

# The cost of caring: secondary traumatic stress and burnout among lay trauma counsellors in the Western Cape Province

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## Abstract

The psychological and emotional risks associated with providing care to traumatized populations have been largely overlooked in the literature on non-professional trauma counselling in South Africa. Non-professional or lay trauma counsellors are frontline service providers and typically the first point of contact for people in community contexts who have experienced traumatic events. The main aim of this study was to investigate the professional quality of life including compassion satisfaction, secondary traumatic stress, and burnout of a sample ( $N=146$ ) of lay trauma counsellors in the Western Cape Province. Demographic factors including age and gender were found to be significant. Older age was associated with compassion satisfaction while younger age predicted burnout. Male lay trauma counsellors were more likely to report high burnout and high secondary traumatic stress compared with their female counterparts. The study underscores the need for organizations to incorporate prevention and intervention approaches to mitigate the negative psychological impact of working with trauma. Male lay trauma counsellors and younger counsellors may particularly benefit from interventions that encourage debriefing.

## Keywords

Burnout, compassion satisfaction, gender, lay trauma counsellors, secondary traumatic stress

In South Africa, exposure to traumatic events is common. The South African Stress and Health Study (SASH), an epidemiological national survey, reported a lifetime traumatic event prevalence rate of 73% (Atwoli et al., 2013). This prevalence rate is markedly higher compared with World Health Organization surveys conducted in Europe (Carmassi et al., 2014) and Asia (Kawakami et al., 2014). Emerging findings from other sub-Saharan countries (Harder et al., 2012; Pence et al.,

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2012) also suggest that South Africa has a comparatively higher rate of exposure to trauma. The most common traumatic events include directly experiencing physical violence and witnessing a violent act occurring to another person (Atwoli et al., 2013).

Exposure to trauma is associated with increased risk of serious mental health problems. The SASH study reported a 12-month prevalence rate of 16.5% for common mental health disorders and 2.3% prevalence rate for post-traumatic stress disorder (PTSD) (Atwoli et al., 2013; Tomlinson et al., 2016). If left untreated, PTSD can become chronic and lead to other mental health problems including depression, anxiety, and substance abuse. In addition, PTSD has adverse implications for occupational and interpersonal functioning. Despite the prevalence of mental health disorders in South Africa, approximately 75% of people in the country do not receive treatment and this is related to limited access to mental health services (Tomlinson et al., 2016). To address resource constraints and increase access to mental healthcare services, the South African government adopted a policy on the training and remuneration of community healthcare workers in 2014 (Dewing et al., 2015).

Community healthcare workers are lay people typically from community settings who are trained to provide particular forms of health services. Lay counselling represents one such service. Lay counsellors in South Africa are non-professional service providers and typically have no formal qualifications or professional certificates and are not affiliated with a professional regulatory body (Thurling & Harris, 2012). They provide social and emotional support and are most active in the provision of trauma counselling, education related to the prevention of gender-based violence, pre- and post-test HIV counselling, and counselling services related to promoting medication adherence for chronic medical health problems (Jansen van Rensburg, 2008; Peltzer, 2012). The training of lay counsellors is largely undertaken by non-governmental organizations (NGOs) and varies based on the setting. It typically involves training in basic counselling skill (Dewing et al., 2015). With regard to trauma counselling, lay trauma counsellors are frontline responders and the first point of contact for individuals from community settings who have experienced a traumatic event (Howlett & Collins, 2014). Unlike professional mental healthcare providers (e.g., psychologists), lay trauma counsellors are tasked with focusing solely on the traumatic event with the aim of restoring pre-trauma functioning (Howlett & Collins, 2014). Given the central role of lay trauma counsellors in mental healthcare service provision in South Africa and other developing countries, assessing their emotional well-being and the extent to which they derive satisfaction from their work is important.

Existing studies on professional and non-professional trauma workers have confirmed that consistent exposure to the traumatic material presented by clients is associated with adverse mental health outcomes, specifically secondary traumatic stress (STS) and burnout (Avieli et al., 2016). STS resembles PTSD and is characterized by intrusive re-experiencing of aspects of the client's trauma, avoidance of reminders, and changes in the trauma worker's worldview. Burnout includes feelings of cynicism and detachment from work, emotional exhaustion, depersonalization, and a reduced sense of accomplishment (Figley, 2013). Although these reactions are common, many trauma workers also derive a sense of personal satisfaction from being able to assist others and believe that they are contributing to the greater good of their communities. This experience has been termed compassion satisfaction (CS; Figley, 2013; Stamm, 2010).

There is some evidence in South Africa that lay counsellors are adversely affected by their work. Ortlepp and Friedman (2002), for example, reported that 10% of lay trauma workers who had been trained to assist bank employees following a bank robbery reported STS in the high range. In a study of lay HIV counsellors, Peltzer et al. (2014) found that STS (51.4%) and burnout (10.4%) were common. Howlett and Collins (2014) in a qualitative study of lay counsellors working with victims of domestic violence reported that symptoms of STS were experienced by these

workers. Studies conducted in other developing countries (Uganda: Ager et al., 2012; India: Shah et al., 2007) have confirmed that lay counsellors in these settings are particularly vulnerable to STS and burnout as a consequence of their work. Nevertheless, the vast majority of South African research in this area has focused on the experiences of professionals including psychologists (Sui & Padmanabhanunni, 2016), nurses (Mashego et al., 2016), and social workers (MacRitchie & Leibowitz, 2010).

Owing to the negative impact of STS and burnout on professional mental healthcare providers, extensive research efforts have focused on identifying risk and protective factors (Sprang et al., 2011; Wagaman et al., 2015). The majority of this work has focused on organizational factors such as case load, practical training, and workplace support (Hensel et al., 2015). Individual risk factors have also been investigated, albeit to a lesser extent (Kulkarni et al., 2013). These include personal history of exposure to trauma (Cieslak et al., 2014; Sodeke-Gregson et al., 2013), age (Sprang et al., 2011), marital status, and social support (Kulkarni et al., 2013). Gender represents one of the individual-level risk factors that have been significantly understudied in relation to professional quality of life (Baum, 2016). This limited focus on gender significantly contrasts with the considerable attention given to the role of gender in studies on PTSD (Norr et al., 2016; Pineles et al., 2017), burnout (Malach-Pines & Ronen, 2016; Verweij et al., 2017), and post-traumatic growth (Jin et al., 2014; Vishnevsky et al., 2010). Baum (2016) in a systematic review on gender differences in susceptibility to STS among mental health professionals could only locate four studies (Craig & Sprang, 2010; Sprang et al., 2007, 2011; Van Hook & Rothenberg, 2009) that have investigated professional quality of life in relation to gender.

In sum, there is limited research on CS, STS, and burnout and existing research has predominantly involved professional groups of mental healthcare providers. There remains a significant gap in the literature on the experiences of lay counsellors and individual risk factors for CS, STS, and burnout. This study aims to address this gap.

## Method

### *Participants*

A cross-sectional survey design was used. The participants ( $N=146$ ) provided lay trauma counseling services to individuals residing in historically disadvantaged communities in the Western Cape Province of South Africa. The participants worked for NGOs in these settings. These communities were created in terms of the Group Areas Act enforced by the Apartheid government. The Act involved the physical separation of race groups in terms of residential area. Black South Africans were forcibly removed to underdeveloped and poorly resourced areas typically situated at the periphery of major cities. The impact of this historical legacy is evident in the high rates of poverty and unemployment, gang activity, and other social ills that continue to affect these communities (Chetty, 2015; Pretorius et al., 2016).

### *Instruments*

Participants completed the Professional Quality of Life Scale (PROQOL) (Stamm, 2010) and a demographic questionnaire that included items pertaining to age, gender, and race. The PROQOL is a 30-item self-report measure on a 5-point scale (1 = *never* to 5 = *very often*). It consists of three 10-item subscales, namely (1) CS, which refers to the pleasure derived from working with trauma survivors; (2) STS, which entails symptoms characteristic of PTSD; and (3) burnout. Stamm (2010) reported Cronbach's alpha values of .82 for CS, .78 for STS, and .71 for burnout. The

**Table 1.** Descriptive statistics for PROQOL, gender differences, and correlation with age.

Scale	Total sample		Men		Women		t-value	Correlation with age
	M	SD	M	SD	M	SD		
CS	42.46	4.52	41.80	4.40	42.61	4.60	-0.85	.30**
Burnout	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	-0.21	-.05

CS: compassion satisfaction; STS: secondary traumatic stress; PROQOL: Professional Quality of Life Scale.

\*\* $p < .01$ .

subscales therefore have sound internal consistency reliability. High scores on all the subscales indicate higher CS, STS, and burnout. In this study, the Cronbach's alpha values were .79 for CS, .76 for STS, and .71 for burnout.

### Procedure

Consenting participants were provided with the questionnaires electronically or in person. The response rate was 58%. Although this response rate can be seen as relatively low, prior research (Morton et al., 2012) has suggested that a response rate approaching 60% is acceptable.

### Ethical considerations

Ethical approval for the study was granted by the Humanities and Social Sciences Research Council of the University of the Western Cape. Subsequently, informed consent was obtained from directors of NGOs to contact lay trauma counsellors working at these sites. Thereafter, informed consent was obtained from the participants. Participants completed the questionnaires anonymously. No identifying information was included in the questionnaires. Participants were informed that they could withdraw from the study at any time without any adverse consequences. Participants were also provided with the contact details of professional mental healthcare providers who they could reach in the event that they experienced any distress as a result of completing the questionnaires. Data from the questionnaires were stored in a password-protected computer and will be kept for a duration of 5 years.

### Data analysis

Data were captured and analysed using the Statistical Package for the Social Sciences (SPSS-25). Descriptive statistics were used to analyse demographic information. Correlational analysis was used to determine the association of demographic variables and CS, STS, and burnout.

### Results

The means and standard deviations of the PROQOL as well as gender differences and correlation with age are reported in Table 1.

Table 1, first, reflects no statistically significant differences between men and women in terms of CS ( $t(125) = -0.85, p > .05$ ), burnout ( $t(129) = 1.17, p > .05$ ), and STS ( $t(125) = -0.21, p > .05$ ). Second, Table 1 also indicates a statistically significant positive relationship between age and CS ( $r(126) = .30, p < .01$ ), and a negative relationship between age and burnout ( $r(130) = -.36, p < .01$ ).

**Table 2.** Frequency distribution of PROQOL scores in terms of cutpoints.

Percentile	Total sample (N= 147)		Men (n= 33)		Women (n= 110)		Odds ratio (CI <sub>95</sub> )
	N	%	n	%	n	%	
<b>Compassion satisfaction</b>							
<25th percentile	38	29.2	11	36.7	27	27.8	
25th and 5th percentile	52	40	13	43.3	38	39.2	
>75th percentile	40	27.2	6	20	32	33	2.17 (0.71–6.65)
<b>Burnout</b>							
<25th percentile	27	20.1	5	16.7	21	20.8	
25th and 5th percentile	77	52.4	17	56.7	58	57.4	
>75th percentile	30	22.4	8	26.7	22	21.8	1.53 (0.43–5.42)
<b>Secondary traumatic stress</b>							
<25th percentile	31	21.1	9	29	21	21.9	
25th and 5th percentile	69	46.9	14	45.2	54	56.3	
>75th percentile	30	20.4	8	25.8	21	21.9	1.12 (0.36–3.48)

PROQOL: Professional Quality of Life Scale.

It is recommended (Stamm, 2010) that the scores on the PROQOL be converted to *t*-scores with an *M* of 50 and an *SD* of 10. The author also provides cutpoints in terms of *t*-scores, namely CS: 44–25th percentile, 57–75th percentile; burnout: 43–25th percentile, 56–75th percentile; and STS 42–25th percentile, 56–75th percentile. The sample distribution in terms of these cutpoints are reported in Table 2.

Table 2 reflects that 29% of the sample reported low CS and 27.2% high CS. In terms of gender, more men (36.7%) compared with women (27.8%) reported low CS. Conversely, more women (33%) than men (20%) reported high CS. The odds ratio indicate that women are 2.17 times (CI<sub>95</sub>: 0.71–6.65) more likely to report high CS.

With respect to burnout, 20% of the sample reported low burnout and 22.4% of the sample reported high burnout. More men (26.7%) reported high burnout compared with women (21.8%). Men were 1.53 times (CI<sub>95</sub>: 0.43–5.42) more likely to report higher burnout.

In the case of STS, an almost equal percentage of the sample reported low STS (21.1%) and high STS (20.4%). Slightly more men (25.8%) than women (21.9%) reported high STS with an odds ratio of 1.12 (CI<sub>95</sub>: 0.36–3.48).

Stamm (2010) also provides guidelines for interpreting subscales of the PROQOL in combination with each other. The five different possible combinations of subscale scores and the number (and percentage of participants) in each of these combinations are presented in Table 3.

Table 3 indicates that 23% of the sample fell into the category that is seen as the most positive outcome, namely high CS together with low burnout and STS. The second category is regarded as an at-risk category since high burnout together with any combination of subscales is considered to be negative and 10% of the sample fell into this category. The category of high STS together with low burnout and CS contains individuals that are overwhelmed by a negative experience at work, possibly related to taking care of other's who suffered trauma, and only 3% of the sample fell into this category. The author describes the fourth category of high STS in combination with high CS and low burnout as 'typically unique to high risk situations such as war and civil violence' (Stamm, 2010, p. 23). It is thus surprising that 13% of the sample fell into this category. While these individuals derive a great deal of satisfaction from their work 'they have a private self that is extremely fearful because of their

**Table 3.** Sample distribution in terms of combination of scale scores.

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

CS: compassion satisfaction; STS: secondary traumatic stress.

engagement with others' (p. 23). The last combination of subscales, namely high STS, high burnout, and low CS is regarded as the most distressing, and 21% of the sample fell into this category.

## Discussion

This study aimed to assess the prevalence of CS, STS, and burnout among a sample of lay trauma counsellors. With respect to Stamm's (2010) risk profiles, a quarter of the sample (23%) fell into the normal work profile category (high CS and moderate to low STS and burnout), which reflects satisfaction and fulfilment with their jobs. Almost half the sample had a profile that suggests significant risk of adverse psychological outcomes due to elevated levels of burnout and STS, with 10% in the at-risk category, 21% in the very distressed category, 3% in the overwhelmed category, and 13% in the high-risk situations category. With reference to existing studies, mental health providers who experience burnout typically demonstrate mental and physical exhaustion that can lead to a lack of productivity and increased difficulties with work relationships (Thompson et al., 2014). Burnout is associated with disengagement from others and can compromise the ability to provide effective care and support to trauma victims (Figley, 2013). In contrast to STS, burnout is related to aspects of the organization including limited supervisory support, high workload, and few established relationships with colleagues rather than with the impact of working with traumatized people (Kulkarni et al., 2013; Lim et al., 2010). The occurrence of high burnout in the current sample may potentially be related to characteristics of their work environment including high workloads and limited supervisory and other forms of support (Howlett & Collins, 2014).

Individuals who score high on STS are generally overwhelmed by the traumatic experiences of others and are at risk of depression and secondary trauma (Stamm, 2010). They experience PTSD-like symptoms related to the traumatic experiences of the people they counsel. Studies suggest that STS is more likely if the service provider does not have adaptive strategies in place to process their feelings in relation to the trauma of others (Gil & Weinberg, 2015). Other risk factors for STS include a personal history of trauma, limited training in providing trauma services, and high case-loads (Hensel et al., 2015). It is plausible that some of these factors may account for the high STS encountered in the sample.

With regard to the association between professional quality of life and demographic characteristics, age was a significant predictor of CS and burnout. Consistent with existing studies (Galek et al., 2011; Kelly et al., 2015), older age was associated with CS while younger age predicated burnout. It is probable that younger service providers tend to be newer to the field of trauma counselling and may not have developed the coping mechanisms to manage the emotional impact of this type of work (Bride et al., 2007), which enhances their vulnerability to burnout. Older service providers have also been found to demonstrate greater self-efficacy, which is a protective factor against burnout (Shoji et al., 2016).

Important gender differences were evident in the study. First, women were more likely to report high CS compared with men. This may partly be a function of gender-role socialization where women are expected to be caregivers and attentive to the needs of others. Meeting these expectations may contribute to a greater sense of fulfilment and job satisfaction (Sprang et al., 2007). Women in South Africa are also at greater risk of exposure to traumatic events and it is probable that female lay trauma counsellors in the study may have personal experiences of trauma and this may enhance their empathy with their clients. Empathy and the capacity to share emotions have been found to have a positive relationship with CS (Wagaman et al., 2015).

Second, more male lay trauma counsellors reported high burnout and high STS compared with their female counterparts. These findings differ from existing research (Baum, 2016; Teffo et al., 2018; Thompson et al., 2014; Van Hook & Rothenberg, 2009) that has consistently indicated greater vulnerability to STS and burnout among women. One possible explanation is that male counsellors may have more difficulty distancing themselves emotionally from traumatic material and this may enhance their risk of STS and burnout (Baum & Moyal, 2020). Male counsellors are also less likely to seek support from colleagues or significant others to cope with the demands of their work and this may further contribute to their heightened risk of adverse psychological outcomes as a result of trauma work (Baum, 2016).

The findings of the study have direct practical implications for organizations involved in the training of lay trauma counsellors. The study underscores the need for organizations to incorporate prevention and intervention approaches to mitigate the negative psychological impact of working with trauma. Currently, there are a wide variety of interventions for burnout and STS and these approaches tend to be universally applied due to the assumption that the experiences of service providers are similar (Sprang et al., 2011). This study suggests that gender-sensitive training and interventions may be needed for lay trauma counsellors in developing contexts. Opportunities for supervision and peer group support are recommended as they offer a space for lay trauma counsellors to share their thoughts and feelings in relation to trauma work and can facilitate the processing of distressing material and thereby prevent STS (Kulkarni et al., 2013). Male lay trauma counsellors may particularly benefit from interventions that encourage debriefing. In addition, incorporating education about STS and burnout into training programmes may assist lay trauma counsellors to identify symptoms early on and engage in self-initiated interventions (Figley, 2013).

The study had certain limitations. Participants were drawn from one geographic region and future research would be needed to investigate the extent to which the current findings generalize to other local contexts. This study also had a relatively low response rate (58%). It is possible that time constraints and limited interest in academic research impacted on the willingness to participate in the study. However, it needs to be noted that a lower response rate does not necessarily equate to lower study validity (Mealing et al., 2010; Morton et al., 2012). Studies with lower response rates have been shown to be only marginally less accurate compared with those with higher rates of participation (Morton et al., 2012).

## Conclusion

The bulk of research on the impact of trauma in South Africa has focused on either victims of traumatic events or on the professional mental health service providers who care for them. However, those at the frontlines of trauma work are often lay counsellors and our knowledge on the impact of STS, burnout, and CS on this group of caregivers is insufficient. This is one of the few studies to address this gap in existing trauma research by investigating the professional quality of life of lay trauma counsellors in South Africa. The study found that a significant proportion of lay trauma

counsellors in the study were at risk of adverse mental health outcomes as a consequence of their work. In addition, the study identified important risk factors related to age and gender. These findings underscore the need for organizations to incorporate preventive strategies to mitigate the risk of STS and burnout among this population group.

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