are sometimes schisms between 'trauma' and 'adversarial events', and who exactly addresses which as often the terms overlap. In SA, it is likely that counsellors will address both, given that poverty, unemployment, and other adversarial events are commonplace. Despite this overlap in services, initial studies show emerging evidence that lay counselling interventions may be effective for individuals experiencing PTSD, and that further trauma focussed interventions are needed. While patients perceive lay counsellors positively, there is a need for clarity regarding their role and scope. Additionally, lay counsellors have

been found to lack confidence and have articulated a need for further support. There are concerns regarding the screening, selection, and training of lay counsellors, both for quality assurance purposes and the protection of the mental health of lay counsellors themselves. Whilst, in terms of definitions, there exists great variety in terms (e.g. lay counsellor, non-professional counsellor, volunteer counsellor, and community worker) and expected level of experience, it is clear that lay counsellors may be a way forward in addressing the gaps of SA's public mental health system.

2.5. The Consequences of Caring for Lay Counsellors

The psychological and emotional risks associated with providing care to traumatised populations have been largely overlooked in the literature on non-professional trauma counselling in SA (Padmanabhanunni, 2019). There are three prominent studies that examine the impact of trauma (including being diagnosed as HIV positive, experiencing IPV, and trauma counselling), one of which includes Padmanabhanunni's (2019) paper on trauma lay counselling.

In the first study, it was found that, in a sample of HIV lay counsellors, not only had there been an experience of 3.7 prior traumas, but over half of the sample (51.4%) constituted potential Secondary Traumatic Stress cases (Peltzer et al., 2014). In addition, 49.5% were dissatisfied with their work environment, a potential predictor of BO. Risk factors that were established included counsellors testing HIV positive themselves, experiencing a high caseload, and multiple exposures to trauma. Qualitatively, counsellors raised concerns regarding general and practical concerns, such as their financial stipends, lack of space, limited training (15 days in total), as well as the general stress of counselling.

The second study was a qualitative investigation into the wellbeing of counsellors trained to debrief and offer supportive counselling services to survivors of IPV (Howlett & Collins, 2014). The experiences of this sample included often feeling out of their depth and

experiencing clients who some described as “mental cases” which, upon exploration, seemed to point to the presence of more complex mental disorders. The counsellors recounted episodes their clients had acted socially inappropriately or had treated them poorly, a feeling mirrored in research with telephonic counsellors (Willems et al., 2020). Although there was some recognition of their challenges, the authors noted a feeling of prevailing stigma amongst volunteers regarding feelings of being burnt out or not coping.

In SA, lay counsellors already play an important role in supporting the service gap for mental illness. For example, the NGO’s Rape Crisis, SADAG, and Lifeline all offer telephonic services and many members of these organisations are unpaid volunteers. Pillay et al. (2013) stress the increasing importance of hotlines and helplines within the scope of mental health service provision in the SA context. Meehan and Broom (2007) note that callers in South Africa indicated that they found the toll-free crisis hotlines helpful, but there is not enough evidence for this statement to be conclusive. Although there were no found published academic studies on this topic in SA, several international studies exist, although longitudinal research is still needed (O’Sullivan & Whelan, 2011; Kitchingman et. al., 2017; Willems et. al., 2020).

In a paper reviewing 13 studies of crisis hotlines, it was found that telephonic services were effective in decreasing psychological pain and preventing suicidality (Willems et al., 2020). It was also found that 22% of counsellors themselves met criteria for a psychiatric diagnosis, and that over 50% suffered from Burn Out. Roche and Ogden (2017), exploring the UK based Samaritans organisation which offers telephonic services for mental health, found that, although there was a low reported Burn Out, a younger age predicted Burn Out and the organisation suffers from a high turnover.

Regarding ProQOL, O’Sullivan and Whelan (2011) note that Compassion Satisfaction is linked to Vicarious Post Traumatic Growth in telephonic counsellors, but that high numbers of calls decreases the potential for growth, suggesting that Burn Out may limit Vicarious Post

Traumatic Growth. Compassion Fatigue was a predictor of increased Vicarious Post Traumatic Growth , and the level of empathy was not found to be a significant predictor of growth. Other factors elsewhere that impacted on counsellors' Burn Out included the urgency of the calls, inappropriate or complicated calls, or calls where there were cultural barriers (Willems et al., 2020). O'Sullivan and Whelan (2011) identified two potential adversarial events that may increase Secondary Traumatic Stress in telephonic counsellors specifically: first, termination of a traumatic call without warning and, second, distressing calls where a lack of visual information allows volunteers to conjure up their own images of distress. All participants in this study reported some form of growth, however, all reported at least one traumatising call, and 77% of counsellors met the criteria for Compassion Fatigue. The study suggests protective factors include supervision and training, an area for which neither clear guidelines nor consistency exists. For example, Kitchingman et al.'s (2017) study, which surveyed 210 telephonic crisis support workers, noted that although the volunteers received 75 hours of training, which included group supervision and observations, a quarter of the volunteers reported increased levels of distress. Those who experienced increased distress were found to be less likely to seek help, which the authors suggest may be related to a fear that help-seeking behaviour may be perceived as an indicator for level of competence.

Another area in which lay-counsellors (or 'task shifted' counsellors) operate is in post-disaster settings. In these scenarios, local and international volunteers are recruited, all who have different backgrounds and different levels of experience. Cooper et al. (2018) discuss how, within local counsellors, counsellor and client experiences become intertwined, as both provider and client have experienced the same event, resulting in a shared trauma. They also note that these volunteers are 'first on the scene' and are thus exposed to the most acute level of trauma, as well as protracted after-effects. The authors state that in these 'traumatogenic' environments, there is an absence of the ability to maintain clinical distance and distinct

boundaries, an observation that is relevant to the 'traumatogenic' environment of SA where community lay counsellors often share the experiences of their patients. Cooper and colleagues (2018) also note that ethical issues may be overlooked, compromising the therapeutic relationship. The scope of the work is also uncontained as disaster workers may have to engage in supportive counselling and psychological first aid, practical social assistance, crisis interventions, as well as solution-focused and problem-solving approaches (Cooper et al., 2018; Thormar et al., 2013). In terms of ProQOL, disaster volunteers articulate their challenges as a sudden loss of income, a lack of training, and the stressful nature of the environment. It may be possible that in these highly traumatic settings, lay counsellors may be at a higher risk of mental illness, as Thormar et al. (2013) found that the mental health of community workers in the post-disaster setting of a 2006 Indonesian earthquake deteriorated to the point that, 18 months after the disaster, 58% of the workers met the criteria for PTSD. In this study, it was found that men were more likely to suffer specifically from depressive symptoms.

In addition to post-disaster settings, lay counsellors also work in the refugee sector, where exposure to trauma amongst clients or patients is almost guaranteed. In Lusk and Terrazas' (2015) quantitative study of ProQOL in refugee volunteer and professional caregivers in Central America, 30% of the sample experienced severe or high levels of Secondary Traumatic Stress. A further 50% of the sample reported emotional numbness, sleep disturbances, and intrusive thoughts related to client trauma. They also reported feelings of frustration, helplessness, and anger in the face of the horrific experiences of their clients. Despite this, 90% of the sample reported some form of Compassion Satisfaction as many indicated a sense of pride in relation to the interpersonal trauma work (Lusk & Terrazas, 2015).

In another study examining mental health workers working with refugees, it was found that 42% fell into the elevated range for Compassion Fatigue, where 25% experienced Burn Out and 25% reported CS (Guhan & Liebling-Kalifani, 2011). Qualitatively, in this study five

themes emerged, related to: (1) aspects of the work, (2) reaping rewards, as well as (3) personal impact, (4) managing the impact, and (5) training and support needs. In the first theme, the respondents discussed pressures and difficulties with the demands of the work, as well as frustration working within a bureaucratic system. In the second, respondents discussed how their beliefs, values, and interests in the lives of others were validated and that seeing change happen and receiving gratitude were particularly meaningful. In terms of the third theme, respondents said that they experienced personal growth, despite the emotional unpredictability of their experiences. In terms of the fourth, the ideas that they needed to 'toughen up' and find ways to cope were brought forward. Finally, respondents spoke about their need for further training and support.

The HPCSA is yet to formally recognise or define the scope or role of lay counsellors in SA. Lay counsellors often receive limited training and often manage an absence of supportive or development programmes, with over half of SA organisations indicating that they do not have programmes for volunteers (Howlett & Collins, 2014). The lack of definition or recognition of lay counsellors, as well as the minimal support provided by organisations, leaves this population unregulated and unsupported, risking their own mental health as well of others.

Literature regarding ProQOL in lay counsellors is scarce. Traditionally and more commonly, the literature is focused on the (mental) healthcare providing professions more broadly, with specific emphasis on nurses, social workers, counselling professionals (Turgoose & Maddox, 2017). From the broader literature, the assumption that lay counsellors working in the mental healthcare would experience changes in their ProQOL can be made. Sparse yet emergent literature on lay counsellors, hotline crisis workers, community workers, disaster volunteers, and refugee caregivers supports this hypothesis. Considering the promise and potential that lay counselling has in SA, often referred to as task shifting, this is an area of

research that is deserving of attention. With a comprehensive understanding of the challenges and experiences of lay counsellors, appropriate planning for training, support, and initiation of interventions may take place.

Chapter Three: Theoretical Framework

This section outlines the lens through which the results of this study are interpreted. With Thematic Analysis (TA) as the supplementary methodological approach, there are two different frameworks within which this study situates itself: (1) the theory of Professional Quality of Life (ProQOL), and (2) Constructivist Self Development Theory (CSDT). Although the constructs of ProQOL were briefly discussed in the literature review, these are expanded upon and clarified here. In addition, ProQOL as a theory is discussed, since ProQOL is both a measurement tool as well as well as a theoretical orientation. CSDT is a foundational theoretical perspective from which the qualitative results of this study are grounded. CSDT is essential to this study, as it aims to take apart and simultaneously combine nomothetic and idiographic data, which is the overarching aim.

3.1. Professional Quality of Life as a Theoretical Pathway

This section provides an overview of the work of Stamm's (2010) theory as presented in the Professional Quality of Life Manual, 2nd Edition. Stamm (2010) speaks of a theoretical pathway that requires a comprehensive understanding of how Compassion Fatigue, Burn Out, Secondary Traumatic Stress, and Compassion Satisfaction interact with and respond to various interpersonal environments which counsellors find themselves.

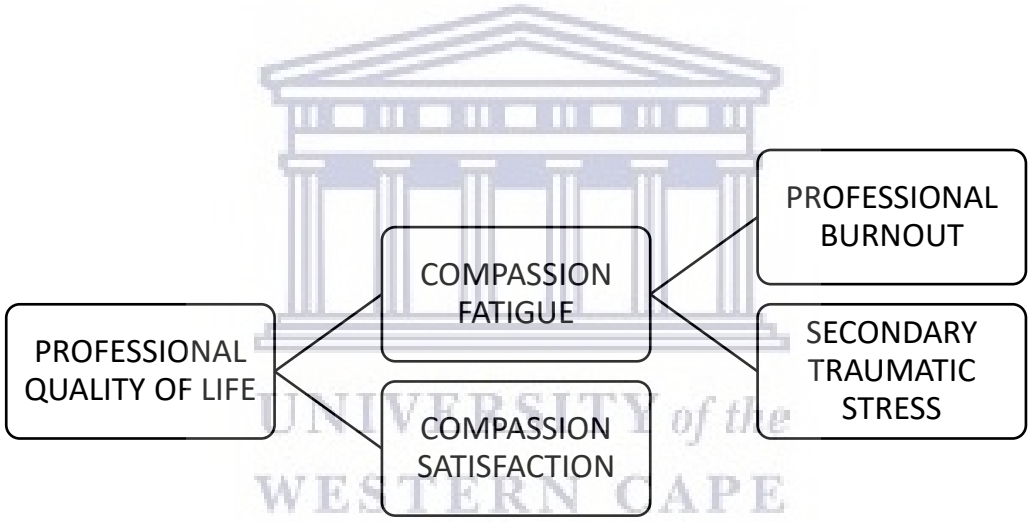
ProQOL aims to capture both the positive and negative aspects of the impact of one's work in the helping professions. The concept is based on the foundations of work by theorists such as Charles Figley, Beth Hudnall Stamm, Lisa McCann, and Laurie Anne Pearlman during the mid-1990s (cf. Figley, 1995; McCann & Pearlman, 1990; Stamm, 1995). Although there are debates regarding taxonomy (as discussed in the literature review), Stamm (2010) asserts that there is yet to be a successful delineation of terms, where they are assigned fully separate and distinct meanings, and so these terms remain generally interchangeable.

Overall, ProQOL brings together characteristics of the work environment, which includes organisational and interpersonal factors and relates them to an individual's exposure to primary and secondary trauma within the workplace.

As definitions of Compassion Fatigue, Compassion Satisfaction, Secondary Traumatic Stress, and Burn Out are discussed in the literature review, they will not be repeated here, although the basic structure of ProQOL is shown in Figure 1.

Figure 1

The Structure of ProQOL



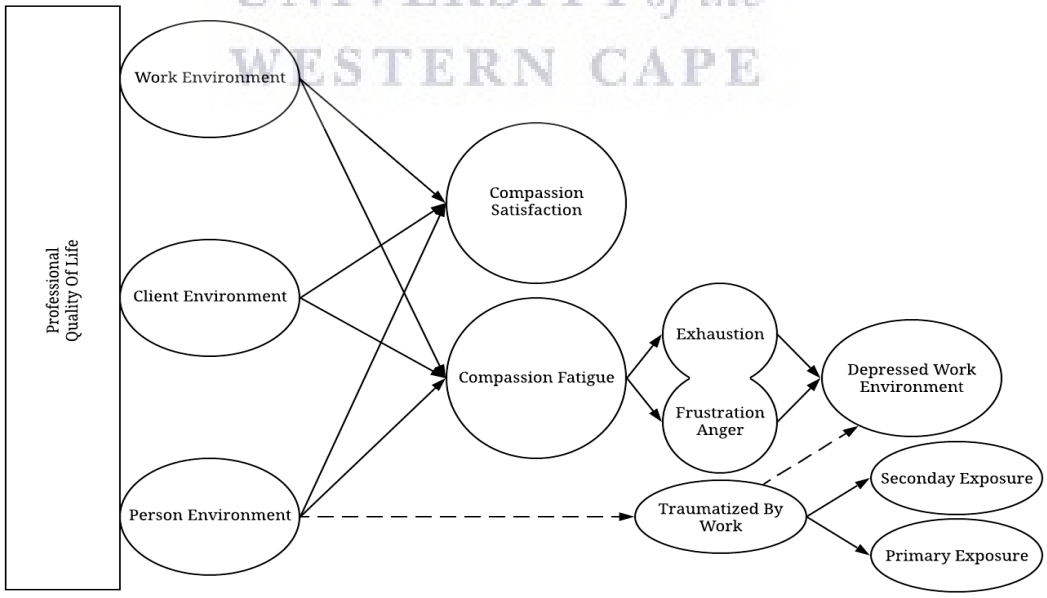
(Stamm, 2010, p. 8)

It is important to re-emphasise that each construct exists independently of the other and that, although there are overlays in their manifestation, they may occur separately. For example, a lay counsellor may experience high Burn Out only, and dissatisfaction with the workplace culture or working environment itself. Alternatively, they could experience STS but without BO, as well as high Compassion Satisfaction. This would mean that they

experience PTSD-like symptoms, but also find deep satisfaction and reward within the interpersonal work they engage in. This would leave them at risk for Compassion Fatigue, but they may not be experiencing it currently. The key difference in Compassion Fatigue between Secondary Traumatic Stress and Burn Out is that Burn Out reflects dissatisfaction with the organisational environment. Secondary Traumatic Stress, on the other hand, is in intrapersonal experience of psychological distress, and includes an acute fear of doing the work itself. While Burn Out may lead to feelings of anger, frustration, depression, and apathy, Secondary Traumatic Stress has a more psychiatric presentation. Stamm's (2010) model of the theoretical pathway, which provides a more comprehensive model of the relationship between emotions, symptoms, and the varying outcomes of different environments, is presented in Figure 2.,

Figure 2

Theoretical Pathway of ProQOL



(Stamm, 2010, p. 11)

According to this model, ProQOL brings together three different 'environments' through which either or both Compassion Fatigue and Compassion Satisfaction may develop. These include the work environment, the client environment (the interpersonal therapeutic or counselling work), as well as the person environment (the intrapersonal experience one has of the self). When Compassion Fatigue develops, it often is the result of work exhaustion, but also deeper feelings of frustration and anger triggered by traumatic material from the client, which perhaps resonates with their own previous trauma or worldview. This culminates in a feeling of depression around the work environment and this feeling gives way to a feeling of traumatisation. Traumatisation is recognised to be either primary or secondary, where primary trauma is the result of first-hand experiences in the work place (such as in the case of emergency or disaster responders) and secondary trauma is the traumatic material verbalised in some form of therapeutic engagement.

In sum, Compassion Satisfaction refers to positive feelings about being able to perform and function well within the work environment. An individual who experiences high Compassion Satisfaction, will mostly likely experience positive emotions related to their work as a helper, while someone who scores poorly on the Compassion Satisfaction scale of the ProQOL is likely to be experiencing some difficulties with their job, or perhaps derives greater satisfaction elsewhere (Stamm, 2010).

Compassion Fatigue is a culmination of both Burn Out and Secondary Traumatic Stress, or perhaps one or the other. More typically, experiences of both are present. Burn Out is an intuitive concept and those who score highly on the Burn Out scale are a higher risk for Burn Out. Burn Out is usually a gradual and cumulative experience that takes place over time and it is the first component of Compassion Fatigue. Secondary Traumatic Stress is related to secondary exposure to trauma that occurs within the workplace, and is specifically relevant to counsellors who may hear detailed and gruesome stories of the trauma their client or patient

has experienced. The symptoms usually have a sudden onset and imitate those of first-hand trauma in PTSD.

It is important to note that, while the ProQOL is not a diagnostic test, it can be helpful in raising concerns to help address clinical concerns. Stamm (2010) argues that both Burn Out and Secondary Traumatic Stress are "frequent co-travels" of depression and PTSD itself (p. 18). In this way, it can highlight the psychological needs of a counsellor, although it would be a "grievous mistake" to make a DSM-5 diagnosis based off the ProQOL alone (Stamm, 2010, p. 18).

ProQOL forms the basis of the first part of this study. As such, it informs the constructs and phenomena explored in the second. However, to better capture and answer the research question which enquires after *experiences*, the framework of CSDT becomes necessary, given that it creates opportunities to further explore the experience of what it means to be a lay counsellor in South Africa.

3.2. Constructivist Self Development Theory (CSDT)

Trauma is transformative and, in its aftermath, comes adaption (Saakvitne et al., 1998). CSDT, in line with the emergent literature on Compassion Fatigue and Vicarious Trauma, first acted as a base through which to explore the complexity of the counselling process (Pearlman & Saakvitne, 1995). The original paper by McCann and Pearlman (1990) examined therapists' reactions to secondary trauma. The theory remains useful in that it helps to describe the interaction between the interpersonal and psychological processes involved in counselling. It is relevant to this study's aims, which include qualitatively understanding the impact of the secondary trauma that occurs during the *process* of counselling a traumatised individual, and how this goes on to affect ProQOL.

CSDT is based on a constructivist orientation, which is founded on the principle that individuals construct their own realities (as described by Pearlman & Saakvitne, 1995).

Through this understanding, the meaning of the trauma is thus created out of the individual's experience of it. The same principle would hold for secondary trauma, as well as the constructs associated with ProQOL. Pearlman and Saakvitne (1995) go on to say that the construction of meaning occurs as new information is incorporated into an individual's beliefs and their systems of meaning. Understood in this way, CSDT describes traumatisation and its related constructs as *process* definitions. The trauma only begins with the exposure and it continues with a process that goes on to change the self.

McCann and Pearlman (1990) state more clearly that traumatic life events are connected to cognitive schemas. The authors note that cognitive structures evolve over time and become increasingly complex as individuals interact with their environment. In this way, psychological adaption occurs post-trauma, whether this adaption be positive (healing responses), negative (further traumatisation), or both (Saakvitne et al., 1998).

McCann and Pearlman (1990) as well as Pearlman and Saakvitne (1995) reference five cognitive schemas that undergo change and are adapted after experiencing a traumatic event: (1) safety, (2) trust, (3) esteem, (4) intimacy, and (5) control/power. With (1) safety, one might experience a heightened sense of vulnerability, and an enhanced awareness of the fragility of life, which may perhaps manifest as intrusive thoughts of the trauma happening to the self or others. In terms of (2) trust, individuals may find themselves more suspicious and cynical of others, or perhaps distrust their own capacities and/or they may expect the worst. For (3) esteem, there may be a pervasive cynicism about how people treat one another. (4) Intimacy may be disrupted and one's connections to others appearing frail, with a subsequent feeling of separateness. (5) Control/power has to do with efficacy and effectiveness, where the counsellor, whose schema of control has been disrupted, may have feelings related to their ability to help, thereby impacting their identity.

In the original literature (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995, Trippany et al., 2004), it was noted that, in addition to these schemas, the self and identity are impacted in further ways. These include changes to one's frame of reference (about the self and the world), one's evaluation of one's own self capacities (such as sense of self, connection, self-esteem, and ability to manage emotions), as well as ego resources (the ability to hold therapeutic boundaries and to self-protect). In addition to these, psychological needs (the five listed cognitive schemas above) need to be held in place and memory and perception need to be intact. The erosion of any of these areas or within the five cognitive schemas may act as a catalyst for compassion fatigue.

There is greater familiarity with the negative aspects of trauma (Saakvitne et al., 1998). Yet, trauma is also associated with the reconstruction of meaning and a renewal of faith, trust, hope, and connection to others. This growth often surpasses expectations and, when this occurs, the self becomes redefined (Saakvitne et al., 1998). This echoes the concept of Vicarious Post Traumatic Growth, which is not explicitly stated in CSDT, but is alluded to when positive changes to identity are discussed.

CSDT considers the impact of trauma on the self and identifies both the damage and the growth that can occur. It advocates for synergy between nomothetic (where X experience is understood to cause Y outcome) and idiographic (where the individual is considered the unit of analysis) processes. It allows for the transferability across samples as well as recognising differences, allowing for complexity. CSDT is interested in integration and meaning, and allows for the exploration between personality, personal history, and traumatic events, and it focuses on the capacity for humans to adapt and survive (Pearlman & Saakvitne, 1995). For these reasons, it is a suitable theoretical framework for this study.

Chapter Four: Methodology

This chapter discusses the methodology of the current study and includes descriptions of the research design, outlines the aims of the study, and describes the participants. It also includes descriptions of the data collection processes, the procedures that were used, and outlines the process of data analysis, before commenting on rigour and trustworthiness in qualitative research. Final comments include a section on reflexivity, and a consideration of ethics.

4.1. Research Design

This study made use of a triangulated design, drawing on both quantitative and qualitative data. Triangulation is recommended when the research question demands an exploration that is comprehensive, and which must provide an articulate understanding of experience (Braun & Clarke, 2014). The integration of quantitative and qualitative data enhances the study in a way that one form of the data does not allow, since the quantitative data provides results from precise instruments, which is then augmented by contextual, field-based information in the form of qualitative data. In this way, synergies between objective and subjective knowledge are elicited (Braun & Clarke, 2014).

The quantitative data referenced here formed part of a larger research project, which focused on the role of fortitude in relation to Compassion Fatigue, Compassion Satisfaction, Secondary Traumatic Streses, and burnout. The findings from the broader study have been published (Padmanabhanunni, 2019). In line with the concept of triangulation, this study sought to expand and support this data using Thematic Analysis (TA). TA is just one form of the rich and compelling qualitative methodologies that can be used to complement quantitative data (Braun & Clarke, 2014). Alhojailan (2012) describes TA as a comprehensive process that allows for both cross-referencing and flexibility to capture evolving themes. It is both inductive and deductive, rendering it a helpful methodology when

seeking the relationship between variables, and comparing evidence across different situations in the same study.

Although there are arguments that insist TA is not a sophisticated and a somewhat unregulated theoretical paradigm, Braun and Clarke (2014) argue that it is particularly useful in presenting results to audiences who fall outside of academic communities. One of the implicit aims of this study is to provide recommendations for the formal recognition of the work of lay counsellors. Further, they argue that, although the tradition of TA does not necessarily offer interpretative depth, the process of TA is wholly dependent on multiple factors; namely, the research topic, the researcher, the researcher's experience, the intended audience, and the theoretical location of the research. In this research study, the process undertaken involved identifying the emergent themes in each individual transcript, before cross-referencing the different theme 'codes' rooted in quoted text across transcripts. This approach attempted to ensure that the rigour of the study was grounded in multiple instances of contextual, quoted evidence.

4.2. Aims and Objectives of the Study

The overarching aim of this study was to investigate professional quality of life among lay counsellors in Cape Town. The broader research project examined the role of fortitude in relation to Compassion Fatigue, Compassion Satisfaction, Secondary Traumatic Stress, and Burn Out. This study both departed from this aim as well as expanded upon it, through the following objectives:

a) Investigating the association between demographic variables (specifically, age and sex) and Compassion Fatigue, Compassion Satisfaction, Secondary Traumatic Stress, and Burn Out among lay counsellors.
b) Exploring the *lived experiences* of trauma work for lay counsellors.

4.3. Participants

For the quantitative section, participants included 146 lay trauma counsellors, who provided counselling services to individuals residing in historically disadvantaged communities in the WCP of SA. The participants worked for NGO's in these settings and inclusion criteria required that they needed to work directly with trauma, and had to have been working in the field for a minimum of one year. These participants were located through non-probability convenience sampling.

Twenty lay trauma counsellors participated in the qualitative component of this study. The number of participants was chosen to allow for lived experience to be fully explored and for as many themes as possible to emerge. The mean age of participants was 37.3 years. In terms of gender, most participants were female (15 female participants, 5 male participants; Ratio = 3:1). For the purposes of the study, pseudonyms were used to protect participant anonymity. The table below provides information on participant demographics.

Table 1

List of Participants and Pseudonyms for Qualitative Study

Pseudonym	Age	Gender	Type of Organisation	Experience
P1. Zara	23	F	Family counselling centre	2 years
P2. Anette	50	F	Family counselling centre	>10 years
P3. Charlotte	32	F	Suicide hotline	2 years
P4. Fiona	54	F	Family counselling centre	3 years
P5. Roslyn	22	F	Family counselling centre	1 year
P6. Claudette	36	F	Refugee peer-counselling NGO	>5 years
P7. Anna	38	F	Refugee peer-counselling NGO	>5 years
P8. Frank	35	M	Refugee peer-counselling NGO	>5 years
P9. Michael	24	M	Refugee peer-counselling NGO	3 years
P10. Ava	38	F	Refugee peer-counselling NGO	2 years

P11. Thomas	56	M	Refugee peer-counselling NGO	>10 years
P12. Tara	33	F	Suicide hotline/Rape hotline	3 years
P13. Irene	30	F	Suicide hotline	2 years
P14. Joseph	43	M	Suicide hotline	2 years
P15. Mila	34	F	Suicide hotline	1 year
P16. Ben	38	M	Suicide hotline	1 year
P17. Faye	65	F	Suicide hotline	>20 years
P18. Amy	36	F	Suicide hotline	5 years
P19. Lara	32	F	Suicide hotline	3 years
P20. Ciara	27	F	Suicide hotline	<3 years
20 participants	x = 37.3	F:M (3:1)		x = 4.4 years

Counsellors Per Place of Work

6 counsellors (30%):	Refugee peer-counselling NGO
4 counsellors (20%):	Family counselling centre
10 counsellors (50%):	Suicide hotline

4.4. Procedure

Participants were recruited through NGOs providing trauma counselling services to the public. Participants for both the quantitative and qualitative studies used the same recruitment procedure. For the quantitative study, instruments including the Fortitude Questionnaire (Pretorius & Heyns, 1998), and the Professional Quality of Life (ProQOL) scale (Appendix A) were used, and demographic variables (age and sex) recorded. For the qualitative component, participants' ages, genders, and type of organisations that they worked or volunteered for were recorded, and semi-structured interviews took place.

Counselling NGOs were sourced through a Google search, using the terms "free counselling in Cape Town", "Cape Town counselling NGOs", "trauma counselling in Cape Town", and "free trauma counselling in Cape Town". Ten pages of results for each of these searches were scanned and vetted for appropriate counselling NGOs. Once identified, each

receptionist and CEO of the NGO was contacted directly via both telephone and email (Appendix B). The research study was explained, and permission was granted for information regarding the study to be further shared via email with the organisation's counsellors. In this email (Appendix C), counsellors were provided with the researchers email and cell phone contact details. Counsellors were then invited to contact the researcher directly if interested in participating. Twenty-three counsellors made contact, from which 20 were interviewed. For logistical reasons to do with the participants' schedules, the last three interviews did not take place. Participants who were interviewed were provided with a detailed Information Sheet (Appendix D) and asked to sign an Informed Consent Form (Appendix E) before the interview commenced. Interviews took place on the NGO premises between July 2019 and October 2019.

Semi-structured interviews (Appendix F) were conducted by the researcher and took place on an individual basis. The purpose of the interviews was to expand and supplement the results of the original study by exploring lay trauma counsellors' *lived* experiences of working with trauma survivors

4.5. Data Analysis

For the quantitative component of the study, data were captured and analysed using the Statistical Package for the Social Sciences (SPSS-25). Thereafter, descriptive statistics were used to analyse demographic information and correlational analysis was used to determine the association of demographic variables and Compassion Satisfaction, Secondary Traumatic Stress, and Burn Out.

Braun and Clarke (2012) argue that TA is a systematic method of identification and organisation that offers insight into patterns of meaning across a data set. This was appropriate for this study in that it needed to complement a highly rigorous quantitative

component, through making sense of a group experience, which could be transferable across the sample.

In this project, the analysis of the qualitative data remains flexible in that it straddles both inductive and deductive means of reaching its conclusions. This was important, as it was necessary to capture the collective lived experience of lay trauma counsellors, which demanded an inductive approach.

The process of TA drew on Braun and Clarke's (2012) systematic yet flexible approach, which utilises six clear steps. In the first step, the researcher familiarised herself with the data by immersing herself in it. This included full immersion in the data collected. This included conducting each individual interview herself, making reflective notes immediately after each interview in a reflective notebook, highlighting themes of potential interest, and listening to the recording of each interview again before transcribing it.

Once the interviews were transcribed, the second step of generating codes for the data was initiated. To generate initial codes, a systematic analysis was undertaken. The entire data set was read through, before each individual interview was analysed. During this process, specific features of the data were identified and provisional labels, relevant to the research question and specific to each feature, were generated. The first codes were descriptive, but through a process in which interviews were reviewed by the researcher and through research supervision, latent codes were generated. An iterative process took place where, as more interviews were coded, codes were reviewed and modified. At the end of this process, the codes were collated and checked for their relevance to the research question. Certain codes were discarded.

In the third step, the data set was reread with codes in mind, and themes were searched for. Themes are identified through patterned responses and it is important that they occur across multiple participants and are not too individualised. Areas of similarity were

identified, and subsequently, the codes were clustered together to reflect and describe meaningful phenomenon in the data. Relationships between themes were identified and noted.

Once themes had been generated and constructed, a process of review and quality checking took place. This is a recursive and iterative process, which the researcher first did individually and then with the aid of the research supervisor. During this process, certain themes were discarded, whilst others were relocated and relabelled. Themes were checked to ensure they had sufficient evidence within the data and checked for consistency and similarity.

In the fifth step, themes were clearly defined and named. While it is natural that themes should 'speak' to one another and that there should be an element of overlap, it is important that there is also a sense of uniqueness and specificity. Themes should also build upon each other and create a narrative, meaning that the selection of data is important. This is particularly necessary for this research project, which is concerned with the lived experiences of trauma lay counsellors.

The final stage involved producing the results. For this section, an argument was not put forward, but rather, a coherent story was told through the selection of data and the careful grouping to confirm themes.

4.6. Rigour: Trustworthiness in Qualitative Research

Trustworthiness in qualitative research refers to the extent to which data collection and analysis is credible and trustworthy. Guba and Lincoln (1994) developed four criteria to guide researchers in establishing trustworthiness in qualitative research: credibility, transferability, dependability, and confirmability.

4.6.1. Credibility. This refers to whether the study measures what it intends to measure. Triangulation is recommended as a means of ensuring credibility. To enhance the

credibility of this study, some transcripts were cross-checked by the research supervisor to see if similar themes were elicited from the data. In addition to this, prolonged exposure took place, where the researcher met with each participant for an extended period of time and communicated prior and on the day of the meeting the aims of the research. After each interview took place, a final question asking participants to reflect on the research question was asked. Participants were asked to reflect whether there was any information that they felt was important to share that *had not* been asked. This invited a space where the saliencies of each participant's lived experience could be stated and recorded.

4.6.2. Transferability. This refers to whether the findings of the study may be replicated. The detail provided in the methodology section, including rich and thick descriptions of each NGOs context and the participants themselves, will allow other researchers to replicate and generalise the results to other studies.

4.6.3. Dependability. Dependability is achieved through ensuring the research process is logical, traceable, and clearly documented (Nowell et al., 2017). If it is, then a study which replicates it will produce comparable results. This study has ensured comprehensive and detailed documentation across the research methodology, including data collection, procedures, and the data analysis. This creates a research 'trail' which would withstand auditing, and which could be followed in the future.

4.6.4. Confirmability. Confirmability, the final trustworthiness criterion, is concerned with establishing that the researcher's interpretations and findings are clearly derived from the data. This requires the researcher to demonstrate how conclusions and interpretations have been reached, and it is clear to the reader how decisions have been made. Confirmability is established when the first three criteria of trustworthiness are reached. Records of raw data, field notes and transcripts have all been kept, and reflexive notes were kept in a journal.

4.7. Reflexivity

Reflexivity in research is an acknowledgement of the human bias that influences the entire research project (Mauthner & Doucet, 2003). Reflexivity is specifically concerned with the way in which the methodology, the data collection, analysis, and conclusions reached are influenced and affected by the researcher's individuality. This includes the researcher's background, experience, and biases. In qualitative research, there is consensus that it is not possible to remain neutral, and that the researcher will influence the research process in unintended ways.

Some of the important considerations that a qualitative researcher needs to be aware of and demonstrate an awareness of include how the researcher's age, race, gender, sex, socio-economic status, as well as the implicit power dynamics that exist between the researcher and the researched impact the collection of data. Background, life experiences, biases, and beliefs will influence the interpretation of results.

To ensure awareness and to encourage honesty and research rigour, a research journal was kept, in which detailed notes regarding reactions and general self-reflection were recorded. The aim of the journal was to promote credibility and trustworthiness of the data.

I am a female, Caucasian, English-speaking, tertiary-educated woman in her late twenties who has lived and been educated in the WCP for the entirety of my life. The connection between myself and the participants in this study was that I had previously volunteered and worked as a lay trauma counsellor. In some ways, we all would have established professional identities as 'helpers'. In addition to this, we would all have been exposed to the traumatic stories of others. Similar to many of the participants in this study, I have experienced multiple traumatic events in my own life. This, as is the case for many of the participants, contributed to an increased sense of empathy and 'a calling' to become an occupational counsellor.

Many of the lay counsellors articulated that part of their hopes and aspirations was to enter a formal Clinical Psychology program, a process that is informally recognised as competitive, highly selective, and relatively prestigious within the humanities and health sciences. As a person currently enrolled in such a programme, I could sense a palpable discomfort and detected feelings of wistfulness within participants when they asked whether the research was part of a clinical or research master's programme. It is possible that this impacted on what and how information was disclosed to me.

When listening to the traumatic stories and difficult experiences of the participants, it was important to hold or 'bracket' my own experiences and to focus on the experience of the participants, allowing them to describe and share their unique encounters with trauma. It was important to be cognisant of my own difficult experiences, as well as the experiences of close friends of others, and not collate or misinterpret the unique feelings and experiences articulated. This was done through writing post-interview reflections and notes, as well as regular debriefing with a psychologist. For those participants who felt distressed by the interview, I engaged in a reflective conversation with them, and together we decided on next steps. Although participants would have been welcome to access free therapeutic services at the WCP university most accessible to them, none of the participants felt as if their distress required this level of intervention.

One of the most difficult experiences that I listened to included accounts of 'sex-callers' at the suicide hotline at which I had previously volunteered. The frequency of these callers had led to me leave the organisation and find occupational counselling work elsewhere. At the time, I had felt despondent and depressed at the level of abuse that the organisation encountered, and it was difficult for me to hear that others experienced similar frustration. I It also concerned me that this level of abuse was continuing. I felt a great deal of

empathy for those counsellors who expressed their own despondency and those who recounted how they would “snap” and react “unprofessionally” in response to these calls.

Other difficulties arose when I listened to the stories of the refugee peer counsellors. Having worked at a refugee organisation for a number of years, performing a counselling service, I have experienced feelings of burnout and fatigue due to the traumatic nature of the stories of Congolese, Rwandan, Burundian, Sudanese, and Somalian refugees who have common experiences of rape, violence, and acute loss. When listening to these experiences second hand, it reminded me of my own feelings of burnout, as well increasing my feelings of empathy. These interviews left me feeling tired and slowed down my data collection process.

The final anxiety I had when conducting these interviews was when I encountered three counsellors at a family counselling centre who were performing counselling without adequate supervision. One interviewee reported charging a fee and seeing clients privately, which is a grey area within the delineated scope of practice guidelines provided by the HPCSA. I was left with an ethical dilemma: should I report these individuals, and deny people of crucial services? I decided to have direct conversations with these participants and encouraged them to seek supervision, citing the HPSCA guidelines as motivation. This aspect of the research convinced me that guidelines for lay counsellors are sorely needed.

Overall, the interviewing process was a rich and rewarding one, allowing me to gain insight beyond my own experiences. I feel grateful for the deep engagement, vulnerability, and honesty with which participants engaged in this research.

4.8. Ethical considerations

This study followed the ethical standards provided by the University of the Western Cape. Ethical approval was provided by the universities Humanities and Social Science Research Ethics Committee (HSSREC). Elements of ethical attention included voluntary

participation, informed consent, confidentiality, data storage, and working with a vulnerable population.

Regarding voluntary participation, it was stressed in the invitation email that participation was completely voluntary. Before an interview commenced, participants were reminded that they could withdraw at any time during the research process, without consequence. Confidentiality and anonymity were explained in detail, and participants were invited to express any concerns before participation. Once the above had been communicated, participants signed an Informed Consent Form (Appendix E), which was then assigned a random number. Regarding informed consent, it was made clear that interviews would be digitally recorded and transferred to a computer that was secured with a password. Participants were told that the interviews would be transcribed verbatim and that these transcripts would be handled by only the researcher and her supervisor.

Regarding confidentiality and anonymity, this was a priority and it was maintained both throughout and post the research process. Interview recordings and transcripts did not have any identifying information contained in them. The names of the specific NGOs were removed and, instead, the type of counselling the NGO provided was used as a reference point. For the research report, pseudonyms were assigned. All recordings are currently stored on the researcher's personal computer, which is password protected. Transcripts are similarly password protected and o hard copy of the transcripts exists.

It was possible that some of the interviews may have been distressing for participants. After each interview, the researcher took some time to check-in with participants. They were informed of various sources of help, which included university training therapeutic centres, which none of them were affiliated with, except for one participant. This participant was fortunately able to access private therapy, which was checked prior to the interview commencing.

Chapter Five: Analysis and Results

In this chapter, the results of the quantitative and qualitative phases of the study are presented separately. The quantitative component of the study aimed to explore whether there were any associations between demographic variables and professional quality of life. The qualitative component focused on capturing the lived experiences of trauma lay-counsellors, supplementing the concept of ProQOL with rich, qualitative data that could capture trauma lay counsellors experiences.

5.1. Quantitative Results

The quantitative component of this study formed part of a larger project that took place over 2017-2018. The broader project focused on investigating the role of psychological fortitude on the ProQOL among a sample of trauma counsellors in the WCP. Data was captured using electronic and hand-delivered surveys. The instruments used for the broader project were the Fortitude Questionnaire (Pretorius & Heyns, 1998), the ProQOL scale (Stamm, 2010) (Appendix A), and the Life Events Checklist (Weathers et al., 2013) (Appendix G). The results of this broader study have been published in two separate papers (Padmanabhanunni, 2019, 2020b). For the current study, the secondary data was analysed with a focus on investigating the association between demographic factors and professional quality of life.

In Table 2 below, the means and standard deviations of the ProQOL, including gender differences and correlation with age are presented.

Table 2

Descriptive Statistics for ProQoL, Gender Differences, and Correlation with Age

	Total sample		Men		Women		t-value	Correlation with age
Scale	Mean	SD	Mean	SD	Mean	SD		

CS	42.46	4.52	41.80	4.40	42.61	4.60	-.85	.30*
BO	19.28	4.83	20.23	5.82	19.07	4.47	1.17	-.36*
STS	21.75	5.76	21.58	7.06	21.83	5.31	-.21	-.05

* p<0.1

According to the results in Table 2, there is no statistically significant difference between occurrence of Compassion Satisfaction, Secondary Traumatic Stress, or Burn Out in terms of gender. However, there is a statistically significant positive relationship between age and Compassion Satisfaction and a negative relationship between age and Burn Out.

Table 3

Frequency Distribution of ProQOL Scores in Terms of Cut-points

Percentile	Total sample (N=147)		Men (n=33)		Women (n=110)		Odds ratio (CI95)
			Compassion Satisfaction				
<25th	N = 38	29.2%	n=11	36.7%	n=27	27.8%	2.17 (0.71-6.65)
25th< >75th	N = 52	40%	n=13	43.3%	n=38	39.2%	
>75th	N = 40	27.2%	n=6	20%	n=32	33%	
			Burnout				
<25th	N=27	20.1%	n=5	16.7%	n=21	20.8%	1.53 (0.43-5.42)
25th< >75th	N=77	52.4%	n=17	56.7%	n=58	57.4%	
>75th	N=30	22.4%	n=8	26.7%	n=22	21.8%	
			Secondary Traumatic Stress				
<25th	N=31	21.1%	n=5	16.7%	n=21	21.9%	1.12 (0.36-3.48)
25th< >75th	N=69	46.9%	n=17	56.7%	n=54	56.3%	
>75th	N=30	20.4%	n=8	26.7%	n=21	21.9%	

To interpret scores on the ProQOL, Stamm (2010) recommends a conversion to t-scores, with an M of 50 and SD of 10. Cut-points in terms of t-scores are also provided, and this is captured in Table 3.

In terms of Compassion Satisfaction, 29% of the sample reported low Compassion Satisfaction and 27.2% a high Compassion Satisfaction. More men (36.7%) than women reported low Compassion Satisfaction (27.8%). Conversely, 33% of women as opposed to 20% of men reported high Compassion Satisfaction. The odds ratio indicate that women are 2.17 times (CI95: 0.71-6.65) more likely to report high Compassion Satisfaction. Regarding BO, 20% of participants in the sample reported low burnout and 22.4% of the sample reported high burnout. Men (26.7%) were 1.53 times (CI95: 0.43-5.42) more likely to report high burnout (21.8%). In the case of Secondary Traumatic Stress, participants in the sample reported similar percentages of low STS (21.1%) and high STS (20.4%). More men (25.8%) than women (21.9%) reported high Secondary Traumatic Stress. Men were 1.12 more likely than women to report high Secondary Traumatic Stress (CI95: 0.36-3.48).

Table 4

Sample Distribution in Terms of Combination of Scale Scores

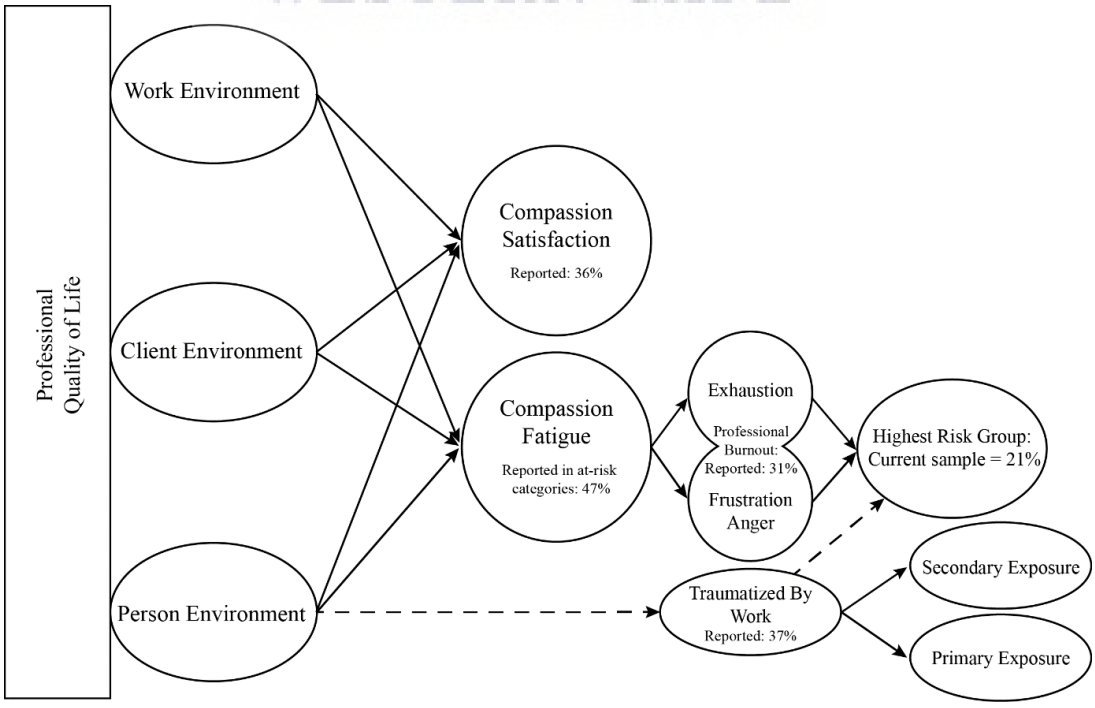
Combination of Scales	N (total = 130)	%
High CS, low burnout, low STS	30	23%
High burnout, low CS, low STS	13	10%
High STS, low burnout, low CS	4	3%
High STS, High CS, low burnout	17	13%
High STS, high burnout, low CS	27	21%

Stamm (2010) suggests interpreting the ProQOL scores in combination with one another. There are five different combinations of subscale scores and these are presented with the number and percentage of participants that fall into each category in Table 4. The

combinations also act to provide a risk-assessment, explained further below. The first possible combination is the most positive, where participants report high Compassion Satisfaction together with low Burn Out and low Secondary Traumatic Stress. Almost a quarter of the sample (23%) fell into this category. The other categories indicate the presence of risk, with either reports of high Burn Out or high Secondary Traumatic Stress. In the second category, high Burn Out is the most pressing issue, with 10% of participants falling in this category. Only 3% of the sample fell into the third category, in which there is a high level of STS, but low Burn Out and Compassion Satisfaction. The fourth category is one in which members of the sample report high Secondary Traumatic Stress, high Compassion Satisfaction, and low Burn Out, and 13% of the sample fell into this category. The final combination of the subscales, which includes high Secondary Traumatic Stress, high Burn Out, and low Compassion Satisfaction is regarded as the most distressing and detrimental combination of a counselling experience. A fifth (21%) of the sample fell into this category.

Figure 3

Results as Modelled on the ProQOL Pathway Theory



5.2. Qualitative Results

The qualitative component of this study aimed to explore the lived experiences of lay counsellors, specifically lay counsellors who work with trauma. This section focuses on the experiences of twenty lay counsellors who worked at different counselling NGOs within the city of Cape Town. The results are divided into four major sub-sections: the lived experience of being a lay trauma counsellor, lived experiences of lay counselling, the psychological impact of lay trauma counselling, and positive personal transformation. An overview is provided in Table 5 below.

Table 5

Summary of Major and Sub-themes within a TA Framework

Major Theme	Sub-themes
1. Lived experiences and identity of *being* a lay trauma counsellor	a) Insecurities and uncertainties: "What if I'm doing a bad job?" b) Enhanced sense of self-worth: "It made me realize I am worthy." c) Meaning and purpose: "I have saved a life". d) Lack of recognition: "Us mere counsellors."
2. Lived experiences of lay counselling	a) Difficulty relating to patients: ["it's like] they're speaking a completely different language to me." b) Emotional regulation and keeping contained: "I can't be angry, I can't be sad, because people are watching me." c) Sense of despondency: "Our counselling helps, but counselling doesn't bring bread."
3. Psychological impact of trauma lay-counselling	a) Feeling overwhelmed: "There were some days I was relieved when the client just wanted to sit there." b) Heightened fear and anxiety: "I feel like I'm just always scared now." c) Triggering of personal traumas: "Suddenly I'm faced with something that has completely disarmed me."

	d) Vicarious trauma: "I also need to take care of myself sometime, you know?"
4. Positive personal transformation	a) Increased sense of compassion: "Your heart becomes soft and filled with compassion. And [I] changed." b) Personal healing and a sense of gratitude: "There's a duality going on: you help somebody and they help you." c) Renewed sense of hope: "I got to the other side as a whole person… it kind of gives me hope that anyone can do that."

While the themes are distilled here as part of a phenomenological study, it is important to acknowledge that many are ubiquitous in their nature and, ultimately, they are connected and superimposed upon one another.

5.2.1. Lived experiences of being a trauma lay-counsellor

Insecurities and uncertainties: "What if I'm doing a bad job?" Several participants in the study reflected on feelings of anxiety, uncertainty, and guilt related to appraisals around professional competence and whether they were doing "a good enough" job in assisting those in need. This can be seen in Zara's comments below:

> In those moment you feel… I don't want to say depressed, because people often use that word loosely. I… anxious, I feel anxious. I'll feel nervous, like I'm not doing enough, like I should be doing enough, and I'll feel like oh my gosh, maybe this is not what I'm supposed to be doing, maybe I am supposed to be doing more, but sometimes I'll sit down, and think, actually you are doing enough, actually you are on the right track. So why am I stressing myself over doing the right thing? When actually I know I am pushing myself to do better. But what is better?

A similar sentiment was expressed by Charlotte, who was afraid she would cause "damage" to her patients by "doing a bad job". It was evident from her narrative that this was partially related to issues of self-esteem:

> What if I'm breaking them, what if I'm doing a bad job? But I can't really afford to think like that. So when that happens, I try to go back on my training, and just trust that I got the right training, and trust that I am here for the right reasons, and I'm doing the best I can … so, like I do struggle with that… self-esteem element sometimes... Because I don't want to cause damage and this is a very serious thing, people come here with really serious stuff,

> trauma and AIDs and abuse and violence, and I can't presume at all that I can fix them. Because that's not really what counselling is about.

For Irene, her self-esteem and self-worth were explicitly measured by how much she felt she was able to provide for others in a counselling interaction, so much so that at times she began to feel isolated from her friends and family:

> I definitely assign like a lot of self-worth to like this work, and when I'm not able to do to I don't feel like I'm doing it well, I definitely feel bad about myself .... That can be quite isolating, I guess.

Tara wondered how long she would be able to counsel, as she felt it was quite taxing on her own mental wellbeing. However, when she considered this, feelings of self-doubt regarding her personal capabilities and self-worth surfaced:

> I'm not sure if I can do this forever. And I think that impacts me hugely, because if I can't do this, how else am I going to help? And so, it's a bit of… I think that there's an inner fight, my view of myself and how I feel about myself is a fight between wanting to help and um, feeling that I just might not be capable of doing it. I think that the South African context plays a huge part in that. Um, ja, it's… I feel worthy in other situations, but I don't feel worthy in this one anymore. I think there's going to be a big learning curve and I hope that I can stick it out.

Tara found that she was often overwhelmed by the negative stories she would hear and became flooded by a sense of helplessness. She doubted her competence and described how her self-esteem had gone "down", and she was often left wondering what she could possibly give in situations so "big":

> I do think that I'm a realist-slash-pessimist and the days are hard and um… I think my view of myself now is that… I always used to think of myself as a super-strong woman, who knew myself, and that isn't the case anymore. Um, I am getting to know myself and there's parts that I like, and parts that I hate, but the parts that I like are new and learnt and sometimes they're in reaction to the bad. So, you know, you'll have a client who… who sits in their cycle of guilt or their cycle of victimization, or whatever it is, and they sit in that cycle and my reaction is to that is try not be the same. Which sounds crazy to say that out loud, but I do think that my self-esteem is not what it used to be. Um, I think I don't see that I always add value to a counselling situation, so my self-esteem's definitely gone down on that, because I wonder what I have to give, in situations so big.

When it came to group counselling, Frank said that numbers mattered from an NGO perspective (meeting targets), but also from a motivational perspective:

> When people drop out of the group, I think, maybe I am not doing it well or maybe there was a problem, maybe I did something wrong. But when the people are many, like they are a good number - I am more devoted to the group.

Franks experiences of interacting with the group impact on his attitudes toward his clients.

Enhanced sense of self-worth: "It made me realize I am worthy". While for some participants, providing counselling services evoked anxieties and uncertainties regarding their competence, other participants reported that, through their work, they were able to build their self-worth. This can be seen in Fiona's account below:

> What I was aware of is that… I seem to be able to generate some peace for people. I was aware of it. And it made me feel worth something, because I didn't have a very high self-esteem myself.

This response was echoed by Roslyn:

> It made me realize that I am worthy. That was something that I really struggled with. My self-worth was really, really low… it's still a challenge for me sometimes but to realize that I've got something to bring to the table, I didn't go through life or go through situations or equip myself just to think of myself less than everybody else around me.

Meaning and purpose: "I have saved a life". Some counsellors articulated a sense of purpose, meaning, and satisfaction that they received from their work. This is commonly recognised as altruism and is an important factor in counselling. Frank describes the impact that he had on one of his participants in a group session:

> So, it's something that, you know, it gives us joy. You feel like I have done something. I have saved a life because if this man didn't come to this support group, he would have killed his wife, you see. So, I think we are doing something good and um, we also um, have seen some other people, who will say okay after this support group, um, I got a job.

A similar sentiment was echoed by Michael who, although had experienced significant trauma himself, found that the sense of purpose he found through his work led to feelings of content:

> So, I'm pretty happy to be here and I can tell you that I have been part of assisting people who give back, um, good testimony, you know. So, that makes me go to sleep easy every single night.

Irene also articulated a sense of purpose and contentment that she received from her counselling work, describing how it not only shaped her sense of self, but how she had taken counselling on as her "purpose":

> The way I've viewed myself, I've definitely taken on, like seen myself as like an instrument of comfort or support for a lot of people and I feel like that's the role that I am playing, whether it to like family or friendships or relationships, like I'm here to kind of do the emotional labour, taking that on as like my purpose.

Lack of recognition: "Us more counsellors". A prevalent theme among participants in the study was that they felt that there was a lack of recognition for their role, and that this had an impact on their sense of worth and competence.

Charlotte said that it was difficult to get positive feedback in the field and that, when it did happen, it meant a great deal to her and acted as "evidence" that she was on "the right track":

> It's really difficult to get positive feedback. People don't just come to you and say, you helped me so much. I think that doesn't happen. But when it does happen, it means so much. It feels like evidence that I'm on the right track, and that I'm okay doing this. And I'm not a failure, and I'm not doing something wrong, and that's important.

Apart from validation from patients, some participants also expressed feelings of frustration related to not being recognised by the professional governing body and how this contributed to a sense that others appraised their work as less valuable. This can be seen in Annette's account below:

> The biggest challenge that I have, is that struggle between the HPCSA, the clinical psychologists and us mere counsellors. I'm not registered with the HPCSA, and therefore, and the HPCSA doesn't like me. I get blocked. And because I'm not part of the HPCSA, I can give counselling to people at a much cheaper price, which is not qualitatively less, obviously I have to be ethical and make sure I don't go past my scope of practice, but it's a bit of a – it's tedious having to almost earn your keep with the different associations. That really is the most frustrating for me. That I can't talk to anybody, because I'm just a counsellor, and I'm not really supposed to be seeing clients. It's this sort of grey area that I'm working in, which is not really a grey area at all, but there's this hierarchy which is really uncomfortable.

Annette's sentiment is one which highlights a lack of recognition and validation from regulatory bodies, other professionals, and perhaps clients.

5.2.2. Lived experiences of lay counsellors

Difficulty relating to patients: ["it's like] they're speaking a completely different language to me". Some of the participants spoke about experiences in which they had difficulty connecting or relating to their patients.

Tara articulated a specific experience where she found it difficult to relate to a patient. This resonated with other participants in that it also made her reflect on whether she was competent or not, a common theme addressed in the section "Lived experience of *being* a trauma lay counsellor". Faced with a client who held cultural beliefs different to her own, she felt as if she could not connect. Doubting her own competence, Tara felt guilty for not being able to provide a better service, feeling "terrible" about her ability to counsel:

> Um, like somebody being spiritually attacked is something… it's come up a few times and I really struggle to connect with that and then feeling guilty about not connecting, and then that guilt goes home with me and I feel like I'm really terrible at what I do.

Lara experienced something similar when encountering a woman with "vivid delusions":

> I really hate walking away from a call, feeling like I didn't do that much. And sometimes callers don't make it easy, either you know um, just one more example that I had, there was this person who called in, who was clearly struggling with some quite vivid delusions, um and it was tough because my initial response was like I almost wanted to roll my eyes. Like, I don't know how to help you with this. And then like it occurred to me like, underneath the delusions were feelings that I can absolutely relate to, that everyone can relate to. Fear, and sadness and paranoia, and um, feeling ostracised by a community, like everyone, everyone has those feelings, it doesn't matter what they're caused by. And so, it was a really interesting call because it felt like for me it helped me overcome like a massive thing in my counselling work. Like being able to engage empathically with someone, even though they're speaking a completely different language to me.

Lara also described how the first time she experienced a suicidal caller, she felt very uncontained, as she had felt unable to connect or be of much help. The second time, however, she phoned a senior counsellor and found that talking it through provided her with some relief:

> I'd had a really difficult call a while ago and I decided not to bother anyone about it, and I got like really quite upset and… it was a suicide call and the person hung up on me. Um and so I just there, staring at the phone, hoping it was going to ring again, but pretty sure it

> wasn't going to ring again, and just like well, freaking out about this person and whether they were okay… I tried to just kind of deal with that by myself it did stay with me a lot. You know, I came home and afterwards I was still sitting feeling quite emotional about it. The next time that happened, I actually decided to immediately call the referral officer. That was a completely different experience, because she basically, she counselled me through my own feelings about the call, right away and that helped me very much to be able to kind of, you know, exhale and go home and drink a cup of tea and go to sleep and to not stay in that space.

Emotional regulation and keeping contained: "I can't be angry, I can't be sad, because people are watching me". For the community and peer-based counsellors, a specific experience related to social pressure was reflected by most of the participants. They often felt as if they had to hide their emotions or, that their work extended beyond counselling, resulting in feelings of pressure and isolation. For example, Ava worried that that she could not show her emotions:

> Sometimes I just want to be… I can't be angry, I can't be sad, because people are watching me. People are watching me. Other people just want me to smile. When I smile for them, they feel like, ah, she knows me. Even if I don't know you, I have to do that. As I am doing that… this job, it makes me control my moods all the time.

Michael described how isolating being a community counsellor could feel, because of this very reason. After speaking about the need for him to contain himself, he reflected that he often felt like he needed to "fend [for myself]". In addition to his counselling work, he found that many of his clients expected him to be an advocate for refugee rights. This led to feelings of pressure:

> So, those are part of the things that I do and… I'm looking at the world like you're asking as, we know, the world is not a bad place to be at the moment. But we are having the other community leaders who are putting pressure on people like us. So, that is by itself pressure being put on us, like we're being put into small boxes and we are left to fend out for ourselves.

Sense of despondency: "Our counselling helps, but counselling doesn't bring bread". Many of the counsellors spoke about working with clients who faced urgent difficulties related to basic physical and safety needs. A sense of needing to do more was expressed. For example, Claudette spoke about working at an NGO that provided counselling

for refugees, many of whom were making difficult choices whether to stay in South Africa in the face of xenophobia or to return home. This meant that she faced cases where issues including food, shelter, and personal safety were pressing. She spoke about how it made her feel helpless and, underneath her frustrated words, is a perception that counselling is limited in the South African context:

> Another challenge is you know also to help them further. You know with these three months, we are helping them, they are changing. We do see how they change from week one to the end. But if they could help them, especially the women, if they can give them something like a business, they can start something to bring income. Because as I was mentioning. There are a few that have up to four kids. Six. Seven, eight. Living here. Is very difficult. Back home, there used to be a farm that you could cut. But here, everything is in the shop. And there's school. There are so many challenges… and that is why I say, I wish we could help them further. Our counselling helps, but counselling doesn't bring bread. Someone is hungry, and the counselling needs to help them overcome what? It's true, it helps them overcome other areas. But they did still need to eat. That is the thing.

Although Michael also recognised that sometimes counselling was not enough, he was able to recognise this limitation, despite it contributing to his stress:

> But at the same time, we are all human being and we go through some of the things, you can't help them financially. You just have to know what to say to them to make them stronger by themselves. And that's what keeps me going. But I cannot tell you that it is not stressful what we're dealing with.

5.2.3. Psychological impact of trauma counselling

Feeling overwhelmed: "There were some days I was relieved when the client just wanted to sit there". Several participants in the study related experiences of feeling emotionally overwhelmed by the volume of their trauma work. This can be seen in Tara's account below:

> I think largely when there are a bunch of people [to counsel], I don't have the ability to just disconnect from the one, I feel I'm still largely part of the case that I was just managing or dealing with, and I guess when there's a lot, it doesn't always feel manageable. It's overwhelming and I it impacts my ability to counsel….and I don't think I've yet learnt to fully disconnect from one to the other.

Roslyn reported a sense of relief when some patients did not engage in the session, as it offered her a chance to emotionally recuperate:

> There were some days when I was actually relieved when some of my clients would just want to sit there and just be silent, cos that helped me as well, cos that has a calming effect for me, cos my day would be so busy, and then to have a client that just wanted to sit, it was really great.

For some participants, the feeling of being emotionally overwhelmed was related to their appraisals that they had to have a high case load to maintain their livelihood and that this was not always ideal for their emotional wellbeing or the care of their patients. This can be seen in Annette's narrative below, where she found that, if she took on too many cases, she would lose focus and become less observant:

> It's a lot. Because this is my livelihood, I have to balance being boundaried and not taking on too much and making sure that I have enough income so that I can support the centre and myself, obviously. So, it's a bit of a tightrope that I am walking. Um. How does my caseload impact my work? I think you know; I think that five is my maximum amount, I always feel sorry for my fifth client of the day. Because it does, I become less, observant… I find myself checking the clock more on my fifth client…

Heightened fear and anxiety: "I feel like I'm just always scared now". Most participants reported heighted feelings of fear and anxiety that they ascribed to their trauma work and an enhanced awareness of the potential for harm. This was expressed well by Tara, who reflected that once she had been a relatively positive person but had, since counselling, experienced a waning of her personal positivity and a shift to a state of cynicism, where she felt acutely anxious about the world:

> I think that I used to be relatively positive and during that time I was specifically pessimistic, to an extent that it didn't seem that there was anything positive left about the world. Every man I encountered I was scared of, in every relationship I wondered what the dark secret was, and it was mostly negative, and it still really is. I think now I'm a bit more of a realist than a pessimist, I think the amount of negativity that I've encountered in just a short two years has created issues for me, um, I feel like I'm just always scared now. And not of the rapist behind the corner, but of the little things… it feels like general stress, like a general anxiety about what the world can bring to me.

Irene reflected that some of the negativity that she experienced, especially concerning stories to do with rape, had impacted the way she experienced intimate relationships:

> Um. I think like specific examples, it definitely affects intimate relationships and things like that. Especially when you're dealing with very traumatic cases and situations. Like you know, it impacts things like sexual life. It impacts your mood you know and then that

> affects quality time with your partner and family. So ja, like moods, things like sexual life, depending on what you've heard, and cases you've dealt with.

Faye said that when she had negative calls that touched on what she called "pivotal" life experiences of her own and they would often impact on her sense of self and the way she interacted with others:

> I'm unsettled. I am very then cautious within my life again, I'm very protective, I overanalyse every, every sort of like outing, um, symptom, is everybody alright, and where's everybody going? I will not be causal anymore. I start to be the mother from hell. And again, because of my anxiety. You know, where is everybody, is everybody okay, you know. Where are you? What's going on? So, so there is that. And then I… it takes, I would say it takes me about a week and I feel. I feel easily, little bit tearful. Just not myself; not in control. And at work I'm not my normal self, you know I'm questioning myself, questioning my role: Do I do enough? Have I been enough? Can I be enough? Am I still relevant?

Frank expressed feeling vulnerable regarding his physical safety. The counselling model used by his organisation involved going out to underprivileged communities and providing counselling there. He described his feelings of vulnerability and feelings of unsafety:

> These are places where, you know, a lot of violence, violent activities are happening, especially during these times where there are a lot of attacks. So that, is a heavy challenge and you can't go there without using a taxi, so most of the times we are using taxis driven by South African [sic.] blacks. So, when you sit in the taxi, you feel like 'Oh god'. If I maybe start talking here, these people can start attacking me or what. Because you never know who can attack you.

Frank further described how a traumatic event the year before made him ask management if he could please stop providing counselling in a certain area:

> So yeah, it impacts negatively. Because most of the times, you are thinking of what might happen if anything goes wrong, you see. Like last year, there was a lot of shootings in Delft… and we are on the management, like please, can we stop these support groups.

Another aspect of community counselling that Thomas raised was the fluidity of boundaries and the expectation that counsellors were expected to be available as a source of support via mobile phone applications such as WhatsApp at any hour of the day. He described how the lack of strict boundaries could be taxing and how it could feel intrusive:

> Those are the challenging aspects of it, where you, people put all their stories on to you, and sometime the, other challenge is that the work seems not to finish, because like you are working 24 hours, 7 days a week, because people can just send you a message, Sundays, Saturdays, see you, when you are not in the office or not your work time, and they ask, they start telling you their issues, expect you to solve them for them.

Later, Thomas recounted how he was once on the beach when he was approached by a client. As a peer-counsellor, the client viewed him as simply that, a peer, someone to talk to, and open up to at any time of the day. The client spoke endlessly to Thomas, who was left feeling used and exhausted by the interaction.

Triggering of personal traumas: "Suddenly I'm faced with something that has completely disarmed me". All the counsellors in the study had experienced difficult and traumatic events in their own lives. For some of them, these experiences would re-emerge when counselling and impact on their internal emotional worlds.

For example, three years prior to the interview, Charlotte had a traumatic experience where her cousin had been hijacked and raped. She spoke ashamedly about her emotional response to this event and how she felt about the perpetrators:

> And they got life, which is great, they got caught, eventually, but that doesn't really make it better. It made me so bitter, to be honest. And that is one thing that I indirectly went through and it just made me so bitter for this country, I was like, I think I'm going to bail, and why do I want to stay and help these people. And an underlying racism, which I didn't think was there or didn't know was there, came up, and I just found myself hating the entire like, coloured community, really, which is just like, red flags everywhere, and it's really difficult for me to talk about it, I mean this is not something I want to admit, I'm ashamed.

Similarly, Tara had a negative experience regarding rape and she recounted how it impacted her ability to counsel in a specific session:

> That impacted the session in that I was angry, and that anger came through more than I would have liked it to have, um and I think it wasn't my space to be angry for the person, but I completely brought in my little cousin's rape into one specific session where the situation was very similar, and I didn't disconnect and I wasn't professional in that moment and I was equally angry with her, and ja, I can say it was mirroring, but it wasn't, um, because I don't even think I was focusing on the person.

Joseph had lost two significant others to suicide and spoke about how he still felt anxious and haunted by this experience, feeling an acute anxiety and helplessness when dealing with a suicidal patient:

> You know I think that the suicide has definitely had an impact, I think, because you know it's… it's… the one thing that I think when I got into the counselling, that I was more worried about, getting sort of those calls. Not being able to deal with that, because I felt, well I couldn't help my other friends, I was quite insecure about it. And so, I still… I've had one call where somebody else called, because they saw somebody try to commit suicide, and it was quite stressful for me, because it sort of brings back kind of a lot of memories, to feeling helpless.

Irene spoke more generally of being triggered by counselling narratives which evoked echoes of her own experiences:

> And then also some things are just quite triggering you know, like they definitely… like there's some people, some issues that will kind of remind me of something that I've either gone through or remind me of someone that I've struggled with in the past, or remind me of an event um, and that's sometimes difficult to… to again separate, like my stuff from… from the situation. In the moment sometimes it, it can be difficult. It will make you kind of feel a little bit anxious or make you really struggle to then keep these boundaries in place that I've worked so hard on in my entire life you know to build-up and now suddenly I'm faced with something that's completely disarmed me.

Faye, who had lost a child, experienced strong emotional reactions and triggering responses when confronted with patients who were going through a similar experience to her own:

> [Being with a patient who lost a child]...That will scare me because it will… then I will think of my child that I have left and the child that I lost. And so, that will make me want to vomit. It will make me want to physically have an experience in my body because I'll be so anxious thinking sure, their child is sick or could this happen to me or they had a child and now they're going to lose another child.

Vicarious trauma: "I also need to take care of myself sometime, you know?" Many participants articulated that the work was difficult and that taking measures, such as turning to a senior counsellor or a manager, was essential. For others, making sure that they spent time looking after themselves was important. Thomas spoke explicitly about secondary trauma, saying that he had to bear witness to "horrible stories" and that this meant that he needed to "take care of myself sometime":

> And most importantly, the, the impactful one is the trauma you, the secondary trauma you get, when you listen to people's stories all the time, you get home on your own, you cry, you are upset, because you cannot, although you wish you could, do more for that person. So those are the challenges of being in this peer counselling team. The trauma you also, the secondary trauma you take all the time, that impacts you as well, that touches you. Various, horrible stories you, you listen to, or, just imagine! I've listened to thousands of horrible stories. You see? So I also need to take care of myself sometime, you know?"

Several participants who volunteered at a suicide hotline were interviewed. One of the frustrations that many of the participants from the hotline raised included a specific type of caller who they collectively labelled a "sex caller". A "sex caller" is a caller who phones the hotline not necessarily to receive counselling, but instead to harass the volunteer on-call by attempting to engage them in phone-sex. There is a mixed response among hotline volunteers to these types of callers: some believe that they're in equal need of assistance as other callers, while some counsellors feel that they are being taken advantage of and do not entertain the call in any capacity. For Charlotte, she had a particularly strong emotional response to a call:

> I did get impatient once, I just got over it. It was my umpteenth night at [the hotline], and there's this one sex caller who keeps f***ing calling, and once he knows you're there, he doesn't stop calling, he just lets the phone ring, and ring, and ring, and ring. And so, this was going on for months, um, with this one specific sex caller. And I just - I lost my shit. Eventually I was just like, you know what, everyone here knows who you are, everyone here has spoken to you, they know your sad story, which is absolutely untrue, and you should really just get a life. I just you know, lost it, I was like, f*** off, what do you want, just go away. So ja, I lost my shit. I don't know if it was because of the stress or because everyone has a limit of how many sex callers they can take.

Tara was the only participant who had worked at a rape-crisis centre and she reflected on how bearing witness to accounts of rape repeatedly impacted on her own sex life:

> Well, there were a lot of different effects, but the biggest one was that it affected my sex life, and I think that maybe wasn't even just the trauma of my cousin's story, but of all the stories that I was hearing. It completely affected my sex life, my husband… we discussed it a lot, because at the time that's why I left Rape Crisis, because it was affecting me so much to hear other people's stories, and marital rape and that kind of thing and it just… all those big experiences in my life that you know, sometimes lived through other people but I felt them just as much.

Lara explained that, when she was faced with a male caller with strong sexist views, she found herself feeling angry and, in response, felt as if she had to "fake" empathy:

> I had in a call very recently, just last week, this guy who was being extremely misogynistic um, and not open to the counselling process either. He wanted me to explain and

> I quote, "Why his girlfriend was being a bitch." And I found that very difficult, like, I had to fake the empathy, I just wanted to put the phone down on him and tell him to stop being a misogynistic douchebag, you know. That kind of thing gets pretty exhausting and makes like… sometimes when I answer the phone and I get very sceptical for a long time and again it's that process of like, faking empathy to try and… you know, until I'm like I'm sure the call is real, so to speak. But ja, then again, even those people need help, I guess.

Other situations led to counsellors feeling traumatised as well. Anna spoke about a time when she had been involved in a case where an intellectually disabled client had misunderstood her and tried to lay a legal complaint against her. In another instance, the organisation witnessed the drowning of an unsupervised child on a youth camp. Anna explained how this led to a protection order being taken out and people spreading gossip about how the child had been intentionally killed. She said that as a member of the organisation, she felt manipulated and vulnerable:

> There are always elements where people they do… they manipulate, they abuse and so on, so on the other note, we do experience all these negative ... um… um… ja.… negativity from the ground, because it's people and we do understand fully that it's what they need, but in a manner that they do which is really damaging also, because we are also human beings, we also get affected. Through their own issues, you know, we're carrying, we're carrying more of their burdens, because we want to make a difference."

Claudette reflected generally on the nature of listening to traumatic stories, describing how the trauma lived with her and how she carried it with her:

> There is still a part of you which carries the loss. There're things that you can't bring back. It takes quite some time… that's why I said some cases, it takes some time, living with me. How can I, or what can I do? You don't sleep some days, wondering if God can change it. Heh? There are some times you wish you could go back and help.

5.2.4. Positive personal transformation

Increased sense of compassion: "Your heart becomes soft and filled with compassion. And [I] changed". Many participants said that their own experiences of trauma, coupled with listening to the difficult stories of others, increased their empathy and compassion for others. For Fiona, the work itself helped her recall her own difficulties, work through them, and then empathise with her clients:

> And I realised in reflecting in that that is the element that has evolved in my character. People, people and the pain, and the suffering, and the distress, and the view that they have in life of themselves and their situations was so hopeless, most of the time. So overwhelming, and I identified with it, in my own pain that I worked through. That your heart becomes soft and filled with compassion. And I changed.

Her reference to change at the end suggests an element of personal growth and transformation, suggesting that there is a duality to counselling – both the counsellor and the counselled find ways in which to understand their experiences and to move forward in some way.

Roslyn described a similar experience, after she had a health scare:

> Well… uh, you know, my compassion went a notch up. Just be reminded again the reality of what people experience… to have more compassion on where they are… and empathy… I definitely went up a notch, that week in my heart, ja, how I framed it, how I look at it. It also infers into how you deal with people. One become more inclined to listen. I was always a good listener, but I listened different. Started to listen different, with a focus. I also think… I sharpened my non-verbal awareness of other people. Maybe become more of that. Because of how I became aware of my own.

Tara said that the counselling relationship made her feel more connected to others, and made the world seem "softer":

> Um, and the thing I love about it, is that… both that I've had the opportunity to be raw, and that I can see the skin for as it is, but at the same time that I get… not only that I've got to experience that, but that I get to see that, and it definitely makes the world feel softer. At the end of the day, we are all the same, and it's a nice reminder. That even with the bad stuff that I've done and the bad stuff they've done that it all comes down to, we're just hurt little children, in an adult's suit. And I like that, I like that, obviously the genuine and the authentic and the rawness is beautiful, but that connection is not one that you get too often in life.

Personal healing and a sense of gratitude: "There's a duality going on: you help somebody and they help you". Many participants reported that through their work and exposure to the suffering of others, they experienced a greater appreciation for their own lives and a sense of catharsis in relation to their personal experiences of adversity.

For Fiona, it was clear that the counselling process was a mutual process that is marked by dual growth:

> Their breakthrough is my breakthrough. That is the injection of it. It makes me very happy, and grateful, very grateful. And when I experience gratitude, my heart softens. And when my heart softens, I just realise, ooh, it gets hard so quickly. Not hard in as the heart is not really a bitterness or resentfulness, hard as in hard, um, not dealing with your own pain and not dealing with your own feelings but embracing your own process, you know? So, it makes me aware of that. It's this whole duality going on; you help somebody and they help you. That to me is marvellous.

Ava, working at the refugee counselling organisation, experienced something similar when, for one session, there was a mutual sharing of life stories in a narrative based exercise:

> I get my healing when I listen to other people's stories. There are also stories that are worse than mine. I stop complaining, so every single day I hear other people's stories, I get better and better and better every single day.

Irene also referenced this duality, describing the counselling process as one which was cathartic in that she was able to "revisit" parts of her own life and, through that experience, feel a sense of personal growth:

> And then when you can kind of relate to what they're going through, you know, that's also kind of a bit of a cathartic process for yourself, you know, you like re-live little bits of your life, your experiences, whether it's afterwards or like in the moment and I think that also… can't always say it's enjoyable, but like you can see how that's… that's good (laughs) to kind of revisit those things sometimes. Um, ja and you just kind of get to connect with sometimes people who live very different lives to you and that also gives you quite a bit of perspective. Makes you grow.

Similarly, Ben, framed his experiences as a form of growth and personal self-discovery:

> But counselling has taught me one thing. The more I talk to someone, the more I discover myself. So, I grow in a way. Developing that skill of listening to someone and hear what that other person can say to you and what that… that means to you and being able to see the difference and also evaluate and see if you can learn something from that person and try and put it into practice and implement it and see if it works. And for me, that's the most, um, important thing. For me, more than trying to help but I'm being helped, you know.

Claudette became emotional, coming close to tears, during the interview. She talked about how her life was still hard but explained that counselling and the positive feedback she received from it, helped her feel "saved". She was able to reflect on painful experiences and find ways of getting in touch with her sadness and find a sense of pride in her healing:

> You know, when I was lonely and I had no one to talk to. My family all went, they were in another country, there was no-one to talk to, it was only myself. The work, the work, what must I do in my life? It was too much. That's what I'm saying. Without the work, I don't know where I'm supposed to be. It is something that motivating me, more than anything. I'm going to open up to you, it was not only about gaining a salary. I went through a tough time. But when I go see someone, and they say, Claudette, thank you so much, because of what you said, what you are saying now, I feel like I am going to change. You know, wow, when I am helping, I am helping myself. And by helping them, you can also find, oh! I can also still cope.

Renewed sense of hope: "I got to the other side as a whole person… it kind of gives me hope that anyone can do that". Despite their difficult experiences, many participants spoke about a meaning-making process in which their difficult experiences reignited their sense of hope, as well as the idea that anyone is capable of healing. This contributed to a sense of their own resilience.

Charlotte spoke about her previous traumatic experiences in a way that suggested that she believed that recovery from trauma was possible. She conveyed a sense of hope:

> I'm a pretty intuitive person, and I think that it is in part because of those things that I went through. And I got to the other side as a whole person – or a whole person again, maybe, which is you know, it kind of gives me hope that anyone can do that.

She talks about her own recovery from a difficult experience and how it makes her more hopeful for others. She also attributes part of her intuitiveness, which she uses to counsel, to her difficult experiences, suggesting a positive outlook and post-traumatic growth.

Roslyn found that her own experience allowed her to recognise her own resilience, a marker of self-growth and a demonstration that her experience had been meaningful and that, importantly, she had "recovered" and come out on the other side:

> Um, I… I appreciate myself, because I actually realise that I built in a lot of resilience, through pain, my own pain. I was made aware, not by myself, but I had to think about it; but when I thought about it… the resilience comes from wanting and hoping and pushing forward out of a situation.

Anna also spoke with a sense of pride and strength about "finding her voice" and realising that recovery from trauma, through the work of counselling, was possible, despite emotions of sadness:

> And then I started coming out and through that I was now able to stand and like, yes, I went through this too. I went through this. Because I know where I come from and I know how it can affect your life. Because this really affect me so badly in a way that I didn't have… I didn't enjoy anything, you know, in life or in this society. I was always very emotional. I always very isolated. I wouldn't talk much. I know my nature is not to like talking too much but when I talk, it was always, um, very sad, it was always very sad.

She went on to say that:

> All I can say is the impact is positive, on the other hand, because I know the journey I experienced, I can see the journey that I came through and I made it through and this is what now, you know, I'm turning to, to change the others, because they might be also in the same life situation though we are all in different situations.

This sentiment is important, as it is due to her own process of healing that Anna can articulate a wish to help others. Importantly, she can recognise that each person will have their own unique story.

Chapter Six: Discussion

This chapter brings together the results of this study with the relevant literature. The underlying premise of this study stated that SA, and specifically Cape Town (within the WCP), is an environment rife with the potential of exposure to traumatic events. The impact of trauma leads not only to CMDs, specifically PTSD, but also has psychologically carcinogenic effects on mental healthcare providers. Due to the duplicitous burden of psychological trauma on the public health system, a task shifting approach has been proposed in previous research, with promising results. Task shifting for mental health explicitly involves the use of lay counsellors. While there are clear effects of secondary trauma impact on ProQOL in trained mental healthcare professionals, evidence suggests lay-counsellors' ProQOL may also change because of counselling work.

This study explored the relationship between the demographic variables of age and gender on the presence of Compassion Fatigue, Compassion Satisfaction, Secondary Traumatic Stress, and Burn Out, using data that was part of a broader project. It supplemented the existent data with qualitative interviews of 20 lay counsellors from three different NGOs based in Cape Town, to better understand the lived experience of lay counsellors and how their ProQOL is affected through their counselling work.

Using both the theoretical pathway suggested by ProQOL theory as well as CSDT, this discussion: compares the quantitative data from this study to international and national studies; interprets the qualitative data in relation to emergent literature on lay counsellors, describing the lived experiences of counsellors in relation to Compassion Fatigue, Burn Out, Secondary Traumatic Stress, and Burn Out, including a discussion regarding professional identities; engages with the practical implications related to task shifting; and, offers a revised model of ProQOL, with potential intervention points in line with the findings of other research.

6.1. ProQOL of Trauma Lay Counsellors in Cape Town

This section discusses the results of the quantitative data. The findings suggest that both age and gender are significantly associated with certain constructs on the ProQOL (Padmanabhanunni, 2019). In addition to this, 21% of the sample fell into the highest risk category (high Burn Out, high Secondary Traumatic Stress, and low Compassion Satisfaction), with almost half (47%) falling into one of categories associated with risk for Compassion Fatigue. Across the different risk profiles, 37% of the total sample reported experienced symptoms of STS, 31% high Burn Out, and 36% high Compassion Satisfaction. The implications of this are discussed below.

6.1.1. Demographic variables in ProQOL: Age and gender. In terms of gender, females in this study were 2.17 times more like to report high Compassion Satisfaction than males. This is different to Stamm's (2010) assertion that gender is not a factor that influences ProQOL scores, echoed in the work of Thomas and Otis (2010). Padmanabhanunni (2019) provides two suggestions regarding elevated scores of Compassion Satisfaction in females. First, she identifies that women have often been socialised in terms of their gender roles to take on caregiving roles, potentially leading to greater personal and career satisfaction. Second, she states that women in South Africa are more vulnerable to the effects of secondary exposure to trauma, perhaps increasing their empathic ability to connect with their patients. That women are more vulnerable to experiencing trauma and its psychological sequelae is affirmed by Kessler et al., (2017), Koenen et al., (2017), and Shalev et al., (2017). This is further supported by Petersen-Williams and colleagues' (2020) finding that trauma is often at the root of treatment-seeking behaviour in females. Brockhouse and colleagues (2011) hypothesise that increased personal trauma exposure raises feelings of empathy toward other trauma survivors and, in a recent study, Padmanabhanunni (2020b) found that

increased personal exposures to trauma were associated with higher CS among lay counsellors

Other gender-based findings include that men were 1.12 times more likely to report symptoms of Burn Out, which is similar to findings in the research conducted by Sprang and colleagues (2011). Gender was not statistically significant in terms of Secondary Traumatic Stress, however, men were 1.12 times more likely to report Secondary Traumatic Stress. This conflicts with the systematic review by Baum (2016), which states that literature on secondary traumatisation has consistently found that females are more likely to experience Secondary Traumatic Stress (as measured by the ProQOL and a PTSD symptom checklist). Yet, Thormar and colleagues (2013) found that male humanitarian aid workers' experiences of PTSD and, by proxy, Secondary Traumatic Stress, were more prevalent at 18 months follow-up than that of females. These findings need to be interpreted cautiously since, within the caring profession, it is recognised that traumatisation may manifest differently in males compared to females (as discussed in Baum, 2016). In terms of overall Compassion Fatigue, studies have found that being female is broadly associated with a greater risk of Compassion Fatigue, which is counter to the findings of the present study (Baum, 2016; Lawson & Myers, 2011; Thompson et al., 2014).

In terms of age, the findings of this study were similar to other literature in that increased age was related to increased Compassion Satisfaction. Being younger and having less experience results in a higher risk of Burn Out (Kelly et al., 2015; Lawson & Myers, 2011; Roche & Ogden, 2017; Sprang et al., 2011). Ray and colleagues' (2013) noted that the number of years in the profession acted as a protective factor against Burn Out. This is similar to the findings of Macchi and colleagues (2014). However, when Macchi and colleagues (2014) explored Compassion Fatigue in community settings, they found that years of experience predicted Compassion Fatigue, which they suggested was a result of

cumulative Burn Out. This is an important finding which deserves consideration, as lay-counsellors are most likely to operate in resource-scarce community settings as opposed to tertiary hospitals. Alternatively, Craig and Sprang (2010) found that increased Compassion Fatigue was not predicted by age or experience.

6.1.2. Risk profiles and understanding their association with ProQOL. Nearly half (47%) of the lay counsellors in this study fell into an at-risk profile, experiencing either STS or Burn Out, or both (see Table 4 in the Chapter 4). These figures are not dissimilar to international or developing national literature. For example, in their systematic review of crisis hotline volunteers, Willems et al. (2020) found that studies generally reported that over 50% of lay counsellors experienced Burn Out. In O'Sullivan and Whelan's (2011) UK-based study, 77% of telephonic lay counsellors reported Compassion Fatigue (thus experiencing either BO, STS, or both). In refugee settings, Lusk and Terrazas (2015) reported that 30% of the sample reported Secondary Traumatic Stress and up to 50% reported Secondary Traumatic Stress symptoms. In a local setting, Peltzer and colleagues (2014) found that 51.4% of their sample constituted Secondary Traumatic Stress cases, and 49.5% reported dissatisfaction with their work environment, suggesting possible Burn Out.

To separate Burn Out from Secondary Traumatic Stress, overall, 31% of lay counsellors in this study reported significantly high symptoms of Burn Out. This indicates a dissatisfaction with the working environment, which could potentially mean that feelings of exhaustion, frustration, and anger are present (Stamm, 2010). This is not necessarily to do with the nature of the work, but rather, organisational factors such as caseload, low support, and poor training (Newell et al., 2016). Within the South African context, Howlett and Collins (2014) noted that there is a lack of development programmes for volunteers at NGOs and little satisfaction with volunteer management. Experiences by lay counsellors, as a result of this, included feeling that they received poor treatment by both clients and management.

Peltzer and colleagues (2014) reported several difficulties in the working environment, such as difficulties with payment in the form of inconsistent stipends, inadequate working space and, again, complaints concerning a lack of training.

A factor also strongly associated with Burn Out is caseload, including both the number and types of cases (Austin et al., 2017; Craig & Sprang, 2010). Based on the high prevalence of trauma in South Africa, counsellors are ensured of being exposed to at least one traumatised client. As O'Sullivan and Whelan (2010) argue, even within the context of a HIC, this scenario is likely. In addition, the literature clearly states that there is a gap in mental healthcare treatment. Together, these factors are likely to result in counsellors taking on more cases and experiencing trauma cases more often, thereby increasing feelings of BO.

To examine Secondary Traumatic Stress, it is of interest that 3% of the sample reported feelings of Secondary Traumatic Stress with neither feelings of Burn Out nor Compassion Satisfaction present. From a professional perspective, this is typical of individuals who feel traumatised by the work itself, but do not necessarily dislike the environment. However, they do not derive satisfaction from the work. This part of the sample could possibly be explained by Kagee's (2020) hypothesis that individuals who express interest and enthusiasm but are poorly suited to counselling work, when faced with the reality of trauma and personal experiences of secondary trauma, only experience feelings of being traumatised themselves. It may be possible that this part of the sample had also experienced recent primary adverse events in their own lives.

Thirteen percent of the sample fell into a category most often observed in warzones and immediate conflict situations (Stamm, 2010). These individuals experience high levels of Secondary Traumatic Stress, but this is counterbalanced by their feelings of Compassion Satisfaction and they do not express feelings of Burn Out. This could be indicative of

adaptive and healing responses to an environment where there is continuous traumatic stress, and constant exposure to trauma (Kaminer et al., 2018).

Twenty-one percent of the sample fell into a high-risk category, a category in which there is high Burn Out, high Secondary Traumatic Stress, and low Compassion Satisfaction. These are individuals who feel traumatised by their work, are dissatisfied with their work environments, and experience incredibly low Compassion Satisfaction. These individuals are likely to experience active Compassion Fatigue, which is best treated by a removal from the workplace or sustainable modification of the working environment (Stamm, 2010). While literature does exist suggesting how to support and ameliorate Compassion Fatigue, understanding the idiographic experiences of these counsellors *first* is paramount.

6.2. Lived Experiences of Trauma for Lay Counsellors in Cape Town

This section summarises the lived experiences of lay counsellors, discussing the four major themes (and subsequent sub-themes) that emerged. Themes included lay counsellors' self-perceptions and identities (experience of *being* a lay counsellor), experiences of counselling, as well as ProQOL from a qualitative perspective. The positive personal transformations that were articulated are also discussed.

6.2.1. Constructing identity: The lived experiences of being a lay counsellor. The first major theme that emerged related to experiences of *being* a lay counsellor. Interpreted through CSDT, this theme is best understood as the construction of a lay counsellor identity. The experiences that emerged included feelings of insecurity and uncertainty, an increase in self-esteem, finding meaning and purpose, as well feeling a lack of recognition.

Professional counsellor identity is thought to be influenced by personal attributes, interpersonal and intrapersonal experiences, and relationships to regulatory bodies (Moss et al., 2014). Moss et al. (2014) consider interpersonal experiences with clients the most important and go on to describe three major developmental tasks in developing a professional

identity: (1) Idealism to Realism, (2) Burnout to Rejuvenation, and (3) Compartmentalization to Integration. The first task is relevant here, as one of the difficulties articulated by the lay counsellors in this study included feelings of insecurity and uncertainty regarding their competency. Moss et al. (2014) have observed that these feelings are natural, as counsellors navigate and adjust their expectations of what they expect counselling to be with its reality. Guhan and Liebling-Kalifani (2011) describe a similar experience as counsellors' transition from training to working within a system. While the average lay counsellor in this study had approximately 4.4 years of experience, it is important to note that lay counsellors tend to operate in a comparative silo to the rest of the health system, and have little to no relationship with formal regulatory bodies. In this sense, they carry the weight of a 'system', but without its support or recognition. The uncertainties and insecurities articulated were predominantly from counsellors who had less than two years' experience and, therefore, may be developmentally appropriate. However, there may be an additional environmental factor present. For example, the lay counsellors interviewed by Howlett and Collins (2014) described feeling out of their depth and so another hypothesis for these feelings may be that lay counsellors do not receive adequate training for the technicality of the intervention which they are required to provide (cf. Van der Water et al., 2018). This undoubtedly would impact on confidence (Myers et al., 2019). In line with CSDT theory, the cognitive schema that is activated is related to trust and control, with some lay counsellors doubting their efficacy and effectiveness, which in turn impacts on their feelings of being able to trust themselves. As feelings of effectiveness are central in protecting against Burn Out (Maslach & Lieter, 2017), these insecurities may lead to Burn Out and, therefore, increased Compassion Fatigue, if left unattended.

Despite insecurities regarding their competence, lay counsellors in this study also articulated feelings of enhanced self-esteem due to their experiences with clients. In CSDT

theory, this is important in the evaluation of self-capacities regarding lay counsellor identity. For example, Frank said that he felt more "devoted" when witnessing better group retention and Fiona felt motivated when she perceived that she could generate a sense of peace for others. Moss and colleagues (2014) write that confidence often results through the learning experiences that come with each client interaction. This is a sentiment echoed by Brockhouse and colleagues (2011), who note that cognitive schemas change slowly per client interaction. This suggests that the therapeutic relationships formed with clients, although at times distressing, may become protective as they influence the schema of intimacy and subsequent feelings of connectedness. Guhan and Liebling-Kalifani (2011) describe this as a process of reaping rewards, the process through which lay counsellors witness change happening in their clients and, therefore, experience change within themselves. This is in line with the idea that positive interpersonal interactions with clients promote Compassion Satisfaction. This highlights the need for competency-based training for lay counsellors, as this would bolster confidence and protect against initial uncertainties within early counsellor-client interactions (Trippany et al., 2004; WHO, 2008). This could possibly inculcate feelings of Compassion Satisfaction earlier on in a counsellor's careers, protecting against BO.

In addition to increased self-worth and self-esteem, lay counsellors further articulated that they derived meaning and purpose through their work. Irene directly articulated that she felt counselling was her purpose and Frank described how he felt he had "saved a life". While Frank's sentiment corresponds with Stamm's (2010) view that Compassion Satisfaction comes about as a direct result of positive client interaction, Irene's sentiment points to something deeper. This could be understood through CSDTs cognitive schema of control, where a counsellor's identity is informed by their perceived efficacy and effectiveness. Irene's reflection that she views herself as an "instrument of support" reflects not only that she perceives an innate effectiveness, but further affirms Willems and colleagues' (2020)

assertion that lay counsellors' motivations play an important role in their feelings of satisfaction. They are more likely to feel satisfied if the work is in line with their motivations for counselling, such as wanting to feel useful, wanting to find a purpose, and wanting to give back to the community. These motivations would be important to assess in the recruitment and training of lay counsellors within the SA context.

Despite the positive aspects of the lay counsellor identity, there was an underlying sentiment from many that it is difficult to find recognition or validation for their work. This was explicitly addressed by Annette, who spoke about the lack of recognition received from the HPCSA. In Petersen and colleagues' (2016) study, lay counsellors expressed that they felt marginalised by their status in relation to other professionals and that this was exacerbated by the opaqueness of their job descriptions. This is an important sentiment, as it has been suggested that, even within an organisation itself, increased recognition results in improved job satisfaction (Kelly et al., 2015). Recognition of the work that lay counsellors do from regulatory bodies is going to be essential as task shifting in mental health progresses. The WHO (2008) argues that a nationally endorsed task shifting framework will ensure harmonisation across the mental health professions, providing stability for the health system, and further improving the quality of the services delivered.

6.2.2. Interpreting experience: Lay counsellors' appraisals of counselling. Central to the identity of a lay counsellor is the experiential meaning-making process they undertake when they appraise the counselling work itself (McCann & Pearlman, 1990). Three sub-themes emerged when lay-counsellors described their experiences of counselling: (1) difficulty relating to patients, (2) difficulty with affect regulation, and (3) feelings of despondency.

Tara spoke about her difficulties understanding the concept of spiritual attacks, saying that she would feel guilty and "terrible at what I do" after receiving a call where there were

overt cultural barriers. Lara had a similar experience when she encountered a caller with a more serious mental illness, feeling at a loss on how to be helpful. Lara was able to problem-solve in that situation, but she described another call where a suicidal caller terminated the call abruptly, leaving her feeling emotionally overwhelmed. In their systematic review, Willems and colleagues (2020) found that cultural barriers create difficulties in lay counsellor service provision, while the post-disaster setting study by Thara and colleagues (2014) found that lay counsellors have the capacity to identify individuals experiencing psychoses. However, studies within SA have found that lay counsellors have expressed the need for additional support to help those patients with more severe mental illnesses (Howlett & Collins, 2014; Myers et al., 2019; Petersen et al., 2016). Lara's experience of a call abruptly terminating is a stressor specifically associated with crisis hotlines (O'Sullivan & Whelan, 2011). These difficulties and ruptures in lay counsellors relationships with their clients are important, as they have the potential to disrupt the schemas of intimacy (ability to connect to others), trust (to trust one's own capacities), and control (sense of effectiveness). Too many of these calls could result in Burn Out, whilst specific calls may be traumatising and begin to cumulatively contribute to the development of Secondary Traumatic Stress.

Ava and Michael described feelings of separateness due to their need to regulate their own emotions. Ava described having to "control my moods all the time", while Michael explained that he often felt that there was pressure on him to act in a certain professional capacity which involved concealing his own emotions. This left him feeling as if "we're being put into small boxes and we are left to fend for ourselves". This feeling of separateness in one's ability to connect to others through affect is one of the processes that Pearlman and Saakvitne (1995) write about in their early paper on CSDT. They write that the capacity to modulate affect is best bolstered by a strong sense of self, which allows for an inner sense of connection to others. For Ava and Michael, it appears that their schemas of intimacy as well

as their self-capacities were under threat (Trippany et al., 2004). This may have been due to the perceived expectations placed on them at a client and/or organisational level. Kagee (2020) states that, of the counselling skills that are needed for effective service provision, affect regulation and emotional coping are more difficult to acquire. Without specialised training, these feelings would allow for a high risk for Burn Out.

Some participants articulated a sense of despondency because of their counselling work. This was most acutely perceived in two counsellors who worked within the refugee sector. These counsellors expressed not only despondency, but also hopelessness and helplessness when they listened to the lack of basic needs that their clients experienced; "Counselling helps, but counselling doesn't bring bread". In Lanfranchi and Akinsulure-Smith's (2018) article on refugee counselling, it was noted that counsellors often feel distressed when faced with clients who request help for their basic needs. They suggest that counselling with a refugee population can be particularly challenging since, before counselling becomes helpful, basic safety needs must be met, which is challenging in the SA context. Another challenge for this particular organisation is that it uses a 'peer' lay counselling model, where lay counsellors come from the refugee community themselves and, therefore, have experienced primary and now, through their work, secondary traumatisation (as explained by Cooper et al., 2018). This is not dissimilar from most other healthcare workers based in SA primary healthcare settings (Petersen et al., 2016). Cooper and colleagues (2018) point out that this may pose ethical dilemmas, such as difficulties holding boundaries. As Kagee (2020) suggests, the boundary between personal and professional may not be easy to maintain for these lay counsellors.

These factors are important when considering the lay counsellors' psychological wellbeing. Ego resources may be weakened by high caseloads, particularly with counsellors who carry more at-risk or traumatised clients (Craig & Sprang, 2010; Lawson & Myers,

2011; Trippany et al., 2004). When lay counsellors are overburdened by both primary and secondary trauma, and the interaction between the two, their frame of reference may change, such as basic beliefs regarding safety in the world and sense of self being disrupted. For these counsellors, the nature of their client interactions, as well as a systemic xenophobic environment in the WCP (Dodson, 2010), seemed to undermine their efforts and feelings of effectiveness as counsellors.

It is worth noting that Tara, a SA counsellor working at a suicide hotline, also wondered if she would be able to counsel "forever". She named the SA environment as a source of her general feelings of stress. If the term 'environment' is expanded to include the socio-economic culture of SA, as described in the literature review, the risk of being traumatised by one's work in the mental health field becomes inevitable, and a pervasive feeling of Burn Out, as well as Secondary Traumatic Stress, may need to be endured.

6.2.3. Scared and helpless: The psychological sequelae of secondary trauma. Many participants conveyed that they had experienced or were currently experiencing symptoms of Secondary Traumatic Stress. This is unsurprising, as 37% of the sample reported high Secondary Traumatic Stress, a statistic that is consistent with the findings in research conducted by Peltzer and colleagues (2014). Lay counsellors reported feeling overwhelmed, with symptoms of heightened fear and anxiety, difficulties with sleep, tearfulness, intrusive thoughts from their own previous traumas, and incidences where situations at work felt traumatising, amongst others.

The descriptions of lay counsellors' experiences most accurately mirror the work of Sui and Padmanabhanunni (2016), who investigated experiences of Vicarious Trauma in SA psychologists. Their study affirmed psychologist's experiences of Vicarious Trauma through understanding them schematically, with relevance to the following specific domains: disruptions in cognitive schemas, recurrent intrusive memories, persistent negative emotions,

as well as alterations in arousal and reactivity and somatic symptoms. The lay counsellors in this study articulated all the above.

Qualitatively, all the counsellors in this study reported at least one disrupted schema, which is consistent with previous research (McCann & Pearlman, 1990; Trippany et al., 2004). Irene and Tara spoke about disruptions in their intimate relationships and sexual lives, suggesting disruptions in their schemas of connectedness to others and intimacy. This is described in the seminal work of Kassam-Adams (1995). Further, at least five counsellors recounted moments in which their internal equilibrium had been disrupted in-session, which they attributed to "personal triggers". This speaks to the established interaction between the client's trauma, the counsellor's response to the trauma, and the role of the counsellor's previous traumatic experiences, which have been well documented (Adams & Riggs, 2008; Deighton et al., 2007; Killian, 2008; Lawson & Myers, 2011; MacRitchie & Liebowitz, 2010; Pearlman & Saakvitne, 1995; Ray et al., 2013; Rossi et al., 2012; Thomas, 2013; Thomas & Otis, 2010).

Basic frames of reference and assumptions that the world is a safe place were also affected. For example, Tara decided to leave the rape-crisis centre she was working at after noticing that her relationship with men had changed, saying "I was just scared all the time". A close family member had previously been raped, which made her vulnerable to this specific type of secondary trauma, and her schema had likely already been disrupted. The secondary trauma experienced through hearing rape stories would have further abraded it.

Frank asked his manager if he could desist working in a specific geographic location in Cape Town after hearing too many difficult stories from the local community, as well as sensing systemic xenophobia in the area (Charman & Piper, 2012). Faye recounted somatic symptoms of nausea whenever a certain type of call that reminded her of a past event would come through, saying how she would experience intrusive anxious thoughts about her own

and others' safety for weeks afterward to the point where it would impact her family and those around her. From these accounts, Pearlman and Saakvitne's (1995) assertion that a basic schema of safety, in terms of a reference that the world is a safe place, can be fractured in the face of secondary trauma.

Lay counsellors who man telephonic crisis lines often experience inappropriate calls (O'Sullivan & Whelan, 2011; Taylor et al., 2018; Willems et al., 2020). Many of the suicide line lay counsellors referenced what they termed "sex-callers", which they described as callers who would call in and use sexual language or engage in overtly sexual conversations. Many of the female lay counsellors described feeling anxious about receiving these calls, as well as angry and upset when they experienced them. For example, Charlotte described "losing my shit" after a male caller "just kept f***ing calling". She was outspoken and angry toward the caller and, subsequently, felt embarrassed by her response. Her schema of control was compromised in this scenario, and her sense of intimacy and trust violated.

Sexual trauma, either primary or secondary, as well as an interaction of both, is a particularly high-risk factor for Secondary Traumatic Stress (cf. Kassam-Adams, 1995). For example, Tara described how, after listening to stories of marital rape, her own sex life was impacted, and she eventually decided to leave the NGO she worked for because of this. She said that, when listening to stories of rape, she felt like she "sometimes lived through other people, but I felt [the feelings] just as much". In this way, her cognitive schema of intimacy was slowly eroded by her experiences of secondary trauma. Related to this, Lara explained how she had to "fake empathy" when listening to a male caller she reported as being misogynistic. Considering that women are more consistently present in the counselling and lay counselling profession (for example, in this sample, a ratio of 3:1), the area of sexual trauma, experienced as either primary or secondary, warrants careful attention and thoughtful planning in terms of training and debriefing.

Thirty-seven percent of the sample in this study experienced high levels of Secondary Traumatic Stress, which amounts to 3.7 per every 10 counsellors. Of interest are the qualitative accounts of positive experiences of counselling. Whilst so many lay counsellors do experience STS, at least 1.3 of every 3.7 effected also experience high Compassion Satisfaction. If how Compassion Satisfaction manifests and is experienced is better understood, interventions to promote Compassion Satisfaction may planned and implemented.

6.2.4. Positive personal transformation: CS or PTG?

Thirty-six percent of the participants in this study expressed feelings of high Compassion Satisfaction. It is essential that these experiences are approached ideographically to understand them in a nuanced way and, hopefully, promote these feelings in others. Compassion Satisfaction refers to the positive feelings experienced in-vivo in a counselling session, followed by a sense of satisfaction and contentment from engaging in counselling work (Stamm, 2010). However, the theme that emerged from the qualitative data seems to point to a greater adaptive or healing response: that of a positive personal transformation. This is similar to the findings of Sui and Padmanabhanunni's (2014) research on South African psychologists' experiences, where it was found that positive personal transformations took place in the form of increased optimism, feelings of personal strength, and experiencing renewed feelings of hope.

For example, Fiona reflected that, through counselling, there was an "element that has *evolved* in my character". She went on to say that, through listening to the painful stories of others, she felt at first overwhelmed but then described how "your heart becomes soft and filled with compassion. And I changed". She describes in this statement an increase in compassion and this is best understood through a lens that goes beyond feelings of

Compassion Satisfaction, and gestures more towards the concept of Vicarious Post Traumatic Growth.

Tedeschi and Calhoun (2004) examined the conceptual foundations and empirical evidence for Post Traumatic Growth and, in a systematic review, Cohen and Collens (2013) suggest that this process may also happen vicariously (i.e. Vicarious Post Traumatic Growth). One of the outcomes of Post Traumatic Growth include more meaningful relationships, which is echoed in Fiona's statement. It is also consistent with a small qualitative study by Hyatt-Burkhart (2014), who noted that the transference of Post Traumatic Growth to Vicarious Post Traumatic Growth occurred across three broad categories, including: (1) self-perception, (2) interpersonal relationships, and (3) philosophy of life. Considering Fiona's experience from the perspective of CSDT, intimacy is the schema that is transformed. Fiona is articulating a sense of increased positive emotion toward others which, in turn, indicates that her schema of intimacy is enhanced or renewed. This would extend to the schemas of both trust and control since Fiona appears to believe in the beneficence of others (in feeling more compassionate toward them) and she perceives her compassion as an effective means through which to connect with others.

A description of increased compassion was echoed by other participants in this study. Roslyn clearly stated that her counselling influenced how she now interacted with other people, citing increased feelings of compassion. Tara, despite her feelings of Secondary Traumatic Stress, described how she felt more connected to others and that counselling, sometimes, allowed her to see the world as a "softer" place. This speaks to both a richer existential life (Tedeschi & Calhoun, 2004) and philosophy of life (Hyatt-Burkhart, 2014), and the potential for change in one's frame of reference (i.e. thinking the world is a place where beneficence is possible) (Saakvitne et al., 1998). It also points to a positive shift in the cognitive schemas of intimacy and trust, where there is a feeling that, through this

compassion, one is able to connect meaningfully with others and, in terms of trust, one can trust others to be benevolent. Feelings of cynicism and suspiciousness are thus counterbalanced.

Feelings of increased personal strength are also one of the outcomes of Vicarious Post Traumatic Growth (Cohen & Collens, 2013; Hyatt-Burkhart, 2014; Tedeschi & Calhoun, 2004). All the participants in Hyatt-Burkhart's (2011) study endorsed feelings of growth, as they described themselves as more open-minded, more tolerant, more flexible, more patient, and more adaptable, because of their counselling processes. This is important, as Newell and colleagues (2016) notes that counsellors need to use their own personal psychological resources to be effective.

Feelings of increased personal strength were described by the participants in this study, in a way that suggests that there is duality in the healing process, affirming the link between Post Traumatic Growth and Vicarious Post Traumatic Growth. Ava described how "I get my healing when I listen to other people's stories… I get better and better and better every single day". Irene said that she found counselling "cathartic" and that it helped her "grow". Ben articulated that he "discovered himself" and, like other counsellors, said that, "More than trying to help … I'm being helped". Claudette said that "When I am helping, I am helping myself… I also find, oh! I can still cope". These experiences convey a subtle sense of strength that counsellors discover within themselves through the helping process and suggests that their schemas of esteem grow and are enhanced in a positive way.

Many counsellors also recounted how working through their previous primary trauma led to them entering the field of trauma lay counselling. Working through their prior traumas or difficulty, either before or through their counselling work, led to feelings of renewed hope. Charlotte said that her experiences of healing allowed her to get to "the other side as a whole person… it kind of gives me hope that anyone can do that". Roslyn spoke about building her

own resilience through her pain and Anna explained that she felt a sense of pride through "finding her voice" when recovering from trauma. In Barnett's (2007) reflections on unconscious motivations for becoming a counsellor, she speaks about the well-referenced concept of a 'wounded healer', describing how early wounds and healthy narcissism lead to those in the psychotherapeutic or counselling professions unconsciously providing healing for themselves through helping others. This hypothesis appears to be a good fit for Manning-Jones and colleagues' (2016) finding that, across a sample of healthcare providers, only psychotherapists experienced Post Traumatic Growth. This may also have to do with Hyatt-Burkhart's (2014) consideration that the health professions are pathology focused since, in her study, counsellors needed to be actively asked to recount the positive experiences of their work.

The exploratory and meaning-making hallmarks of counselling, combined with human connection, seem to have healing properties for both parties. This speaks to the 'duality' that many counsellors referenced, which is different to other professions where cognitive schemas (as articulated by CSDT) are activated for both parties and an interaction occurs.

While the literature has focused largely on Compassion Fatigue and, broadly ProQOL, it may be helpful to renew the model and actively incorporate Vicarious Post Traumatic Growth into it. Through doing this, the lay counsellor or healthcare provider moves beyond the promotion of increasing feelings of Compassion Satisfaction in that they aim to use their difficult experiences to enhance, grow, and positively adapt to the stress of the environment, building strength and resilience. When considering the incorporation of lay counsellors into the public health system, as well as the context from which they come from and within which they work, an agenda of resilience (or Vicarious Post Traumatic Growth) building is of paramount importance.

6.3. Practical Implications for Task Shifting

Task shifting has long been cited as a public health development priority and has more recently gained traction in SA (De Kock & Pillay, 2018; WHO, 2008). In this section, the practical implications of this research are discussed. Specifically, data which may be helpful in informing task shifting practices is put forward.

Based on the findings of this study, while only 23% of lay counsellors were satisfied with their work environments and their work, at least 47% were at risk for Compassion Fatigue. Literature points to organisational factors and 31% of the sample reported acute dissatisfaction with their work environment. To this end, many of the recommendations here are directed at organisations.

First, periodic monitoring and support is essential (Thara et al., 2014). Prior to training, careful selection needs to take place (Kagee, 2020; Petersen et al., 2016). Kagee's (2020) observation that recruitment is understudied points to a potential research agenda that is relevant to the mental health profession more generally. Adequate training is often assumed, but training protocols and policies which need to be standardised regarding length and quality of training should be put into place. The issue of training has been identified as urgent by allied healthcare professionals (Kagee, 2020), lay counsellors themselves (Myers et al., 2019, Newell et al., 2016), and is a directive issued in the recommendations regarding task shifting made by the WHO (2008). Sufficient minimum supervision hours should be included as a requirement for practice. Supervised practice, including supportive supervision and the possibility of peer supervision, will be essential (Newell et al., 2016; Petersen et al., 2014). Training should also address the concepts of Compassion Fatigue, Secondary Traumatic Stress, Burn Out, and Compassion Satisfaction, particularly for those most at-risk for Compassion Fatigue (Padmanabhanunni, 2019). To avoid discrimination, it is recommended that this becomes standardised practice.

Recognition by regulatory bodies, such as the HPCSA, is critical to the effective implementation of a lay counselling task force (Petersen et al., 2014). Organisational recognition and sensitisation of allied health professionals is also important (Kelly et al., 2015). A clear scope of practice should be delineated, and specific tasks should be allocated. The following tasks may be appropriately considered in line with the emerging evidence base: psychoeducation and health promotion, mental illness identification, appropriate subsequent referral, treatment and medication adherence, and conducting follow-ups post-treatment to assist with the implementation of broader treatment management plan (Petersen et al., 2014; Thara et al., 2014). It may also include crisis management (Howlett & Collins, 2014) and solution-focused counselling (Cooper et al., 2018). Collaboration with traditional or religious healers, as well as family caregivers, is essential (Kagee, 2020; Thara et al., 2014). Caseloads should be carefully monitored (Petersen et al., 2016) and consistent stipends should be made available at the level of a minimum wage, especially since the WHO considers task shifting based on a volunteering model unsustainable (Peltzer et al., 2014; WHO, 2008).

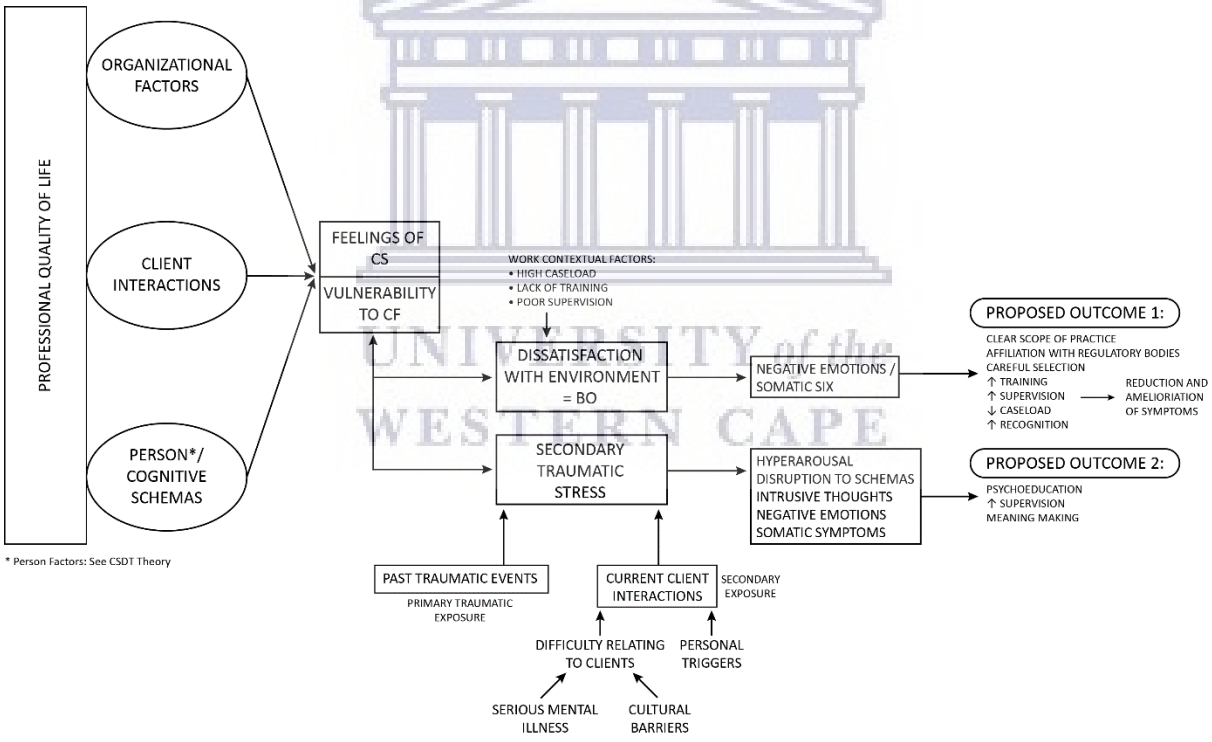
These considerations are important in that they can ensure the quality, consistency, and the protection of lay counsellors as well as the public (Kagee, 2020). They are equally important in ensuring a working and sustainable model to address the mental healthcare gap in SA (De Kock & Pillay, 2018; WHO, 2008). The promise and evidence that lay counsellors are effective in alleviating trauma has been presented in this study from both direct sources and the body of literature it falls within.

In sum, this study has two proposed outcomes in relation to the enhancement of the task-shifting model. The two models for training are presented below, in Figure 4 and Figure 5. In Figure 4, the model of risk for Compassion Fatigue as demonstrated in this study, is presented. There are two outcomes suggested: one for Burn Out and one for Secondary

Traumatic Stress. Simply put, Burn Out can be prevented through organisational change (Proposed outcome 1). Secondary Traumatic Stress, on the other hand, needs careful thought and planning and, perhaps, would require external intervention. What is important, however, is that the three elements of: (1) psychoeducation, (2) increased support through supervision, and (3) the process of meaning making, take place. This could be facilitated either internally or externally but should, ideally, be included as part of mandatory training and regular peer-supervision or debriefing sessions.

Figure 4

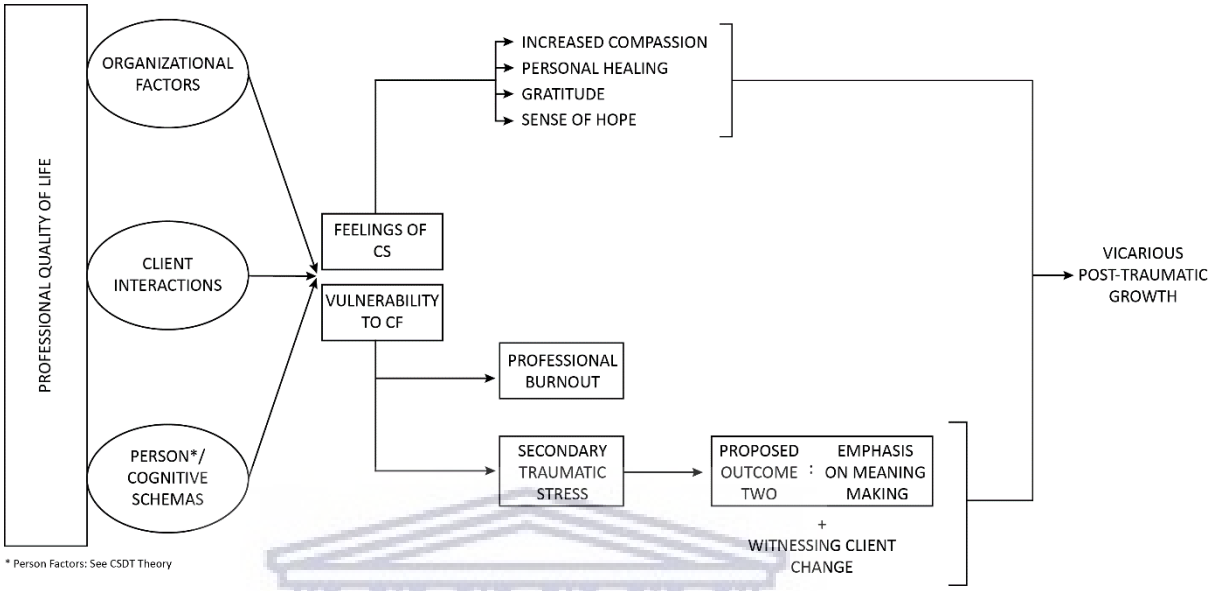
Model of ProQOL with Proposed Outcomes



In Figure 5, a final model for the promotion and possibility of Vicarious Post Traumatic Growth is proposed. If healthcare professionals look beyond ProQOL and recognise the potential for Vicarious Post Traumatic Growth, then perhaps a much-needed resilience can be enhanced, and healing and growth can begin.

Figure 5

Model for the Promotion of VPTG



Chapter Seven: Conclusion

The underlying premise of this study was that SA, specifically Cape Town in the WCP, is what Padmanabhanunni (2020a) calls a 'trauma nation'. The environment is rife with the risk of traumatic exposure, due to the high incidence of violent crime and the impact of trauma exposure is the result of CMDs and, more prominently, PTSD. The impact of psychological trauma is that it is psychologically carcinogenic. In other words, it impacts on the healthcare worker, mentally, physically, emotionally, and behaviourally. In a country where mental health needs are often not met, a task shifting approach has been strongly advocated for and numerous studies suggest the efficacy of lay counsellors. This study sought to better understand the ProQOL of lay counsellors working within the Cape Town metropole, a traumatised city that records the highest number of reported murders. Whilst more mental healthcare is needed, what would the impact of secondary traumatisation be on lay counsellors, who are often minimally trained, minimally supervised, and have no clear scope of practice or recognition from regulatory bodies?

The data presented has begun to answer this question: many lay counsellor experience BO and STS, and appear to be experiencing Compassion Fatigue. However, many also report great personal growth and derive satisfaction from their jobs. This is an area which demands further attention as the path for task shifting moves forward.

7.1. Limitations of the Present Study

The present study has several limitations, which are openly put forward and analysed in this section. The implications of these shortcomings are discussed.

Whilst this research acknowledged the conceptual differences and alternative uses of terminology within the literature, the variability of terms and concepts can reduce the richness and relevance of the study as some of the intricacies may not apply equally to each concept. For example, the qualitative data relates more directly to the initial concept of

Vicarious Trauma, where the quantitative data is based on the more modern concept of ProQOL. Whilst referring broadly to the same phenomena, some theorists may argue that the differences between concepts are too vast to allow for comparison, and complexities are sometimes lost (Sinclair et al., 2016). Quite simply, the interchangeable use of terms within the literature makes it difficult to situate this study within it. Furthermore, this study is inclusive of many concepts in its suggestion of expanding the ProQOL. This is relevant but also limits comparability to other studies, which are interested in the specific concepts of Vicarious Trauma, Secondary Traumatic Stress, and Compassion Fatigue, but do not necessarily examine ProQOL or Vicarious Post Traumatic Growth. Whilst the ProQOL is thought to be one of the more widely used instruments, its use in this study may limit comparability within the broader literature.

A second limitation related to definitions and concepts is that the term "lay counsellor" is not well utilised within academic research and only a few studies use the term. There are multiple other labels which have been discussed (see Literature Review) but, again, comparability is limited due to the choice of terminology for this study. However, the term lay counsellors is relevant and used within the SA context and was, therefore, appropriate (Kagee, 2020; Padmanabhanunni, 2019; Peltzer et al., 2014; Petersen et al., 2014).

Regarding the quantitative data, the sample size was relatively small and circumscribed to the WCP. This makes it difficult to compare across geographic regions within SA provinces. The same limitation is relevant to the qualitative data. The participants for the qualitative data were all located within urban settings and the data obtained cannot be generalised without further research on either a provincial or national level. However, this is a common limitation within studies which utilise qualitative data: rich, compelling accounts provide depth into a specific subject at the cost of generalisability (but not transferability).

A further limitation within the qualitative sample is that the organisational contexts and mediums of counselling differed from organisation to organisation. For example, one organisation provided individual and family face-to-face sessions, another offered only individual telephonic counselling, while the third offered both face-to-face individual and family counselling but operated predominantly in the medium of group counselling. This provides both a more general and collective sense of what trauma counselling looks like across different organisations in Cape Town (for example, general descriptions of Secondary Traumatic Stress and Burn Out came from members of all three organisations), but also highlights the need for further exploratory work for individual contexts. For instance, it seems that there are specific experiences which occur more commonly and with greater intensity in some contexts (for example, "sex-callers" or an acute sense of despondency when dealing with clients who articulate a lack of basic resources in refugee settings). Because of these highly different contexts, transferability of experience needs to be interpreted with caution.

7.2. Opportunities for Further Research

Despite the limitations discussed above, this study highlights many opportunities for further research.

First, a systematic review of research related to lay counsellors, non-professional counsellors, telephonic volunteers, trauma workers, and humanitarian aid workers who offer counselling services should be conducted, to aggregate and explore the topic and find areas for further research within this field.

Second, further investigation into the demographic variables associated with CS and Vicarious Post Traumatic Growth within the field of mental healthcare and, specifically with lay counsellors, would be a helpful endeavour to better understand risk and resilience factors in healthcare providers. Qualitatively, this is also an area for further research, given that the

better Compassion Satisfaction and Vicarious Post Traumatic Growth are understood, the easier it will become to design interventions that promote them.

Third, exploring the impact specific types of primary or secondary trauma and their association with different constructs on the ProQOL would be useful. While literature has established that prior trauma is correlated with increased Compassion Fatigue, finding out which types would be helpful for implementing protective measures. For example, Kassam-Adams (1995) seem to point to the high risk for counsellors working with sexual trauma.

Fourth, understanding the recruitment and selection of lay counsellors will be important. It has been suggested that there are inherent personal traits that could be explored in interviews and standardising recruitment will promote equity and equality in terms of human resource operations.

Last, attitudes toward lay counsellors from both allied healthcare professionals as well as the public needs to be further explored. Without 'buy-in' from these stakeholders, the feasibility of a task shifting approach becomes compromised.

Lay counselling for trauma specific interventions is a rich and nuanced area of healthcare work in South Africa. It is relevant due to the limitations and burdens of the healthcare system of a LMIC and has been shown to have great potential. Further research into this topic would not only be informative, but also useful in informing policy and, eventually, practice. It is time to bring together theory and practice and to develop a task shifting *praxis*.

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Appendices

Appendix A: Professional Quality of Life (ProQOL)

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue

(ProQOL) Version 5 (2009)

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

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

1. I am happy.
2. I am preoccupied with more than one person I [help].
3. I get satisfaction from being able to [help] people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I [help].
7. I find it difficult to separate my personal life from my life as a [helper].
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
9. I think that I might have been affected by the traumatic stress of those I [help].
10. I feel trapped by my job as a [helper].
11. Because of my [helping], I have felt "on edge" about various things.
12. I like my work as a [helper].
13. I feel depressed because of the traumatic experiences of the people I [help].
14. I feel as though I am experiencing the trauma of someone I have [helped].
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a [helper].
20. I have happy thoughts and feelings about those I [help] and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
24. I am proud of what I can do to [help].
25. As a result of my [helping], I have intrusive, frightening thoughts.

26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a [helper].
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

Appendix B: Email to NGO Requesting Access to Recruit Participants

Dear [CEO/NGO name]

I hope you are well. I am a researcher from the psychology department at the University of the Western Cape. I am conducting a research study where I am looking to interview counsellors who work with mental health to find out more about their experience of counselling, specifically related to burnout and fulfilment factors.

I have attached the information sheet as well as the full proposal to this email. Please let me know if you have any questions.

I would be happy to travel to your offices to conduct the interviews, should you be willing to participate.

Please let me know. Looking forward to hearing from you.

Kind regards,
Kirsty

--
Kirsty Rice
Contact: +27 73 207 3179
Email: kirstyricect@gmail.com

Appendix C: Email to Participants Requesting Participation

Dear [NGO/Organization] Counselors,

How do previous life events impact on your counselling?

I am interviewing counselors on their experiences of counselling, and how their previous life events play a role in their current counselling. **This is an invitation for you to participate!**

The study forms part of a broader research project being conducted by the **University of the Western Cape.** The research looks to understand compassion fatigue and compassion satisfaction in counselors.

If you are interested in participating, please **email me directly** or **Whatsapp me on 073 207 3179** and we can set up a time to meet. I will travel to you. The interview will last 30-40 minutes. The study has ethical approval from the University of the Western Cape's Ethics Committee.

Hoping to hear from you!

Kind regards,
Kirsty

--
Kirsty Rice
Contact: +27 73 207 3179
Email: kirstyricect@gmail.com

Appendix D: Information Sheet

UNIVERSITY *of the*
WESTERN CAPE

INFORMATION SHEET

Project Title: Professional quality of life: compassion satisfaction, compassion fatigue and burnout among lay-counsellors in Cape Town.

What is this study about?

This is a research project being conducted by Kirsty Rice at the University of the Western Cape. I am inviting you to participate in this research project because you are a lay counsellor who works with trauma victims. The purpose of this research project is to explore the role of traumatic life events amongst lay counsellors who work with victims of trauma and the development of compassion fatigue.

What will I be asked to do if I agree to participate?

You will be asked to participate in a one on one interview of approximately 30 minutes. This process will take place at your place of work.

Confidentiality

To ensure your confidentiality, physical data will be stored in locked filing cabinets and secure storage areas, and electronic information will be password protected. The interview will be audio recorded. The audio recording will be transcribed by the researcher herself and once it has been transcribed, the audio file will be deleted. If we write a report or article about this research project, your identity will be protected.

What are the risks of this research?

There may be some risks from participating in this research study. All human interactions and talking about self or others carry some amount of risks. I will act to minimize such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about the psychological impact of working with victims of trauma on lay counsellors. We hope that, in the future, other people might benefit from this study through improved understanding of how best to promote compassion satisfaction. The study also hopes to act as a resource that could inform development programs made to support lay-counselors.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Ethical considerations
This study has sought and received ethical clearance from UWCs Humanities and Social Sciences Research Ethics Committee.

What if I have questions?

This research is being conducted by **Dr Anita Padmanabhanunni, Phd** at the University of the Western Cape. If you have any questions about the research study itself, please contact **Dr Anita Padmanabhanunni** at: apadmana@uwc.ac.za. The current researcher is **Kirsty Rice,** a student psychologist at UWC. You can reach Kirsty at kirstyricect@gmail.com. Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department:
Dr. Maria Florence
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mflorence@uwc.ac.za.

Dean
Prof. Anthea Rhoda
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This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

HSSREC
Research Development
Email research-ethics@uwc.ac.za
Tel: 021 959 4111

Appendix E: Informed Consent Form

CONSENT FORM

Title of Research Project: Professional Quality of Life: compassion fatigue, compassion satisfaction and burnout in lay-counsellors in Cape Town

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

I give permission for the interview to be audio-recorded on the researcher's cellular phone. I understand that the audio recording will not be shared with anyone but the researcher. Once th recording has been transcribed by the researcher, the audio recording will be deleted.

Participant's name……..

Participant's signature…….

Date……

Appendix F: Semi-structured Interview Schedule

The interview will begin with an introduction. The researcher will introduce herself, and explain the study. The informed consent form will be explained and signed. The researcher will obtain permission to audio record the interview.

1. Tell me about your work as a lay-counsellor. What made you decide to work as a lay-counsellor?

2. How does your caseload impact your work as a lay-counsellor?

3. What do you find most challenging about your work?

4. If you feel comfortable, could you tell me about a time where a stressful life event or a previous traumatic experience impacted your work as a lay-counsellor?

5. How did this event impact you?

6. How did it impact the way in which you viewed the world?

7. How did it impact the way in which you view other people?

8. How did it impact the way in which you viewed yourself?

9. What do you find most satisfying about your work?

10. Is there anything else that you would like to add to what we have spoken about?

Once the interview has taken place, the researcher will conduct a short debriefing with the participant through checking in with their mood. In the case that the participant feels distressed or overwhelmed, a recommendation and referral to an appropriate service provider will be made.

Appendix G: Life Events Checklist

LEC-5

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); or (e) you're not sure if it fits.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	*Happened to me*	*Witnessed it*	*Learned about it*	*Part of my job*	*Not Sure*
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted					

rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					

Event	*Happened to me*	*Witnessed it*	*Learned about it*	*Part of my job*	*Not Sure*
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden violent death (for example, homicide, suicide)					
15. Sudden accidental death					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					