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Depressive symptoms, burnout and the impact of events in non-professional volunteer counselors in Durban, South Africa

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South Africa has high levels of interpersonal violence with 144 536 cases of assault against women being reported and 217 989 protection orders lodged mostly by women (against their partners) for the period 2011/2012[1]. As mental health services are in a state of neglect in KwaZulu-Natal, [2]non-governmental organizations (NGO's) often rely on volunteers to provide "first line" care for survivors of such acts. However, working with survivors of violence can be emotionally hazardous occupation for the helpers[3] and continuous exposure to traumatic material can lead to burnout.[4]

While professional counselors are trained to engage in this work, the psychological sequelae for non-professional counselors, who may have limited or no formal psychological training is relatively unknown. Due to the large number of such volunteers which serve NGO's in countries which have limited resources, this pilot, exploratory study was undertaken to establish the prevalence of depressive symptoms and burnout among lay counselors, the coping mechanisms used and any associations between variables.

Volunteer counselors from a non-governmental organization (NGO) providing crisis intervention, a safe-house, liason with the police, legal services and social workers to survivors of interpersonal violence (domestic violence, rape, abuse) based in Durban, South Africa agreed to participate. They were unpaid and had received basic in-service counseling training but no formal mental health training. The University of KwaZulu-Natal Research Ethics Committee provided ethical clearance and participants signed informed consent.

They completed a demographic questionnaire covering various personal variables such as age, gender, personal history if trauma, years worked as a counselor etc and three standardized psychometric instruments. These instruments were: Beck's Depression Inventory (BDI-II)[4] which assesses depressive symptomatology; Maslach's Burnout Inventory (MBI)[5] with three subscales: Emotional Exhaustion (MBI-EE) (examines a lack of energy and enthusiasm and the draining of ones emotional resources), Depersonalization (MBI-DP) (negative, cynical attitude and impersonal feelings towards clients) and reduced Personal Accomplishment (PA) (feeling that there is low productivity, perceiving ones work negatively or ineffective). The Impact of Events Scale[6] which measures two effects (intrusion and avoidance) believed to interfere with providing effective treatment was also

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used. Intrusion is characterized by unbidden thoughts and images, troubled dreams, waves of feelings and repetitive behaviour. Avoidance includes ideational constriction, denial of the meanings and consequences of the event, blunted sensation, behavioural inhibition or counter-phobic activity. 6 Basic descriptive statistics and the Pearson product moment correlation were calculated to establish associations between variables.

There were 16 participants with the mean age being 41.8 years (range 18 to 60). All were female, with 10 being of Indian ethnicity, 5 Black and 1 White. Regarding their religious affiliations, 6 were Christian, 4 were Hindu and 6 did not specify what religion they followed. Eight (50%) were married, 7 were single and 1 participant reported being divorced. The duration worked as a counselor ranged from 1 to 12 years (Mean = 4.56 years). Seven volunteered full time, while 9 worked part time. Eight participants (50%) reported a personal history of violence and rape. Two (12.5%) participants reported having seen a mental health professional for their trauma.

In terms of the results, no significant associations were reported between a personal history of trauma, working as a counselor full time or part time and any of the variables/ psychometric scales. Findings of the psychometric instruments indicated the following: on the BDI- II, five participants did not report any depressive symptoms, 43.8 % (N= 7) reported mild symptoms and 4 (25%) reported moderate/severe depressive symptoms. This is in keeping with the literature which indicates that counselors experience depressed mood.[7]

On the MBI, 18.75% (N=3) of the participants reported moderate levels of EE and 12.50% (N=2) reported high levels of EE. Thus, almost one third of the participants reported moderate to high EE which has been found to be a precursor of burnout[8].

Regarding, Depersonalization (DP), 37.50% (N=6) had low scores, 43.75% (N = 7) reported moderate DP, while 18.75% (N =3) reported high levels of DP. Moderate to high levels of DP in this sample support findings indicating that involvement in emotionally demanding situations relates to feelings of depersonalization towards ones clients[9]. In terms of personal accomplishment, seven participants (43.75%) reported reduced PA, with 37.50% (N = 6) reporting moderate levels of PA. Three participants had high scores on PA.

In terms of associations between variables (as indicated in Table 1 below), a positive correlation between emotional exhaustion (EE) and depressive symptoms on the BDI- II ($r=.51$, $p<.05$), indicate that EE is the main burnout dimension and reflects the stress dimension of this syndrome, with high levels of EE predicting depression[10].

With Depersonalization positively correlated with EE ($r=.71$, $p<0.01$), it appears that in the development of burnout, EE emerges first with the counselor feeling tired and lacking mental energy as a result of the intense emotional load associated with client care. The counselor then distances him/herself (depersonalization) from the client as a protective measure to manage the intensity of direct emotional impact. The third component is a direct result of the first two: exhaustion and depersonalization can prevent the counselor from feeling effective leading to a reduced sense of personal accomplishment[8,10]. Furthermore in this study, reduced personal accomplishment was positively correlated with avoidance (r =.

61,p <.05) and intrusion (r =.51, p<.05), indicating possible boundary violations by counselors leading to compromised or poor quality of care[8].

The role of religion or spirituality among non-professional counselors has not been explored in the literature to the authors knowledge. This study indicates negative correlations between EE and religion (r =.−50, p <.05) and between depressive symptoms and religion (r = 0.−70, p< .01). Although a significant number of counselors did not identify what, if any religion they belonged to, their beliefs appear to serve a protective function in the development of depressive symptoms and burnout. The findings could be interpreted by understanding the sample as being spiritual. Spirituality, defined as having both religious and existential components, indicates a relationship with God or a higher power coupled with a sense of life purpose and meaning beyond oneself. Research indicates that increased exposure to trauma enhanced counselors spiritual well being because suffering is implied as part of spiritual growth, creating a crisis which leads to a stronger sense of spirituality[11]. Alternatively, counselors may be drawn to work with trauma survivors because of their belief in a higher power, which may give them the necessary strength to do trauma work[11]. As many NGO's in Africa have religious or faith based roots, this has implications for the selection of lay counselors and the long term prevention of depression and burnout.

In conclusion, there are some limitations, for example, limited generalizability due to the small sample size and the lack of a control group, and other NGO's may offer staff support which would militate against such findings. Larger studies are recommended to address this. This study indicates that some lay counselors experience depressive symptoms and burnout and that RPA is associated with avoidance and intrusion coping mechanisms which may impact on client care. The study hopes to create awareness among organizations using lay counselors on the impact that working with survivors of violence can have on their staff. It is recommended that organizational support such as reduced or varied work load, supervision, compulsory debriefing and stress management should be offered to limit negative outcomes. Failure to do so may lead to compromised quality of client care and may impact on organizational costs such as staff turnover.

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Table 1

Associations between various scales

Characteristic/scale	Characteristic/scale	Pearsons r	p value
Emotional Exhaustion (MBI)	Depressive symptoms (BDI-II)	r =.50	<.05
Depersonalization (MBI)	Emotional exhaustion (MBI)	r =.71	<.01
Reduced personal accomplishment (PA) (MBI)	Avoidance (IES)	r =.61	<.05
Reduced personal accomplishment (PA) (MBI)	Intrusion (IES)	r. =.51	<.05
Intrusion (IES)	Avoidance (IES)	r = .66	<.01
Emotional Exhaustion (MBI)	Religion	r = −.50	<.05
Depressive symptoms (BDI-II)	Religion	r = −.70	<.01