The emotional wellbeing of lay HIV counselling and testing counsellors

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The HIV testing, treatment and care programme of the South African public healthcare system depends on HIV counselling and testing (HCT) that is primarily delivered by lay counsellors. Lay counsellors are expected to educate clients about HIV/AIDS, advocate behaviour change, convey test results and support those infected and affected to cope with the emotional and social challenges associated with HIV/AIDS. This research focuses on the emotional wellbeing of lay HCT counsellors because this influences the quality of services they provide. A mixed methods approach was used. The emotional wellbeing, level of burnout, depression and coping style of 50 lay HCT counsellors working at the City of Tshwane clinics were assessed. Additionally, five focus group discussions were conducted. The results showed that HCT counsellors reported average emotional wellbeing, high levels of emotional exhaustion and depression. They had a sense of personal accomplishment and positive coping skills. The results revealed that they may have difficulty dealing with clients' emotional distress without adequate training and supervision. This creates a dilemma for service delivery. In the light of the important role they play in service delivery, the role of the lay HCT counsellor needs to be reconsidered. HCT should develop as a profession with specific training and supervision to develop their emotional competencies to conduct effective counselling sessions.

Keywords: burnout, depression, emotional wellbeing, HIV-counselling and testing, lay counsellors, mixed methods

Introduction

South Africa ranks among the countries with the highest HIV prevalence in the world. The proportion of South Africans infected with HIV increased from 10.6% in 2008 to 12.3% in 2012. In the age group 15 to 49 years the HIV prevalence among females is 23.3% and 13.5% amongst males (Shisana et al., 2014). The HIV/AIDS pandemic in South Africa resulted in an escalating need for medical services and care and support for people living with HIV (PLHIV). A far-reaching and reliable HIV counselling and testing programme (HCT) is essential to support all the HIV prevention and intervention strategies (Department of Health [DoH], 2010, 2011). In rolling out HIV testing and treatment, a system of lay counsellors was implemented as part of the comprehensive care, management and treatment programmes to compensate for a shortage of professionals (Schneider et al., 2008). Lay counsellors are individuals with no formal professional or paraprofessional qualifications that are trained to provide specific healthcare services (Lewin et al., 2005).

Tremendous responsibility has been placed on the shoulders of lay HCT counsellors as they occupy the front line of HIV/AIDS service delivery in the public healthcare sector (Schneider and Lehman, 2010). Lay HCT counsellors are expected to educate clients about HIV/AIDS, advocate behaviour change, convey test results and assist those infected and affected to cope with the emotional, psychological and social challenges associated with the diagnosis (Van Dyk, 2013). Lay HCT counsellors are thus exposed to intense emotional contexts during counselling, although their training does not prepare them for such contexts (Kabamba, 2009; Mavhandu-Mudzusi et al., 2007; Nulty and Edwards, 2005; Schneider et al., 2008). Their work can thus influence their emotional wellbeing. Furthermore, the emotional wellbeing of counsellors is important as it directly influences their ability to provide effective counselling (Corey, 2009). This research explores the emotional wellbeing of lay HCT counsellors as a component of effective counselling.

This study is specifically relevant because community based or lay health workers are playing increasingly important roles in health service delivery in resource-limited developing countries (Dewing et al., 2015; DoH, 2012; Rohleder and Swartz, 2005). This is part of a task-shifting strategy to compensate for critical shortages of human resources in health care (Callaghan et al., 2010; World Health Organization [WHO], 2007 Wouters et al., 2012). Currently, lay counsellors have to provide integrated HIV counselling service, antiretroviral therapy (ART) adherence, mental health and trauma counselling services (Rispel et al., 2010). The emotional wellbeing of these lay counsellors can play an important role in the effectiveness of their services.

Lay HCT counsellors

HCT serves as an entry point to all HIV prevention and treatment services (DoH, 2010, 2011). HCT is the counselling process to enable an individual make an informed choice about being tested for HIV and to learn about their HIV status. Clients should receive support to alleviate the distress and accept a positive HIV diagnosis (Van Dyk, 2013).

Research on HCT mostly focuses on the implementation challenges (Friedman et al., 2007) and effectiveness of services (Myint & Mash, 2008; Petersen et al., 2014) and the experiences of HCT counsellors (Mavhandu-Mudzusi et al., 2007; Richards and Marquez, 2005; Rohleder & Swartz, 2005). The governance, remuneration, lack of training and supervision and management of lay counsellors were identified as crucial challenges in implementation (Daniels et al., 2010; Friedman, 2005; Peltzer & Davids, 2011; Petersen et al., 2014; Schneider et al., 2008; Thurling & Harris, 2012). A few studies evaluated the ability of lay counsellors to implement counselling. Dewing et al. (2013) raised concern about the quality of counselling delivered by lay counsellors, because they mainly provide information and advice and not counselling and support (Haffejee et al., 2010; Van Rooyen, 2013). A systematic review of 29 studies showed that lay counsellors in the South African context can be effective if they are appropriately trained and supervised (Peterson et al., 2014). This is confirmed in recent literature (Dewing et al., 2015; Kabamba, 2009; Murray et al., 2011; Peltzer et al., 2009).

Another crucial element of effective counselling that has been neglected in research, is the emotional wellbeing of HCT counsellors. Emotional wellbeing can directly affect the quality of counselling services (Corey, 2009). Core counselling competencies include how a person relates to him/herself, others and the social environment (Moss et al., 2014). Lambie et al. (2010) identified empathy, flexibility, taking alternative perspectives, self-care and emotional wellbeing as key components of effective counselling. The expectation is that counsellors should function on a higher level of emotional wellbeing than their clients to model a way of being for their clients (Corey, 2009).

Emotional wellbeing

Bar-On (2010) defines emotional wellbeing as an array of interrelated emotional and social competencies that determine how well individuals understand and express themselves, understand others and relate to them and cope with daily demands, challenges and pressures. This includes strengths and characteristics, such as self-regard, empathy, social awareness, self-regulation of emotions, self-actualisation and the ability to generate happiness.

Ryff's (1995) definition of psychological wellbeing clearly shows the overlap between wellbeing and effective counsellor characteristics. He defines wellbeing as a positive evaluation of oneself and one's past life (self-acceptance); sustained growth and development (personal growth); the belief that life is meaningful (purpose in life); the establishment and sustaining of quality relations with others (interpersonal ability); and the capacity to effectively manage one's life and surrounding world (self-determination and autonomy). This describes the effective counsellor as self-aware, emotionally sensitive and having effective relational capacity. These aspects will be assessed in this research.

Keyes (2007) presents an interesting perspective on wellbeing. He states that the presence and absence of symptoms of mental illness can coexist with various subjective experiences of wellbeing. This means that the presence of psychological symptoms can coexist with positive feelings of having meaning in life. This multidimensional approach will be used in this research to understand the wellbeing of HCT counsellors.

In previous research HCT counsellors reported that counselling has both negative and positive effects on their emotional wellbeing (Kabamba, 2009). Many counsellors experience HCT as emotionally draining. The main sources of emotional stress among lay HCT counsellors were: emotional involvement and internalisation of some of the hardships of their clients; uncertainty and being unprepared for situations that may arise in counselling; and a lack of emotional outlet and support (Held and Brann, 2007). Other stressors were the consistent exposure to illness and death and their own personal fears and vulnerability of being infected and being stigmatised based on their work in an HIV context (Akintola, 2008; Mavhandu-Mudzusi et al., 2007; Molefe, 2005; Peltzer & Davids, 2011; Rohleder & Swartz, 2005). HCT counsellors often experience the same fears and vulnerabilities as the clients they counsel. These experiences can negatively influence the emotional wellbeing of HCT counsellors. Peltzer and Davids (2011) found that 78% of lay counsellors in their study experienced high levels of job stress and that 31% felt emotionally drained by their work. At the same time almost two-thirds experienced high levels of job satisfaction. In another study Peltzer (2012) found that 20% lay HIV counsellors experience symptoms of post-traumatic stress disorder (PTSD) symptoms (much higher than the population average). In this study 20.5% of the counsellors indicated that they were HIV-positive, which could affect their emotional wellbeing/mental health (Breuer et al., 2011). About half the counsellors (49.5%) were unsatisfied with their work environment.

However, various studies reported positive experiences of counsellors which included feelings of empathy, hopefulness, compassion and a desire to help (Dageid et al., 2007; Mavhandu-Mudzusi et al., 2007; Molefe, 2005; van Dyk, 2007). HIV caregivers identified self-growth, inner strength and psychological development as rewards of providing support. They feel socially connected and that they have something of value to offer (Akintola, 2010). The perceived rewards can serve as a buffer against emotional stress.

This research explores the emotional wellbeing of lay HCT counsellors as one of the components that contribute to effective counselling. The expectation is that depression and burnout of HCT counsellors might be high, but that they may have positive relationships and experience personal accomplishment in their work.

Research methods

A mixed methods design was used (Cresswell & Clark, 2011). The emotional wellbeing of lay counsellors was assessed and focus group discussions were held to facilitate understanding of their experiences. Mixed methods contribute to the validity of the results.

Study population

Participants in the study were 50 lay HCT counsellors working in the City of Tshwane health clinics (a typical metropolitan area in Gauteng, South Africa). The researcher contacted all 28 clinic managers where HCT counsellors were based to request their participation in the research. Two clinic managers were unavailable and another two did not allow the HCT counsellors to participate in the research, as they felt it would disrupt the clinic activities. The researcher contacted all the lay HCT counsellors at the 24 participating clinics. Those who agreed to participate signed informed consent forms. The questionnaires were administered in small groups at their respective clinics; the focus group discussions were conducted at a central venue close to the clinics.

Data collection tools

A self-report data collection battery was used to assess emotional wellbeing, as it was only the respondents who can report on their subjective experiences (Diener et al., 2005). The multidimensionality of wellbeing was assessed through aspects of positive wellbeing (emotional wellbeing and coping) and negative components (depression and burnout).

Demographic questionnaire

Participants' age, educational level, average number of clients per day and number of hours they work per day were recorded.

Bar-On Emotional Quotient Inventory

The Bar-On Emotional Quotient Inventory (EQ-i) gives a comprehensive assessment of emotional wellbeing as an array of non-cognitive capabilities and skills (Bar-On, 2010). It contains 133 items, which make up 5 scales and 15 sub-scales. The five scales measure: intrapersonal and interpersonal capacities, stress management, adaptability and general mood (Bar-On, 2002, 2005). The EQ-i showed high internal consistency in various studies. A test-re-test reliability of 0.75 was obtained after four months for a sample of South African students (Bar-On, 2002). In our study a Cronbach alpha of 0.85 was obtained. Various studies have established the validity of the EQ-i for South African populations (Ramesar et al., 2009). The responses of HCT counsellors were compared to a South African general population norm group.

The Maslach Burnout Inventory for Human Services Survey

The Maslach Burnout Inventory for Human Services Survey (MBI-HSS) is a 21-item survey that comprises 3 sub-scales: Emotional exhaustion (e.g. 'I feel emotionally drained from my work'), depersonalisation (e.g. 'I feel I treat some of my recipients as though they were impersonal objects') and personal accomplishment (e.g. 'I have accomplished many worthwhile things in my job') (Maslach et al., 1996). A high degree of burnout is reflected in high scores on emotional exhaustion and depersonalisation and low scores on personal accomplishment. Cut-off points indicating high levels of burnout were developed for a sample of mental health workers and are internationally used. A meta-analysis of 51 MBI-HSS studies found high levels of reliability for all scales (Aguayo et al., 2011). In our study a Cronbach alpha of 0.86 was obtained for the scale as a whole. Support for the construct validity of the MBI-HSS for South African samples was confirmed using the international cut-off points (Naudé and Rothmann, 2004).

The Centre for Epidemiologic Studies Depression Scale

The Centre for Epidemiologic Studies Depression Scale (CES-D) is a 20-item scale designed to assess the intensity of depression symptoms, as defined by the DSM IV criteria in the general population. It assesses positive affect, negative affect, somatic symptoms and interpersonal feelings. The scale assesses how often the participant experiences symptoms associated with depression during the past week on a 4-point scale (Radloff, 1977). A Cronbach alpha coefficient of 0.88 was reported in a South African study (Makin et al., 2008). In our study a Cronbach alpha of 0.81 was obtained. The validity of the CES-D to detect depressive symptoms in low income countries as well as in HIV and primary healthcare settings has been established (Akena et al., 2012; Makin et al., 2008). Some South African studies used the US developed cut-off points for depression (Hamad et al., 2008) while others (Simbayi et al., 2007) used a midpoint or the three-level categorisation to categorise levels of depression: <16 not depressed; 16–22 distressed and >23 depressed.

The Brief COPE Scale

Coping refers to cognitive and behavioural efforts to manage specific external and internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus & Folkman, 1984). The Brief COPE scale consists of 14 scales of 2 items each (Carver, 1997). The scale assesses the use of the following positive coping strategies: active coping, planning, instrumental support, emotional support, positive reframing, religion, acceptance, humour; and negative coping strategies: emotional venting, behavioural disengagement, mental disengagement, self-blame, substance abuse and denial (Carver, 1997). In a South African study the Cronbach alpha was 0.63 for the scale as a whole, 0.75 for positive and 0.54 for negative coping (Makin et al., 2008). In our study a Cronbach alpha of 0.77 was obtained for the scale as a whole.

Focus group discussions

Five focus group discussions were conducted including all the lay HCT counsellors. In each group there was an average of eight counsellors from different clinics. The discussions were conducted in the vernacular of the counsellors (Sesotho and IsiZulu) as the researcher is fluent in both languages. This was done to encourage participation and increase the validity of findings. The following questions were discussed:

- What is the most rewarding experience in HIV/AIDS counselling?
- What is the most challenging experience?

All discussions were audio-recorded with permission from the participants. The researcher verified her interpretation of the information shared.

Data analysis

Descriptive analysis was done by calculating mean scale scores. The results of the EQ-i scales were compared to a South African general population norm group (Van Rooyen, 2006) while the cut-off scores of the burnout and depression scales were used to interpret the results. Non-parametric tests were used to compare the scores

of participants in different age and gender groups. Inter-correlations of all variables were done followed by a backward stepwise multiple regression analysis with depression as dependent variable. This was done to determine the variables contributing to negative wellbeing that should be addressed in an effort to promote wellbeing. Quantitative analysis was done using SPSS 20.0 for Windows.

Recordings of focus group discussions were transcribed and translated into English and integrated with the field observations. Thematic analysis was done to identify and categorise themes and patterns in the data (Braun & Clarke, 2006). To enhance the validity of the data interpretation, the researcher's initial understanding was confirmed by the participants (member checking) and a co-researcher assisted in data interpretation. The qualitative data related to emotional wellbeing is presented to confirm and clarify aspects of the quantitative data.

Ethical approval

The study was ethically approved by the Ethics Committee of the Faculty of Humanities, University of Pretoria. Permission to conduct the study was obtained from the provincial Department of Health, the City of Tshwane Health Services and clinic managers.

Results

Work context

Participants in the study consisted of 46 women and 4 men aged between 20 and 74 years. Most of the counsellors had some secondary school education and completed Grade 11 (42%) or Grade 12 (44%). Lay HCT counsellors reported that they worked between 20 and 40 hours per week. They counselled between 10 and 30 clients per day. Most counsellors (48%) counselled 10 to 16 clients, while 20% counselled 24 to 30 clients per day (15 minutes maximum per client.) The training that counsellors received varied across clinics, although most had training in HIV/AIDS facts (82%) and basic counselling skills (88%).

Emotional wellbeing

The total self-reported emotional wellbeing of lay HCT counsellors was below average (88.76) on the EQ-i, compared to the South African general population norms. This suggests that the emotional functioning of the counsellors is lower than that of the general population. The highest scores of the counsellors were on the *interpersonal* scale (97.17) and *stress management* (98.26), which was within the average range. Counsellors scored lower on the *intrapersonal* (90.68), *general mood* (90.22) and *adaptability* scales (86.48) (Figure 1).

The highest sub-scale scores were for self-regard, interpersonal relationships, and impulse control — all characteristics of value in counselling relationships. Subscales with the lowest scores (below average) were independence, self-actualisation, reality testing and happiness. The below average level of self-actualisation and happiness cause some concern. Counsellors thus do not feel able to reach their potential (lower self-actualisation) and express a generally negative mood (lower happiness). These EQ-i scores indicate that the effective functioning of counsellors could be compromised somewhat by a lower level of emotional functioning — less than expected from a person in the helping professions (Corey, 2009).

Burnout

Lay HCT counsellors experienced high levels of emotional exhaustion, as well as high levels of personal accomplishment (Table 1). Depersonalisation scores were less than the cut-off point for burnout.

Emotional exhaustion was the highest amongst counsellors between the ages 20 and 39 years (Figure 2). Counsellors 50 years and older had the lowest emotional exhaustion and the highest sense of personal accomplishment (chi square = 9.953; $p < 0.05$).

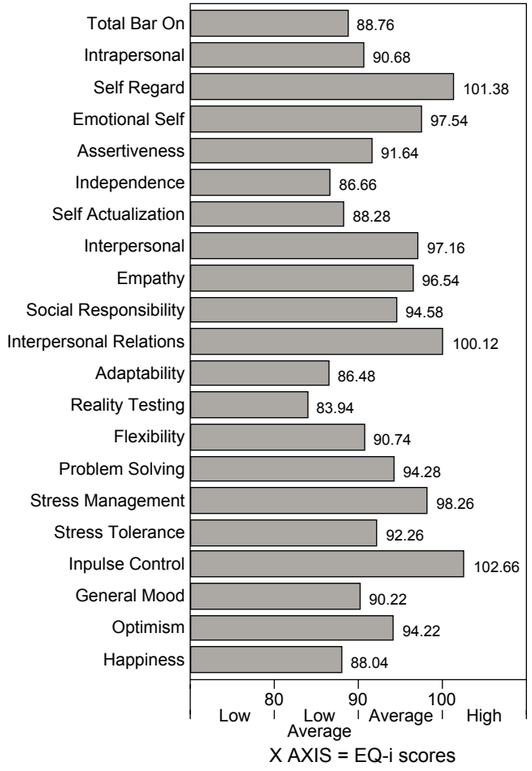

Figure 1: Bar-On EQ-i composite and sub-scale scores of HCT counsellors

Table 1: Maslach Burnout Inventory — HSS scores of HCT counsellors (n = 50)

	Cut-off points	Mean	SD	Min	Max
Emotional exhaustion	≥21	27.66	12.671	0	51
Personal accomplishment	≤28	38.64	5.791	22	48
Depersonalisation	≥8	6.50	5.791	0	20

*Cut-off point indicates the level when burnout is implied (28)

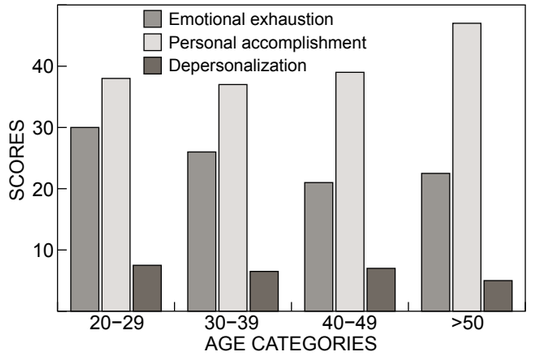

Figure 2: MBI-HSS scores of HCT counsellors by age categories

In the qualitative data HCT counsellors related their feelings of emotional exhaustion to the trauma of working with highly emotional topics like illness, fear and death:

> *"I was doing couple counselling and the husband died as I was busy with them. You know he (the husband) was so shocked that he died in front of me. That experience is in my mind and it does not come out."*
>
> *"All of a sudden the clients would stop coming for treatment and you try to call and they don't answer the phone and then later you hear that the person has passed away. We worry about them all the time once they have stopped coming." ARE THESE FROM DIFFERENT COUNSELLORS?*

Emotional exhaustion scores seemed to increase with the number of reported clients counselled per day. Counsellors with more than 20 clients per day experienced more *emotional exhaustion* than those with fewer clients. The pressure of high work load is illustrated in the qualitative data:

> *"When I talk with a client, I am told that 'can't you see that there is a queue outside?' And the client leaves very unsatisfied because he was pushed away because of the queue. You should know that chances are that the client won't come back."*

Burnout is often related to over-identification and over-involvement with clients**.** Lay HCT counsellors described how they took on the responsibility of doing all they could to meet their clients' needs, even if it was beyond the boundaries of HCT. They had difficulty maintaining healthy boundaries with their clients and over-extended themselves to help:

> *"I had a client whose child tested positive. The challenge was that she had no money. I was in such a personal predicament, I bought baby formula for the lady's child and it is expensive."*
>
> *"Sometimes clients come for follow-ups without taxi fare, and I would end up giving them money and a little for bread when they get home." ARE THESE FROM DIFFERENT COUNSELLORS?*

Counsellors expressed feelings of loneliness and being overwhelmed when dealing with the highly emotional content in their sessions. They did not receive guidance and supervision and felt left to their own devices to deal with the emotional challenges they face:

> *"There is no one responsible for counsellors. We have no one who guides us or listens to us."*

The counsellors' sense of personal accomplishment is echoed in their responses in the focus group discussions. They experienced counselling as rewarding. They could see the positive effect of their work and the appreciation of their clients:

> *"Sometimes the people appreciate you. It makes you feel good. You realise that you are doing an important job. You are doing something good for them."*
>
> *"The appreciation they give us is amazing and it makes you feel very good- like you matter. Last week there was a client who came to thank me. She said: you have given me my life back." ARE THESE FROM DIFFERENT COUNSELLORS?*

Depression

The lay HCT counsellors reported moderate to high levels of depression with a mean score of 26.08 (using both types of scoring systems mentioned). Younger counsellors in the 20–29 years and 30–39 years age groups had the highest depression scores (scores of 27.58 and 29.05), which can be interpreted as an indication of major depression. The results showed there is an increase in the level of depression with increasing numbers of clients per day. Counsellors with more than 20 clients per day had the highest depression scores.

Coping strategies

Lay HCT counsellors used more positive or active coping strategies than negative or avoidant coping strategies (Figure 3). They used religion, planning and direct action the most. In the negative coping category they used distraction and emotional venting. They did not use humor, behavioural disengagement, self-blame and substance abuse often as coping strategies.

Inter-correlations of variables

The inter-correlation of all sub-scales of the EQ-i, MBI, CES-D, and Brief COPE was calculated. All sub-scales of the EQ-i showed high inter-correlations and are not reported here. All other significant correlations are presented in Table 2.

There were significant positive correlations between depression, emotional exhaustion and depersonalisation. Depression also correlates negatively with positive coping, emotional self-awareness, assertiveness, reality testing and impulse control, all positive characteristics counsellors need to provide effective counselling. Depression is thus related to less positive coping and ability to help their clients.

Emotional exhaustion was positively correlated with interpersonal relationship, empathy and flexibility (sub-scales of interpersonal scale). This may imply that counsellors with positive interpersonal skills and empathy may be more inclined to emotional exhaustion. However,

none of the relationships identified can be regarded as causal without further analysis.

To understand these inter-correlations and to exclude interactive effects, the variables with significant correlations were entered into a backward stepwise multiple regression analysis, with the CES-D score as dependent variable (Table 3). The model fitted the data well ($F = 4.769$, $p < 0.001$) and explained 35% of the variance. Depression was related with depersonalisation and inversely related to positive coping, assertiveness and emotional self-awareness. If an individual's coping, assertiveness and self-awareness can increase, levels of depression might decrease.

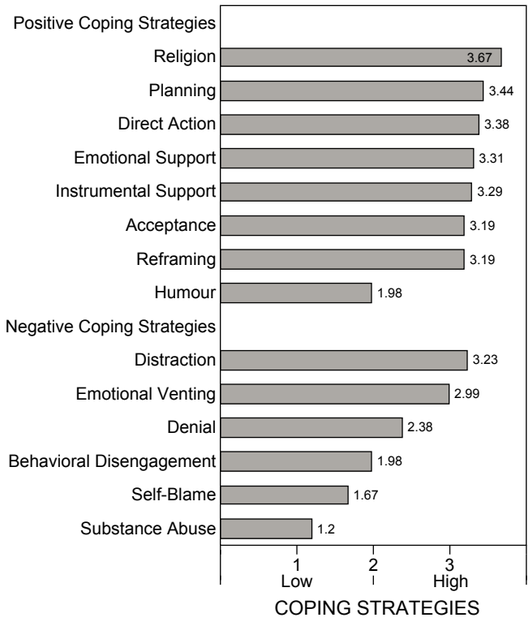

Figure 3: HCT counsellors' coping strategies

Table 2: Inter-correlations of sub-scales

Scale	Sub-scale	*r*-value	*p*-value
CES-D	Depersonalisation	0.310	$p < 0.05$
CES-D	Emotional exhaustion	0.185	$p < 0.05$
CES-D	Positive or active coping	−0.407	$p < 0.01$
CES-D	EQ-i emotional self-awareness	−0.287	$p < 0.01$
CES-D	EQ-i assertiveness	−0.382	$p < 0.01$
CES-D	EQ-i reality testing	−0.294	$p < 0.05$
CES-D	EQ-i impulse control	−0.255	$p < 0.01$
Emotional exhaustion	Depersonalisation	0.408	$p < 0.01$
Emotional exhaustion	EQ-i interpersonal relationships	0.361	$p < 0.01$
Emotional exhaustion	EQ-i empathy	0.316	$p < 0.05$
Emotional exhaustion	EQ-i flexibility	0.290	$p < 0.05$

Table 3: Regression analysis with CES-D as dependent variable

Model	Unstandardised coefficients		Standardised coefficients	*t*	Sig. IS THIS SIGNIFICANCE?
	B	Std. Error	Beta		
MBI-HSS Depersonalisation	0.493	0.242	0.260	2.038	0.048
Positive or active coping	−0.452	0.169	−0.338	−2.682	0.010
EQ-i assertiveness	−0.237	0.102	−0.377	−2.315	0.025
Emotional self-awareness	−0.158	0.104	−0.099	−1.560	0.050

Discussion

The research highlights that the emotional wellbeing of lay HCT counsellors employed in the public healthcare system was below average. They experienced high levels of emotional exhaustion and depression that could influence the quality of counselling they can offer. This is in agreement with the expectations and previous research.

The emotional wellbeing scores were below average in comparison with a general population norm group. Their interpersonal relationships, self-regard and impulse control were high, which are positive characteristics for counsellors. They reported low average scores on independence, self-actualisation (intrapersonal) and low levels of happiness. Their adaptability and reality testing reflected a lower level of adjustment. One would expect that a counsellor should score higher on these components of emotional wellbeing to be able to counsel others (Corey, 2009).

It is also of concern that the HCT counsellors reported high levels of emotional exhaustion. Emotional exhaustion often results from high efforts of time, emotional involvement and highly demanding working conditions (Polikandrioiti, 2009), such as high client loads in this study. The qualitative data showed that counsellors were often over-involved with the emotional trauma of their clients. They worried about their clients, were affected by the intense emotional trauma and extended themselves beyond the boundaries of counselling to provide clients with food or money. This resulted in a lack of professional boundaries and added emotional burdens for the counsellors, resulting in emotional exhaustion/compassion fatigue (Ward-Griffin et al., 2011). It was the counsellors with high interpersonal relationships and empathy who reported more emotional exhaustion. This process can become a negative cycle which results in ineffective counselling and poor client outcomes (Thorsen et al., 2011).

Similarly, the moderate to high levels of depression lower the counsellors' ability to relate to clients. The regression analysis showed that depression was associated with lower levels of positive coping, lower assertiveness and lower self-awareness. It may thus be difficult for a person with high levels of depression to provide effective counselling. The high depression scores may partly be explained by the context, since depression was found to be higher in low socio-economic contexts and among HIV-infected individuals (Myer et al., 2008). In their work, HCT counsellors are constantly confronted with emotional issues of illness and fear of death without appropriate supervision and support systems. This may decrease the effectiveness of the counselling services they provide, as stress lowers one's emotional sensitivity (Bar-On, 2002).

In contrast, the counsellors reported positive ways of coping and high levels of personal accomplishment. They experienced their work as intrinsically rewarding and of value to others. Counsellors thus have strengths to cope with the high level of stressors related to their work.

Lay HCT counsellors play a crucial role in the healthcare system and form a cornerstone of the HIV/AIDS treatment programme. The dilemma is that the lay HCT counsellors are not qualified to deal with the clients' emotional distress. They do not receive adequate training and supervision for the work they have to do (Daniels et al., 2010; Dewing et al., 2013). This therefore results in the counsellors' high levels of emotional exhaustion and depression which could negatively affect the quality of the counselling they provide. From a healthcare perspective it may even be regarded as unethical to allow people with very basic training to deal with the emotional traumas of HIV-patients without appropriate training, support and supervision. These gaps in the system of using lay HCT counsellors need to be addressed urgently.

It is essential that a measure of formal professionalism is brought into the system by providing teams of HCT counsellors with formally appointed qualified supervisors. This needs to be augmented by developing an effective system of recruiting and selecting volunteers who will be able to balance empathy and professional boundaries. There is a need to formalise the training of lay counsellors so that they can develop the emotional capacity to deal with their own emotions and that of their clients. In fact, Bar-On (2007) suggests that emotional wellbeing can be enhanced through educational methods in a short period of time. Counselling training should help them to establish boundaries in professional relationships. The results of the regression analysis emphasised that counsellors need more self-awareness, self-assertiveness and positive coping skills to enhance their emotional wellbeing.

The most positive aspect from this research is the finding that counsellors find rewards and purpose in their work and experience high levels of personal achievement leading them to remain committed to their work.

Limitations of the study

The scales used to collect data were self-report measures which could result in some bias responses. The EQ-i is a psychological instrument which requires a reading ability of Grade 4. All counsellors had secondary school education and a functional knowledge of English, but English was not their vernacular. The researcher explained everything in their vernacular and encouraged counsellors to ask if they did not understand the questions. There could have been items which they did not understand completely.

The research was conducted among all HCT counsellors in a specific region (Tshwane, a typical metropolitan area) and not among a representative sample of all lay HCT counsellors in the country. This could have influenced the generalisability of the results.

Conclusion

This study provides valuable information on the emotional wellbeing of lay HCT counsellors as a requirement for effective counselling. The findings indicate that counsellors present with high levels of emotional exhaustion, depression and average emotional wellbeing. This shows that they do not have the emotional capacity to deliver counselling services beyond providing of information. Because of the importance of lay counsellors in the healthcare system in developing countries it is important to optimise these services. Petersen et al. (2014) made it clear that optimising lay counsellor services requires clear definitions of scope of practice, in-service-training, formal supervision and recognition of the importance of lay counselling. The results of the study provide key lessons learnt which could contribute to the development of lay counsellors in various health contexts.

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