

Lay Counselor Experiences Providing a Family-Based Therapy in Kenya: A Focus on
Identity, Stress, Burnout, Motivation, and Self-Efficacy

by

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Thesis submitted in partial fulfillment of
the requirements for the degree of
Master of Science in the Duke Global Health Institute
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ABSTRACT

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Abstract

As health systems continue to implement task shifting models to overcome health access barriers and inequity, it is critical to understand the experiences of lay individuals in these new roles. This is particularly true for lay counselors who provide mental health services. This study sought to understand lay counselor experiences through the lens of identity, stress, motivation, burnout, and self-efficacy. Semi-structured interviews and focus group discussions were conducted with three groups of lay counselors with varying levels of counseling experience from a family therapy program in Eldoret, Kenya. Using thematic analysis, emergent themes were explored to characterize counselor experiences and inform task shifting implementation improvements. Such research provides crucial insight so that future interventions can improve support of lay providers.

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1. Introduction

A major issue experienced by low- and middle-income countries (LMICs) is a lack of adequate healthcare access due to a limited number of healthcare professionals. This is especially true regarding mental healthcare (Bruckner et al., 2011; Kock & Pillay, 2018). The healthcare approach of task-shifting, or task-sharing, helps alleviate this problem by training local community members to provide certain treatment services, often under the supervision of a healthcare professional. This system includes a variety of lay individuals, most often community health workers (CHWs), extending a diverse set of healthcare services from paramedical emergency to maternal healthcare (Lehmann & Sanders, 2007).

Studies have also shown that task-shifting models can be effective and feasible for mental healthcare, the topic of the current study (Kakuma et al., 2011). Examples include the “Friendship Bench” suicide ideation intervention in Zimbabwe (Munetsi et al., 2018), a psychological distress intervention in Pakistan (Rahman et al., 2016), a mobile phone assisted schizophrenia intervention in Liuyang, China (Xu et al., 2016), and recently the “PASS Plus” intervention for Autism Spectrum Disorders in India (Divan et al., 2019).

The purpose of this study was to better understand the experiences of community-based lay counselors delivering a family-based therapy. The primary focus was the ways in which their social roles and sense of identity shift when becoming a counselor, and the ways this shift may influence their levels of stress, motivation, burnout, and self-efficacy.

1.1 Challenges of Task-shifting Approaches

For decades, lay health workers have worked in low-resource countries to decrease health disparities (Newell, 1975). Numerous studies showing the benefits of their community presence have led to the World Health Organization (WHO) affirming their

necessity in such settings (World Health Organization, 2007). Despite their necessity, a growing research body details many challenges faced by lay health workers. Most commonly documented are cases of severe social and economic inequities experienced by CHWs (K. C. Maes, Kohrt, & Closser, 2010). This inequity is due to current task-shifting models that employ volunteerism without substantial compensation. Such models are perpetuated by limited funding and dismissal of the need to pay CHWs due to “conflict of interest,” whereby lay providers may lose their intrinsic motivations to perform their roles if paid (Kohrt & Mendenhall, 2015; K. C. Maes et al., 2010).

Beyond social and economic inequities, major problems associated with this current model also include issues of maintaining motivation, overwork and burnout, and worker retention (Strachan et al., 2015). These are all key areas for concern because they have direct consequences on the efficacy and quality of task-shifting activities in the low-resource areas they typically serve. Ultimately, the problem with current task-shifting models is that CHWs are too often treated as means to an end, rather than as actual individuals in need of special support. There is not enough focus on CHWs as people themselves, or on the support networks they may need to optimize the care they provide. Some of the most extensive work on experiences of lay health workers and suggestions for future action has been by Maes and colleagues. In particular, they advocate for future research into understanding individual motivations for becoming and remaining CHWs (K. Maes & Kalofonos, 2013). The goal is to foster a humanistic view of CHWs and encourage global health actors to stop treating CHWs as “magic bullet” human resources, and instead as people with unique skills, desires, and perspectives (K. Maes, 2015). In doing so, the

global health community will be able to better support this crucial population of healthcare workers.

1.2 Role Identity Theory: Role Shifts

The question that arises following this review of task-shifting challenges influencing CHW experiences is what exactly is causing these changes in areas like stress and motivation. Past studies have pointed to the additional workload, or responsibilities, in combination with the socioeconomic inequalities CHWs contend with. However, one possibility we examine is that the cause of these changes may be a step further back, found in simply taking on the new role.

Useful in framing this issue, role identity theory posits that all people have multiple identities and roles, under a hierarchical arrangement, that motivate behaviors (Siebert & Siebert, 2007). Within role identity theory, roles can be seen as a set of relationships which receive feedback from each other. This feedback shapes and reshapes the meaning of individual identities constructed from these roles (Mlotshwa, Harris, Schneider, & Moshabela, 2015). As individuals move about their lives, learn new skills, and interact with new people, they constantly take on new roles. These roles are added to their “role set,” or group of roles, like adding unique tools to a toolkit. Within this framework, and the present study, role shifts are defined as changes or reshaping of a role set due to relationship interactions, new social positions, and new duties or expectations. Such shifts in social roles occur after lay individuals receive health-related training and take on a new role as a health worker.

This theory can be better explained using a theater analogy, which is a common reference point used to describe and explain role theory (Goffman, 1959). Roles can be

seen as different characters an individual performs, depending on the social context, or “shows,” when they find themselves participating in a certain context. Such interactions include a special script of acceptable actions and expectations of the actor’s character, that are also shaped by the actions of other actors on the stage. Thus, the process of taking on a new role (i.e. learning one’s lines, choreography, expectations, etc.) and integrating it into the expansive repertoire of one’s role set can be an experience that produces positive and negative changes in the individual. This is especially true as an individual may have to reassess their identity, given this new role. This process and interactions represent the basic concept of role identity theory.

Such role shifts have been examined in community health workers in the work of Mlotshwa and colleagues (2015). For their work with CHWs in South Africa, Mlotshwa (2015) found CHWs often began their “caring work” before they formally joined the health organizations. After taking on their provider role, there was a sense of elevated status within the community, but also a shift or creation of community role identities that Mlotshwa classified as “insider,” “outsider,” and “broker,” which were all associated with tensions faced by the CHWs. Mlotshwa concluded that understanding the role identities, and how best to support them, would potentially contribute to strategies of retention and sustainability of CHW programs (Mlotshwa et al., 2015). With this in mind, role shifts are the primary focus of this study because they have been shown to influence the key areas of CHW experiences as they take on their new provider roles.

1.3 Stress, Burnout, Motivation, and Self-Efficacy

Reviewing the current literature on lay health workers, the four most common areas that are discussed include lay provider stress, burnout, motivation, and self-efficacy. Given

the utility and applicability of these domains in previous studies, we used these four constructs to try to understand the experiences of lay counselors as they fulfill their daily responsibilities.

The first construct is feelings of motivation for lay counselors. Motivation is defined as the intrinsic and extrinsic forces, beliefs, and ideals that incline an individual to pursue and maintain their position as a lay counselor (Brief & Aldag, 1977). Although current policy discourse often turns to financial incentives to motivate lay health workers, other salient motivating factors have been found. In their qualitative study of primary care workers in Nigeria, Bhatnagar and colleagues (2017) found that motivation can be influenced by individual factors (such as religion, humanity, and vocation), organization factors (such as work environment), and community recognition. For their population of CHWs in North India, Tripathy, Goel, and Kumar (2016) described positive and negative influences on worker motivation, such as burnout, poor supportive supervision, love for work, and community support/recognition. They advocate for investment in non-financial motivators including interpersonal relations, family support, and skill/career development opportunities to improve motivation.

The second construct is self-efficacy of lay counselors, meaning their individual perceptions and assessments in their capability to be competent and effective in counseling their client (Gecas, 1989). Feelings of self-efficacy and the importance of competency and training were expressed by the participants in Tilahun and colleagues' (2017) study of child mental health CHWs in sub-Saharan Africa. Although their initial training was brief, participants not only felt it improved their knowledge and care provision capabilities, but also advocated for future training because of its perceived importance. Along the same

lines, for their study of CHWs in various countries in sub-Saharan Africa, Kok and colleagues (2017) found that feelings of connectedness, familiarity, perceived support, competency, honesty, and trust between CHWs, the health sector, and community, all influenced their ability to perform their jobs.

The third construct is stress (physical, psychological, emotional, social) experienced by the lay counselors. Stress is defined as the positive and negative stimuli that affect a lay counselor, through the avenues listed previously, due to trying to fulfill the duties and responsibilities expected of them by their clients, supervisors, and communities. In their study of community health agents in Brazil, Santos and David (2010) found that common sources of stress included overwork combined with short deadlines and complex client visits, emotionally charged situations dealing with extreme poverty, and concerns for security and safety. Further sources of stress described by CHWs in Kenya included community member expectations and dealing with situations that fall outside their training, such as what to do if they discovered a case of child abuse (Oliver, Geniets, Winters, Rega, & Mbae, 2015).

The final construct is feelings of burnout experienced by lay counselors. Burnout, is defined as a combination of feelings of work-related exhaustion, cynicism, and inefficacy due to the daily routine and duties required for a counselor, which can manifest in physical and behavioral changes (Cedoline, 1982; Freudenberger, 1974). This term has been described using a spring analogy. Normally, a spring may be stretched or strained during use and can return to its original form, but can be stretched or pulled so much it breaks and cannot continue to fulfill its role. In their study of CHWs in Liaoning Province, China, Ding and colleagues (2014) found that burnout was a mediator for the effects of

occupational stress on anxiety symptoms. They concluded that burnout management must be considered to reduce anxious outcomes. Pandey and Singh (2016) found similar results in their population of women CHWs in India, in that there is a strong relationship between emotional health, job satisfaction, and burnout symptoms. Even more concerning is Selamu and colleagues' (2017) qualitative study of CHWs in Ethiopia concerning job-related wellbeing, stress, and burnout. Not only was burnout recognized and stigmatized in long-term workers "drained of all compassion," but it was also seen as inevitable if current workplace conditions persisted without career progression.

1.4 Study Rationale and Aims

In addition to previous research that has illuminated different challenges faced by CHWs, there is a need to improve an understanding of both what causes such tensions and how individuals cope when they occur. The current study builds upon the previous work in the field and aims to address this gap.

This study's primary research question is: How do people trained as lay counselors experience role and identity shifts, and how are these perceived shifts related to experiences of stress, burnout, motivation, and self-efficacy? We examined this change within a group of lay counselors delivering a family-based intervention in Kenya. To understand how these experiences vary by experience level, we compared across counselors with varying levels and length of experience in their new counseling roles. This included newly trained lay counselors, those who have been counselors for over a year, and those who were trained but not ultimately assigned a client family for a variety of reasons. This study also contributes to the literature in that the implementation of this intervention, described in the methods, is unique in some ways and designed to address some of the stressors facing lay

providers. Thus, results speak to whether the experiences of lay providers may be different than those working within more typical community health worker roles, in positive or negative ways.

Aim 1. Describe social role and identity shifts in counselors, as well as the causes of those shifts: We examined ways in which the roles of people who become community-based lay counselors have changed in their social groups, such as experiencing changes in expectations or status, and how those have affected their sense of identity.

Aim 2. Describe stress, burnout, motivation, and self-efficacy and their interactions in counselors: We examined counselor perspectives on their experiences of stress and feelings of burnout, and any changes in motivation or feelings of self-efficacy since taking on their new counseling role. We also looked at connections and interactions between these domains and identified existing supports and coping strategies of lay providers when experiencing fluctuating changes in these areas.

2. Methods

As detailed below, semi-structured interviews and focus group discussions (FGDs) were conducted to explore lay counselor experiences providing a family-based therapy in Eldoret, Kenya. Lay counselors were providing the intervention as part of pilot studies testing the intervention content and implementation strategy, both of which are described in subsequent sections.

2.1 Setting

The study was located in peri-urban communities which surround the town of Eldoret in Uasin Gishu County, Kenya (3,345 km²) as part of a collaboration with AMPATH and Moi Teaching and Referral Hospital. Eldoret is the fifth largest city in Kenya with a population of almost 300,000 in the 2009 census (USAID, 2012). Some residents in this area have access to mental health services through Moi Teaching and Referral Hospital that provides some limited inpatient and outpatient care; available treatment focuses primarily on adults with serious mental illness and, to some extent, common mental disorders. However, very little child- or family-specific training or treatment is available, and community-based approaches are uncommon.

2.2. Intervention and Implementation Strategy

The family-based therapy intervention was designed to intervene in child mental health for families with complex issues and needs by improving their family functioning and behavioral interactions. *Tuko Pamoja* (TP, “We are Together” in Kiswahili) was delivered by supervised lay providers recruited from the community and not part of a government or NGO organization. They were referred by community leaders asking for community or church leaders, and local churches because they were identified as “natural

counselors,” described below. Although they were from different pilot studies, which varied slightly in design and recruitment, every study participant completed identical training regimens to provide the TP therapy.

The TP intervention is module-based, tailor-made to fit the specific needs of each family, delivered in homes, with a focus on generating solutions to influence the entire family system. It is not time-limited, with families allowed to move at their own pace; guidelines suggest one hour-long sessions. In its first pilot trial, counselors held an average of 15 sessions with a mean length of 40 minutes, totaling an average treatment exposure of 9 contact hours. Prior to beginning, TP counselors complete approximately 60 hours of training. After training, counselors are very active in recruiting families to participate mirroring the natural ways in which they have already been connecting with families for informal counseling.

The implementation model for this intervention is different in some ways from the approaches in many task-shifting interventions. One main difference is that rather than having absolutely no experience, the lay care providers are from religious and community organizations who are recruited because they already engage in informal counseling roles; that is, they already spend time in an informal counseling role and have shown sustained interest in these types of activities. The training in the family therapy intervention is then meant to augment and, in some cases, replace, some of their current informal advice-giving practices with more evidence-based strategies. After being trained, counselors are expected to give about the same time commitment to counseling that they already had before they were trained, therefore not increasing their workload; in most cases, this means maintaining

a very low caseload by design. This strategy was chosen to reduce some of the lay provider concerns mentioned previously.

2.3 Participants

Individuals were included in the study if they attended or completed TP counselor training as part of the TP pilot studies. The individuals who fit these criteria were directly recruited by a TP supervisor using paper handouts and verbal summaries of study components. The counselors belonged to three groups based on their counseling experience with TP. The experience groups, “Moderate,” “Minimal,” and “No TP Experience,” were defined as having provided a specific level of supervised counseling of the TP therapy. The Minimal group had just recently completed training and started TP counseling in 2017 with a single family (Pilot Study 2) while the Moderate experience group contained individuals who started TP counseling in 2015 and had counseled 2 to 3 families (Pilot Study 1). The No TP Experience group contained individuals from both pilot studies who had not yet provided TP for various reasons, including changes in their availability or difficulties engaging families. Individuals within the No TP Experience group may have been applying some of the TP strategies within their informal counseling roles, but had not yet had the role of a TP counselor.

2.4 Data Collection Materials

Data collection was completed using an Interview Guide, a Focus Group Discussion Guide, and a Free-Listing/Pile-Sorting activity.

2.4.1 Interview Guide

The interview guide was semi-structured in that it included open-ended questions followed by probes that were asked based on participants’ responses to the overarching

questions. The guide was divided into five sections with introduction prompts, opening questions, and anticipated probes. The first section was an identity section asking questions related to changes in identity or sense of self since becoming a TP counselor and about their approaches to counseling before TP training to clarify the scope of their previous role and gauge how it changed after training. This was followed by four separate sections on how TP counseling affected experiences of stress, burnout, motivation, and self-efficacy (Appendix A1).

An adapted version of the guide was used with the No TP Experience group due to their unique circumstances of not providing supervised TP counseling. The difference between the two were the sections related to formal counseling experiences (Appendix A2).

The interview guides were developed and piloted using a collaborative process involving both US-based investigators, Kenyan research staff, and interviewers themselves during the training process. They were first drafted by the PI and then revised through collaboration with Duke University colleagues. After a final draft was reached, the interview guides were piloted with a Kenyan TP counselor supervisor to ensure clarity. Following initial piloting, the interview guides were translated and then back-translated by two Kenyan collaborators. The back-translated versions were then verified through reconciliation discussions with the original translator.

During interviewer training, the interview guides were further revised as trainees role-played 1) with each other and 2) with local Kenyan community members. Each question was assessed for clarity and comprehension between the English and Kiswahili versions and included making changes to examples and metaphors to fit local contexts.

Finally, the guides were verified by two other local research team members and counselor supervisors to ensure question validity and clarity. The guides were further assessed and revised throughout data collection based on the interviewer's experiences administering the guide. This process was intended to facilitate quality checks of the data collection process. These meetings identified questions that needed to be re-worded for clarity, topics that were successfully clear, and topics that needed greater specification.

2.4.2 Focus Group Discussion Guide Development

The Focus Group Discussion (FGD) guide was developed during the completion of the individual interviews to be informed by collected data for the purpose of "member checking" rather than simply further data collection (Creswell & Creswell, 2018). We conducted preliminary data analyses, as individual interview transcripts were completed, using close reading of transcripts, memoing, and preliminary code development. FGD questions were geared towards clarification, expanding upon specific ideas individuals mentioned, and allowing participants to verify information gathered and preliminary interpretations made. An alternate version was created for the No TP Experience group due to their unique characteristics described previously.

Following an introduction section, which set discussion ground rules, the FGD guide had four sections with questions and probes related to counselor identity, stress, burnout, motivation, and self-efficacy (Appendix A3 and A4). Each section started with a prompt to set the focus for the section and allow the facilitator to review a summarized list of participant responses from individual interviews. The ten accompanying questions and probes allowed for further clarification of interview findings.

2.4.3 Participatory Stress Free-Listing, Pile Sorting, and Mapping

During individual interviews, every participant completed a free-listing activity where they wrote a list of current sources of stress, not necessarily associated with the counselor role. The interviewer prompted the participant to be thorough and probed to ensure a comprehensive list. The participant then ranked the items from most to least stressful, with the option to rank multiple items at the same level. During each focus group, participants completed a pile sorting activity, a method used to understand how participants evaluate social experiences and categorize elements of interest (Spradley, 1979). Participants sorted cards of the compiled stressors obtained from individual interviews into related categories with as few or as many stressors as deemed appropriate. Following the sorting, they were asked to label the stressor categories with a representative name. The goal was to consolidate the numerous stressors into higher-level groups to assist with later stress mapping. Interviewer instructions for facilitating the interview and FGD activities can be found in Appendix A3 and A6, respectively.

Using the written, ranked lists of stressors from individual interviews and grouped categories from FGDs, a Stress Map was created for each experience group to provide a better understanding of the stressors that are most influential in the lives of those counselors. The arts-based methods of “Participatory Risk Mapping,” discussed by Smith and colleagues (2000), were utilized to analyze the stress lists and produce the stress maps reviewed in the results section. The idea is to visually display the incidence and severity of stressors experienced by TP counselors.

2.5 Procedures

2.5.1 Study Personnel

A group of five Kenyan TP research volunteers (1 male, 4 female), who did not have any qualitative data collection experience, were trained by the PI on qualitative data collection. The training covered interviewing methods and research ethics through an active, participatory five-day course. Following the five-day training, two of the trainees were hired by the PI to assist with data collection based on their performance during the training. Transcription was completed by a Kenyan research assistant who had transcription experience and who was fluent in Kiswahili and English.

2.5.2 Individual Interviews and Stress-Map Free-Listing

Individual, semi-structured interviews were held with participants to understand their individual experiences as TP counselors. The interviews were conducted in the local TP office where counselors regularly visit in the course of their other research activities.

The sessions were facilitated in Kiswahili by the hired research volunteer. Halfway through the session, the interviewer administered the free listing activity described previously. The sessions lasted about two hours each. The interview recording was transcribed from Kiswahili directly into English. Participant privacy was maintained by assignment of participant identification numbers to de-identify transcript data.

2.5.3 Focus Group Discussion

Focus Group Discussions (FGDs) were held with each of the three counselor experience groups once all participants from the group completed an individual interview. For the Moderate and No TP Experience groups, the FGD session was held in the TP office. The Minimal experience group's FGD was held at their church at a special request by the

group to decrease their travel time. During each session, participants were presented with preliminary results from individual interviews from other TP counselors within their group, and asked to clarify, comment on, and verify the information. They also completed the pile sort activity described previously.

The discussions lasted around two hours and were conducted primarily in Kiswahili. They were audio recorded and transcribed directly into English by a Kenyan research assistant.

2.6 Ethical Review

All study procedures were approved by the ethical review boards at Duke University (Protocol Number: C0058) and Moi University in Kenya. Written informed consent was obtained for all activities.

2.7 Analysis

2.7.1 Interview and FGD Transcripts

Thematic content analysis was used to analyze the data (Braun & Clarke 2006). Interview and FGD transcripts were first reviewed by the project PI using close-reading techniques to extract emergent themes. The PI also met with the interviewer after interviews and FGDs to discuss their perceptions on session content. Themes were organized into a codebook containing parent and child codes, code definitions, examples, and inclusion/exclusion criteria. All codes were based on the domains of interest (Identity, Stress, Burnout, Motivation, and Self-Efficacy) and informed by transcript summaries produced from the initial readthrough. Transcripts were imported in NVivo (version 12), organized into sets by counselor experience groups, and assigned to cases with demographic attributes (e.g. gender, age).

To begin intercoder agreement, three transcripts (15%), one from each experience group, were coded with another researcher on the TP team using the initial codebook to help validate code definitions and usage. Inconsistencies and disagreement on code applications were addressed through clarification discussions, which resulted in modifications to the codebook. Following discussions, two more rounds of transcript co-coding, discussions, and codebook updating were performed. Once a Kappa coefficient of 0.51 and overall agreement percentage of 94%, calculated by the NVivo software, were reached, the remaining transcripts were coded by the PI. This combination of Kappa and Overall Agreement percentage were deemed sufficient because, upon visual inspection of coded regions, it was determined that the remaining disagreement reflected in the Kappa were primarily due to differences in amount of text coders included for similar regions.

Following coding, we developed memo summaries of each of the parent codes that included the accompanying child codes for the domains of interest. This facilitated theme development, interpretation of participant narratives, and comparison between counselor experience groups. Dynamics and interactions between study domains of stress, burnout, motivation, and self-efficacy were examined using participant narratives to understand how they influenced each other and related to emergent themes. Memo summaries were then used to create counselor group profiles for each study domain and descriptions of what factors improve and detract from each study domain. Finally, a concept diagram was devised from data interpretations to provide a visual description of the interactions among the study domains.

2.7.2 Participatory Stress Mapping

A stress map was created for each group using data from the free-listing and pile sorting activities. First, individual stressors were relabeled according to the categorical groups created from the FGD pile-sorting activity. Stressors' incidence and severity indexes were then calculated using calculation approaches described in Smith and colleagues (2000). The incidence index was calculated as the proportion of a group that listed a stressor category at least once. For example, if five of the six counselors of the Minimal experience group were to list a "Poverty" item, then incidence of that item would be 0.833. The incidence index is therefore ordered between 0 and 1, with higher values representing stressors which are experienced by a higher proportion of individuals within a group.

The severity index required multiple steps to standardize the scales between participant lists within a group because individuals could have produced ranked lists with as few as one stressor, or as many as ten or more. Each stressor item (i) and its rank (r) with total (n) risks identified by each participant (j) was calculated as $s_{ji} = 1 - \frac{(r_i-1)}{(n_j-1)}$. For example, if a participant were to rank "Poverty" as 2 from a list of 4 items, they would have a Poverty item severity value of $1 - \frac{(2-1)}{(4-1)}$, or 0.667. If an individual listed multiple "Poverty" items, their severity scores were averaged together. The severity index is therefore ordered between 0 and 1, with higher values representing stressors participants ranked as being most stressful. These individual severity values were then averaged across the group to produce a group severity index value for each stressor category.

After both index scales were calculated for all counselor experience groups, they were scatter plotted and labeled in Excel (2016). Guidelines were placed at the midpoint

of each index scale (0.5) to divide the plot into four quadrants which represent, 1) top-right: more severe and prevalent, 2) top-left: more severe, less prevalent, 3) bottom-left: less severe, less prevalent, 4) less severe, more prevalent. These quadrants help visually identify key stressors clusters within and between counselor groups.

3. Results

3.1 Description of sample

Of the 27 eligible individuals, 20 participated in the study (10 females). Of the remaining seven, three had moved away from Eldoret, two were unreachable due to outdated contact information, and two were excluded due to having trained for a specialized alcohol use intervention within TP, which gave them different experiences from the rest of the sample. All 20 participants completed an individual interview while only 16 were able to attend their FGD, with two from the No TP Experience and two from the Minimal Experience not attending. The age range of participants was 28-63 years with a mean age of 46. The counselors were active members in their communities working, paid or unpaid, as community or church leaders, community security, and for themselves as farmers or in business. Table 1 provides a breakdown of the counselors by their experience groups.

Table 1. TP Counselor Demographics by Experience Group

	Experience Group		
	Moderate	Minimal	No TP
Group Size (N)	8	6	6
Gender (male)	50%	50%	50%
Age Range (Mean)	35-57 (47)	43-63 (51)	28-53 (43)
Education			
Unreported	--	--	1
Some Primary	2	1	2
Some Secondary	5	2	2
Diploma ^a	1	2	1
University	--	1	--
Natural Counselor Role			
Community Leader ^b	2	--	--
Church Leader ^c	5	3	4
Farmer	--	1	--
Business	--	1	--
Security	1	--	2

Unemployed	--	1 ^d	--
^a Lower than a University degree			
^b Policymaker, Village Elder			
^c Pastor, Sunday School Teacher			
^d Participant had some coursework and training in counseling, but no work experience			

3.2 Identity Role Shifts

In this section, we present how the counselors described their informal counseling role, their perceived TP counselor role, how they both emerged over time, and how the counselors were personally changed by enacting their TP counseling role.

3.2.1 Counseling Skills and Approaches Before TP

Due to the uniqueness of this population holding an informal counseling role before TP training and not being naïve to counseling, it was important to understand how counselors approached their informal counseling. During their individual interviews, participants were asked about their approaches to counseling before TP training to clarify the scope of their previous role and gauge how it changed after training.

Before TP training, participants said they offered advice and counsel anywhere they went, including after church, on the streets, while running errands, or wherever they met someone in need. Their advice focused on Bible scriptures, praying with the individual, pulling from personal experiences, advice from elders, and using lecturing and direct advice-giving of how to solve the situation. Recipients of “advising,” as they often called it, were either people who sought their advice directly, those referred to them by someone else, or even others in the community whom they observed to have a problem or strangers encountered in the community.

3.2.2 The Counselor Role and Identity

To understand the counselors' personal expectations in their new formal counseling roles and their perceived counselor identity, participants were asked what they think it means to be, and the qualities of, a TP counselor. A general list of qualities given by all counselors included: a good listener, empathy, readiness, flexibility, good communication skills, responsible leader, and "taking your time." These qualities were said to help make the work more efficient, comprehensive, and helpful:

"Patience, humble, one who has perseverance and not easily angered also who is keen and calm. It helps me to do early and prior preparations and set aside enough time in order to counsel my clients satisfactorily. In general these qualities make the work to be efficient (Female, 53, Minimal Group)."

Many highlighted the importance of "readiness" and preparation for sessions so that "when you are doing counseling, you look like one who knows what he or she is doing (Male, 58, Minimal Group)." Accompanying this is the sense that a TP counselor is one who is skilled and more prepared to help families due to their training. This included having an appropriate approach to counseling, being able to "comfort and empathize with the clients (Female, 35, Moderate Group)," and being able to handle a broader range of problems:

"The counselor should be willing. They should be of sound mind and be positive when dealing with the families' problems (Female, 43, Minimal Group)."

Compared to "the community elders who judge and decide on cases (Female, 57, Moderate Group)," being a TP counselor is different in that they are not judgmental, try to understand the full problem, help the client family identify their own solutions, and gain client trust through maintaining confidentiality:

"The qualities are, being humble, being honest. That means that when a family shares with me their issues I should be able to keep them as secrets. One should be

loving. Because you have to be loving to be able to help a family. If you don't love them, you will not be able to help them (Female, 46, Minimal Group)."

Finally, being a TP counselor means "being a good role model (Male, 40, Moderate Group)," for the community and being an example for others to follow. This was important for gaining trust and ensuring people followed a counselor's guidance:

"Yes, my character and setting a good example to the community, nobody will love your work if your actions are not straight (Male, 46, Moderate Group)."

3.2.3 Personal Relationship Changes

As counselors integrated their new counselor role into their lives, they reported experiencing changes in their social networks as evidenced by changes in relationships and interactions with others.

Several counselors from all experience groups mentioned positive relationship changes. They attributed changes in family relationships to applying skills from TP training to their *own* lives and families. They reported increased love and togetherness due to less quarreling, more open discussions with family members, and actively interacting and spending time together:

"The training that I got from TP helped me reflect in my life and of my relation with my spouse whereby we would quarrel on top of our voices not caring disclosing family issues to the public. Our togetherness as a result of that change so far has helped us accomplish a lot (Female, 47, Moderate Group)."

They also described being more approachable, getting along easier, and having stronger bonds with their church and community. Many counselors further mentioned having developed relationships with counseled families outside of therapy sessions, which was seen as positive. The improvements were sometimes attributed to new conflict resolution skills and learning to "talk as adults," to resolve the situation instead of quarreling and making it worse. Changes also included increased respect and

encouragement from community members as people appreciate them for the positive changes the counselors have brought to the community. This sometimes included being honored at community events:

“But one thing I must say is I have received acceptance in the community, and more people are approaching me for assistance than before (Male, 63, Minimal Group).”

A few counselors expressed only small changes to their relationships with people in the community. While they expressed some changes in their relationship with the families they counseled, in terms of seeing them outside of sessions, they did not report experiencing feeling more respected or recognized by others. They attributed this to the confidential nature of their work, dealing with “sensitive family issues” that led to their discretion and lack of awareness of others that they were even known to be a counselor. One newer counselor also said it was due to only being a counselor for one year, saying “maybe they [the community] still are not aware of me.”

One counselor mentioned a negative change in that they perceived that others began to fear him because they were worried he would share their secrets to harm them:

“Maybe being feared by people. At time people fear you. When we are discussing, they worry that you will know what his weakness is. In that instance it becomes a challenge. Such a person must get someone who can refer him or her to me -- someone whom I have helped before... Otherwise, the person will fear knowing that I am a counselor he will think that maybe I want to know his or her secrets to destroy him or her (Male, 47, Moderate Group).”

3.2.4 Tensions Between Counseling and Non-counseling Roles

Consistent with Identity Role Theory, as the counselors begin to integrate their new formal counselor role into their role set, they faced some challenges and tensions between their old and new roles. Counselors from all experience groups expressed inter-role tension in the form of trying to balance their new roles, having to sacrifice time doing their own tasks and be “ready and available” as a counselor, and trying not to inconvenience families

as the counselor works through their busy schedule. Results highlighted that while these individuals had been spending significant amounts of time on informal counseling before TP, this had been much less structured and unscheduled such that the need to have regularly scheduled TP sessions led to some additional strain.

As counselors with other roles as parents, pastors, and sole-providers, they have responsibilities to their families, their children, and also to their congregation or church. Although counselors reported wishing that they could always be available to counsel, sometimes these other roles must come first. This was especially true as participants tried to take care of their family and remain a positive role model for others to emulate. Accompanying this discourse was a characterization of such decisions as “sacrificing time” for one role and struggling with time allocation as one is “forced to postpone your own activities and give them [*families*] your time (Male, 46, Moderate Group)”. This sense of sacrifice was further fueled by counselors feeling a responsibility to their client families and did not want to “inconvenience a family I had scheduled with, but sometimes I can get so busy (Female, 57, Moderate Group).”

“I also pray to God that when I continue counseling, it will not affect me. That when I am helping others I should not forget about my own family. You know you can help others and your home is in a mess? So, I pray to God that I will be able to have time to counsel people, time to do my own work, time to minister in church and time to be with my children. Since I am the sole provider for my children if I don’t work what will they eat (Female, 55, Moderate Group)?”

3.2.5 Self-Counseling

An emergent theme from the individual interviews from all counselor groups was the idea of “self-counseling.” This was where participants described changes in their lives that spilled into other roles due to applying TP counseling concepts and strategies to their *own* lives. Some saw this process as a necessary step to “live the life,” be role models, and

gain counselor credibility. They describe a direct pathway that explains how these personal changes led to their improved relationships described previously. A major theme was the application of counseling skills to their own families, which improved their functioning and relationships:

“My role as a counselor has changed my lifestyle in my Boma [home]. One, it helped remove bad thoughts in me. Secondly it helped me in awareness like to understand that all people are equal. Why I am saying so is because of the counseling that I got from them it transformed even my inner part of me, I had become aware of many things. It helped build my inner resources and it is after that I became competent and was able to offer sound counseling to my children because my skills had widened up. I would also teach my neighbors when I would spend time with them. I share with them about my experiences before and after acquiring the skills. And I tell them counseling has helped my life become easy and less stressful (Female, 48, No TP Experience Group).”

Such changes were also initiated in cases where counselors observed community problems they wished to prevent in their own families:

“The program is making me grow as I reach out to other families, in Proverbs they say you use one stone to kill two birds, so as I reach out to other family, I gain more experience on how to make mine good. You get to a family and you learn that they are going through problems, you find a child complaining of hunger, as you counsel them, and you personally will work hard to prevent such issues happening in your family (Male, 46, Moderate Group).”

A few counselors from each experience group first mentioned being able to better communicate with others following training by being less harsh, using polite language, and being less judgmental. Similarly, many counselors also mentioned an improved ability to problem solve, improved awareness of personal behavior, and a new approach to thinking. Such improvements allowed counselors to effectively perform their roles with client families and in settings outside of therapy:

“I can say that I used to be very harsh and judgmental giving final answers to issues unlike now I know where I have come to learn that counseling is a process for instance now I can sit with my wife and children as a family and I listen to them so

that I can be able to help them because as a parent I am also a counselor at home (Male, 40, Moderate Group)."

Many counselors with both experience and no TP experience mentioned a change in how they expressed and controlled their emotions, which allowed them to better control their anger, be less sensitive to issues, and better relate to others:

"On my side, even if am angry, I remember about the family I advised and how anger might have destroyed their relationship, so I prevent my family from going the same path by working on my anger (Male, 50, Moderate Group)."

Majority of counselors with assigned families saw further changes in their approach to parenting. This included a change in child discipline and behavioral management techniques, communication between family members, improved family dynamics, and fewer quarrels with their spouse and family by "internalizing it [anger] and work[ing] on it from within (Female, 57, Moderate Group)." These changes were said to bring significant improvements and make life easier:

"What has changed is there has to be problems. It has helped me to change on how to handle problems. Also in my daily life, I have learnt that there new things happening in my life. For example, when a child does something wrong, it is not a must that you beat the child to change their behavior. It is important to talk to the child. And when there are challenges in the family, people do not have to quarrel. People should talk so that they can find solutions (Male, 44, Minimal Group)."

3.3 Motivation

To gain an understanding of motivation, participants were asked about their initial motivations for becoming a TP counselor and how such feelings of motivation have changed since they completed TP training and, for two experience groups, were assigned a family.

3.3.1 Initial Motivation

To understand initial motivations for wanting to be a TP counselor, participants were asked about their decision process for wanting to join TP. The goal was to be able to compare this beginning motivation to their current motivation and describe any changes. Counselors typically discussed intrinsic motivations first, followed by more extrinsic motivating factors. As expected, every counselor experience group mentioned a general desire to “be in a position to help other people (Female, 47, Moderate Group).” Although the counselors were already performing informal counseling roles, they wanted to do even more to help their communities. They therefore saw TP as the perfect opportunity to achieve such goals:

“Our Pastor told us that there is a project that is called TP, and they wanted some members who can do counseling for families that have conflicts. When he said that, I felt touched. I thought about it, and I just felt I should join. I wanted to help those families that have conflicts so that they can live good lives. That was the only thing I felt the burden. That family members can be able to live as a family and live a life of happiness. That is what gave me the burden to join and also to learn a lot. So that I can also help others not just the families that I have been given (Female, 46, Minimal Group).”

Beyond a general desire to further help the community, participants from each experience group also mentioned a deeper-rooted origin in the form of a calling and passion for counseling. This was both attributed to their experience as informal counselors, and due to a sense that it was an opportunity that God had prepared them for. Others also saw it as an opportunity to reach more people in their religious work as a pastor or church leader. Some also viewed this work as being for the church because they were recruited through their church, or even likened the TP program to “mission evangelism (Female, 57, Moderate Group).”

“I think it is just because it was my vocation or my area of interest because it is my belief that God had already prepared me for such a role and so I believe it is Him

who opened this door of opportunity for me in TP (Female, 48, No TP Experience Group)."

"It's not an employment opportunity but a work you do from your heart, it like a calling to help families (Female, 57, Moderate Group)."

Counselors from each experience group also mentioned having a particular interest in advancing their own skills and knowledge sets related to counseling "in order to serve the people better (Male, 46, Moderate Group)." This was both to become better at counseling, but also to improve one's own resources and capabilities in other mentorship roles, such as being a pastor:

"I perceived that it was in harmony with my role as a Pastor and I liked it I therefore joined them. I also perceived that it would benefit me personally and my knowledge and skills will be increased. I will get to learn more skills from TP on how to deal with families (Female, 53, Minimal Group)."

Alongside this desire to improve skills and knowledge was to then use such opportunities to expand one's reach as a counselor. This was in lieu of observing how prevalent problems in the community are, the need to take further action to actualize a vision for their community, and the desire to make the most impact as one can. They often felt it was their responsibility to take up the role to have the ability to fix their community's problems:

"Another objective was to see people living happy and good lifestyles. To see them stress free with no issues. I was never happy at heart to see people languishing in their sorrows. I could never assume/abandon or neglect them; I had to do something about it, like giving them advices (Male, 28, No TP Experience Group)."

"My motivating factor was my childhood experiences. The situation got better in our lives just recently. Whenever I encounter these group of children, I usually feel burdened and want to talk to them and see where I can help them because I wouldn't want to see them experience what I had experienced myself (Female, 48, No TP Experience Group)."

3.3.2 Current Motivation and Change

Following their initial motivations, counselors were asked about changes and persistence in motivation despite the challenges they face. Every counselor expressed maintaining their intrinsic desire to help their community and the church because they “loved peace” or “wanted people to live in harmony.” Many expressed improved motivation following training because they had increased knowledge and new skills to handle a broader set of cases. This seemed to build up their sense of self-efficacy and helped sustain them through challenges or mixed reviews from community members:

“There are those who are happy with your work and there are those who are malicious. But that cannot kill our spirit of helping keep going on... I remain strong and happy and say to myself, “as long as I know what I am doing/I don’t need anybody’s approval” and maybe it is a God given opportunity because I already has started before joining TP (Female, 47, Moderate Group).”

Others indicated that they were motivated to continue counseling because they want others to have better lives due to having overcome a personal struggle in the past, or because the counselor experienced changes from the program due to the “self-counseling” effect described earlier:

“The program has helped me to live well with my family and so I would like to see other people in my community live well like me (Male, 46, Moderate Group).”

In terms of changes in motivation experienced after TP training, counselors reported receiving encouragement, respect, and empowerment from supervisors and fellow counselors, as well from family and community members. These were especially helpful when client families were struggling, not progressing, or having issues scheduling sessions:

*“The other thing I loved is when I had problems I could call [**supervisors**], they could then help me, so I really loved the fact that I wasn’t left alone after the training but had someone who could always help me when I got stuck during the process so I got a lot of encouragement to continue with the process (Male, 63, Minimal Group).”*

“...like what I had shared before about the support groups that we have as counselors it’s very healthy and helpful when we meet it is therapeutic indeed because it motivates even those who were almost giving up (Male, 40, Moderate Group).”

The belief that they were making a difference and fulfilling God’s work was highly motivating. When families engage in the treatment, attend sessions, and show positive changes or outcomes, the counselors are motivated to continue working. Motivation also increased as their own lives improved, as explained by self-counseling:

“Despite the challenges, if you get the family to finally sit down and talk to each other it becomes very easy (Female, 57, Moderate Group).”

“[How has counseling changed daily life?] It has really changed my life, because the more you advise people the more even your personal life improves. And whenever I hear that a family has solved their problems I am very happy (Male, 41, No TP Experience Group).”

3.4 Self-Efficacy

To gain an understanding of feelings of self-efficacy, counselors were asked about their feelings of preparedness as a counselor and ability to meet expectations. Participants typically made statements regarding their confidence as a counselor relative to before they received training from TP. The resounding narrative was that counselors felt empowered and strengthened in their abilities to fulfill their counselor role after completing TP training.

The first area was an increase in overall knowledge of the scope of problems families can face. Before, counselors primarily could only provide support and advice on issues they had either experienced or heard about. After completing training and beginning formal counseling, counselors noticed increased awareness of community issues and were better equipped to intervene:

“This one from TP is a learnt skill whereby we are taught until we understand before the application but the previous one was not based on anything but just a thought that would come to mind and I implement, a personal revelation applied in

hope that it would help. But I came to learn that was much better when trained because you would gain a better understanding and learn many things (Female, 48, No TP Experience Group)."

A second area of improvement with training was the ability to be more systematic with their counseling. Before, counselors did not have a manual or list of steps or procedures. They could only work from what they learned from their personal lives or perhaps from their other roles as a pastor or church trainings. Now they have training, a manual, and supervision to help them prepare and know how to take families through therapy:

"Before it was hard, you would sit down and you will wonder who should start, and how to start," but now "I have experience and enough skills to explore issues...how to begin and how to end (Male, 47, Moderate Group)."

Following training, counselors felt empowered, more competent, and "able to offer sound counseling (Female, 48, No TP Experience Group)," because they had a more systematic approach to help families resolve their problems. They feel they can easily understand a problem and find the best way to approach the situation:

"I remember my counseling was not so skillful...but I thank TP because they have helped us by guiding us and showing us how to do proper counseling." "There has been a big difference in that I now know the right procedure to take a client through." "TP has facilitated and equipped me that I can now give proper counseling to the clients at large unlike before (Male, 40, Moderate Group)."

With this improved self-confidence and empowerment from training came a change in how counselors viewed their counselor role. When discussing their counseling approach before, many described their role as "shallow," "reckless," and "no consistency." With the invitation to receive training from TP, many saw it as an opportunity for self-improvement, to "take my counseling skills to the next level (Male, 63, Minimal Group)," and to make

themselves better as counselors. Now, counselors feel like they are more “professional” and are able to meet the expectations of their client families:

“Before we were practicing in the dark unlike now we are working in the light. TP has given us knowledge, equipped us and widened our minds (Female, 47, Moderate Group).”

Despite these positive improvements in self-efficacy and empowerment received from being trained as a TP counselor, their counselor identity and self-confidence is tested and often gauged relative to how client families progress through therapy. This is both in terms of family trust and openness with counselors, and overall changes or improvements in the family:

“I had expected that the family was improving and them deteriorating made me question if I had done all that was expected of me (Female, 35, Moderate Group).”

Overall, the TP counselors agree that their counseling skills and sessions are more effective, systematic, and easier now that they have completed training:

“This one under TP is much easier and more helpful because there is a manual and can help when one is stuck because you can refer. Before I used to struggle a lot because I had to look for words to use (Female, 55, Moderate Group).”

Though they clearly observed that their knowledge and skills had expanded greatly, the counselors consistently requested that TP continue to provide more trainings. The counselors have a consistent and persistent desire to improve in their counseling abilities because they have realized the breadth of problems they could face and for which they have to be ready:

“They should just continue with the training, because I consider this an introduction we haven’t gone so deep, so if we could get more trainings we will be very good at counselling (Male, 50, Moderate Group).”

3.5 Stress

As participants take on their new TP counselor roles, an important aspect to understand is their experiences of stress and the ways in which their types and levels of stress have changed since assuming their new roles as counselors. For this section, we will discuss the stressors involved in counseling and methods of stress reduction.

3.5.1 Counseling Stress

During their interviews, counselors were asked about stress specific to counseling. Across each experience group, they all expressed similar stressors connected to therapy scheduling, family attendance, and perceptions of the counseled family's progress.

A couple counselors from both experienced groups of counselors described multiple difficulties related to their new formal counseling roles. Stress first came from getting used to their new formal counseling role and processes associated with it. One counselor said, "I was not confident and had many worries (Male, 46, Moderate Group)" because of the new process of providing reports, recording sessions, making follow-ups, and the longer time spent on therapy sessions.

Attendance problems also led to stress. These could be due to family members being busy with other priorities, such as working, or for clinically-relevant reasons such as a family member not trusting or avoiding the counselor. Counselors described some instances, saying, "you go as per the agreement only to find a padlock on the door," or "you arrive for a session and you find they are all gone, so you are left to wonder whether they refused or what could have happened." Not only is this time consuming, but it also causes the counselor to question their past actions and capabilities as a counselor:

“I would begin to reflect on the past to see if I ever wronged them or mishandled them during my counseling sessions. It would make me have many questions in my mind (Female, 48, No TP Experience Group).”

These situations also contributed to a feeling of being “dragged back” because clients backslide despite almost finishing up a section of therapy. The families could not make progress if every member did not attend therapy consistently. Even when families did attend sessions, it can be stressful if “one person is willing to listen and the other one [is] not interested (Female, 35, No TP Experience Group). Such frustrations were summarized as:

“It would have been a very simple thing if a client would accept the counselor right from the first day because it can help the counseling to move faster (Male, 40, Moderate Group).”

Travel to and from therapy sessions was also a significant source of stress. This was due to the time and cost as well as weather conditions. This was best summarized as:

“During the rainy season, it becomes cumbersome for us to move around because of heavy mud and being rained on. You can fall sick because of being rained on. Also the motor bikes as the only means of transport at that time charges double the normal rate (Female, 47, Moderate Group).”

Another source of stress is difficulties encountered within the sessions, including difficulty engaging families or experiencing intense interactions. A common instance was described by one counselor as difficulty “getting them to open up; it takes a lot of time sometimes when none of them believed that their problems will remain confidential (Female, 57, Moderate Group).” Related, one observation was that the research-related recordings and documents may make it even harder for them to build rapport and client trust. An additional specific challenge to building rapport and trust was trying to navigate providing treatment across gender and age differences, such as a female counselor advising

a male, a younger counselor counseling elders, or a counselor attempting to facilitate inter-generational communication in the family:

“You see it now becomes a challenge because of traditions whereby you might end telling this old man something that is against the tradition and culture and might think you are taking him to be like a small child (Male, 40, Moderate Group).”

“What was stressing me was that of trying to get the man of the house to agree to sit and talk, it was not easy for them to open up. Some can say that now you have infringed into family domestic issues. There are those who still hold traditional values. The man would say that children cannot speak in front of Him, and also he would say that a woman cannot say anything in front of him (Male, 44, Minimal Group).”

It was also difficult to maintain engagement and progress when families were undergoing acute hardships, which made it hard for them to focus during the sessions. Examples included losing a job, not having enough money to buy food, or experiencing a medical emergency. There have been cases where, “some families end up dropping out to prioritize on meeting their physical needs (Male, 63, Minimal Group). Such a situation was best described as:

“You might go and find they do not have anything in the house so if you go empty handed, they tell you to hurry up because they have an appointment somewhere for work so they can get money for food. But if they see you have come carrying something, they will avail their time and will talk to you (Female, 47, Moderate Group).”

For other stress during sessions, sources included “drunkard fathers” who would arrive home drunk and interrupt the sessions or a counselor arriving for a session during a heated fight between spouses. Even if the session continued, “it becomes difficult when you have to try to cool them down (Female, 55, Moderate Group),” from the fighting or emotional state. As expected, another source of stress was from families not making progress or “backsliding” and becoming worse. This was connected to a counselor’s personal expectations and hopes for the family:

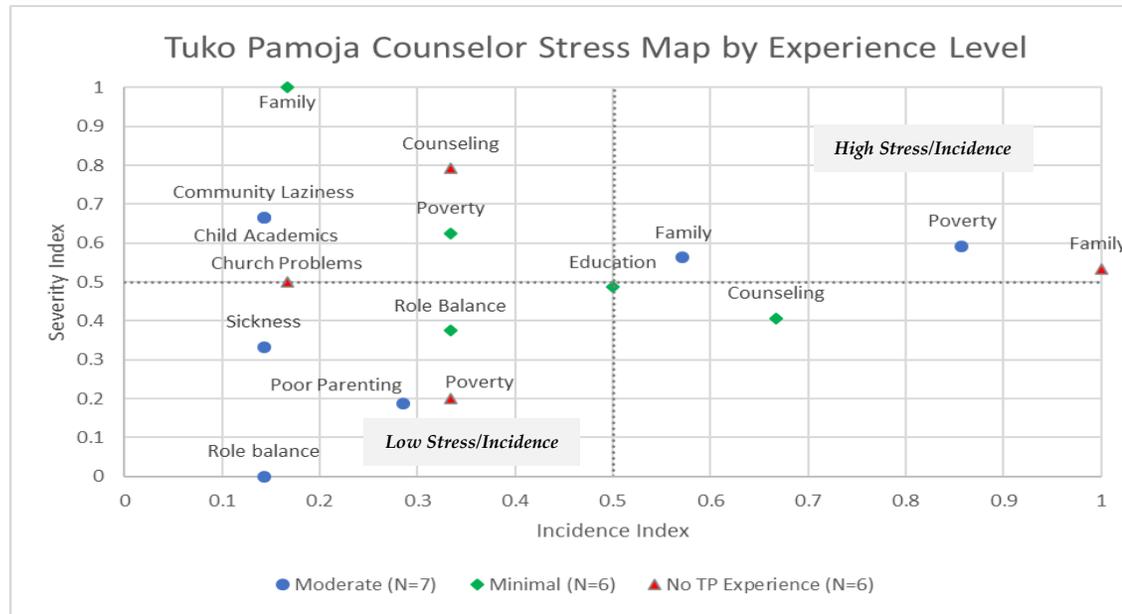
“[There are] times when you are almost finishing, then it all falls apart completely. Then you have to start afresh again...you have to continue trying to be patient and try to resolve issue for them (Female, 55, Moderate Group).”

“It does disturb me because I want the best for them. When I feel in my heart that they can change, but they are not interested in changing their lives (Female, 46, Minimal Group).”

3.5.2 Participatory Stress Mapping

The TP Stress Map (Figure 1), derived from the free-listing and pile sorting activities, helped identify top stress areas for each counselor experience group. As described in the methods, a top stress area is one that has both a high Incidence Score (higher proportion of group listed this stress) and high Severity Score (rated more stressful overall).

Every participant was included in the calculation of incidence and severity indexes except for one from the Moderate group who did not rank their stressor list. According to the TP Stress Map (Figure 1), for all counselor experience groups, a top stressor is Poverty, describing both personal (e.g. acquiring daily provisions, paying school fees) or community (e.g. children taking drugs, huge hospital bills) sources. Another top stressor common across multiple groups was family, describing both personal (e.g. marriage disputes, family relationships) and community (e.g. homeless individuals, alcoholic children) sources. Another was counseling, describing challenges with being a TP counselor both logistically (e.g. family cooperation, client attendance) and emotionally (e.g. church support, hatred from clients). The specific prevalence and severity of these stressors were different between experience groups. The top stress areas for Moderate counselors are Poverty, Family, and Poor Parenting. For Minimal counselors, they are Counseling, Education, Poverty, and Role Balance. For No TP Experience counselors, they are Family, Counseling, and Poverty.



Stress Category	Stressors
Family	Family relationships, men drinking too much, husband and wife fighting, men not taking care of families, women taking on family responsibilities (instead of the man), marriage disputes, parent-child favoritism, work not appreciated, school fees, children not going to school, homeless individuals, alcoholic children, no time to stay with immediate family and children
Poverty	Daily provisions, Community Poverty, lack of employment, school fees, housing cost, "Hali ya Maisha kua ngumu" (life status is difficult), lost loved one, people not taking children to school, laziness in the family, children taking drugs, huge hospital bills experienced by sick people, lack of insurance enrollment in the youth, not leading a good life, lack of money, children needing something but can't get it, health problems, parents misusing income, lack of clothing for children
Counseling	Counseled family cooperation, church cooperation, starting counseling in local community, client attendance, client being late for sessions, clients regressing, client absence from sessions, hatred from clients, feeling like you're disrespecting clients, people with no time to listen to you, counseling sessions take too long
Education	Student discipline, unprepared teachers, parent-teacher respect, children employment problems despite education, plans to advance profession, learning computer skills
Role Balance	Balancing responsibilities, people not being responsible, balancing time with roles, balancing roles
Poor Parenting	Child neglect, Adolescent problems, parenting, parents beating their children,
Church Problems	People not cooperating in the church
Community Laziness	Neighbors destroying property, people not working hard, people not going to church, people waiting for government to do everything, people stealing other peoples' property, needy people not getting help from the community,
Child Academics	Child academics
Sickness	Being sick

Figure 1. TP Counselor Stress Map

3.6 Burnout

After obtaining an understanding of counselor stress, we explored instances that caused participants to feel burnout, how they responded to such situations, and how they either reduced or resisted burnout entirely. Burnout was introduced to participants with a spring metaphor. A spring was described as something that may be stretched and pulled by stress and strain, but is able to sustain itself and continue working. In thinking about their own experiences counseling, they were asked to describe a time they felt so overstretched or pulled by situations and stress, like a spring, to the point they could not return to their normal shape and continue being a counselor. This metaphor arose from discussions with local collaborators during interview piloting to improve comprehension of the concept of burnout.

3.6.1 Causes of Burnout

When discussing burnout, counselors often described acute situations of overwhelming stress which brought on a desire to quit, or lose hope in, being a counselor, or instances where stress piled on so much burnout feelings developed. Of all the counselors, 12 of the 20 counselors described feelings of burnout occurring related to counseling; these included counselors from all experience groups.

A first area that caused burnout feelings, as described by a couple counselors from the Moderate group, were instances, “beyond our scope of solving,” where it was highly emotional, or they were treated poorly as they fulfilled their roles. For the remaining counselors, burnout feelings arose in connection to the scheduling and attendance stressors described previously. The difference is that, if these negative situations were unresolved

for an extended period, the stress would pile up and lead to feelings of burnout and loss of hope:

“If you find they are not there, then when you go there again, they tell you they are not ready for you, then it happens again for the third time, you feel like you are tired. That is what can make you lose hope...This is caused by the progress of how the family is fairing on. If the family is not progressing the way you expected, it gives you a lot of stress. You will be affected even more than the family you are counseling (Male, 47, Moderate Group).”

On top of all of these overwhelming situations was the pressure to meet personal and supervisor expectations. When counselors experienced difficulties getting family members to meet together, open up about their problems, and trust them, they sometimes felt they were in impossible situations they could not solve:

“When I go back on the morrow the man disappears. So, the supervisor said, ‘no! You cannot be counseling a mother alone,’ that I should make sure that I get the man and counsel the two of them as per the expectation. That is when I reasoned to myself and said, ‘actually this task isn’t easy’ so the supervisor would be on my heels about this man who kept missing on purposely. So, there were there times that I felt overwhelmed by the situation to the point I didn’t want to talk (Female, 47, Moderate Group).”

Members of the No TP Experience group also mentioned burnout feelings related to applying TP skills outside of the formal program rather than within the context of delivering the full intervention as part of the program.

A counselor from the No TP Experience group mentioned a time before TP training where they were offering informal advice to a family with constant quarreling between the husband and his two wives. It soon escalated and “reached a time when the husband carried a table and even wanted to hit me with it,” due to a false accusation from the husband about the counselor’s actions. As to be expected, a situation of physical violence during a therapy session contributed to feelings of burnout. This also extended to instances of where people

were “confident enough [to] abuse you verbally to your face,” as described by one counselor:

“If it is the elderly people they will tell me, they can tell me, ‘who do you think you are and what experience do you have, you are just but a little child and there is nothing you can tell us’ or even ask me, ‘do you think you are [more] clever than us (Female, 48, No TP Experience Group)?”

3.6.2 Experience of Burnout

“My heart has been tormented and my brain exhausted. I felt very tired! The whole of my body same as the head. I just had experienced pain in my head because of tension I guess because I was dealing with a lot. [In your heart?] Pain (Male, 28, No TP Experience Group).”

After hearing a story of situations that led to burnout, they were asked to reflect on how such situations made them feel in their head, heart, and body. This was to assess the full experience of burnout in physical, mental, and emotional expressions. For feelings in body, all counselor groups expressed feeling fatigue, pain, exhaustion, or sickness during such instances of overwhelming stress:

“[It] makes you feel troubled. You lack peace. You feel even more tired as though you have been digging a shamba [field] (Male, 47, Moderate Group).”

“I feel bad. [In your body?] I felt pain and even became sick. Takes away all your energy (Male, 41, No TP Experience Group).”

For feelings in their head, counselors expressed a sense of self-doubt and questioning of their capabilities as a counselor and a family’s understanding of the counselor’s role. Given motivations discussed previously, there seemed to be tension between the desire to help, having the skills to help as a counselor, but families not cooperating or showing interest, that caused further strain. There were also many questions that fill their heads as they judged themselves because they could not make positive progress with their client families:

“I will keep asking myself questions. For instance, I would ask myself, ‘didn’t I teach the people properly, or did I mentioned to him/her a bad thing?’ (Female, 48, No TP Experience Group)”

When such feelings accumulated as they continue to question themselves; some counselors even mentioned or implied feelings of momentarily regretting their decision to join TP during such situations. In all cases, this was temporary, but in some cases the thoughts were intense. For feelings in their heart, participants mentioned an overall lack of peace, loss of hope, and feeling “burdened in my heart (Female, 46, Minimal Group).” This was especially coupled with clients not showing adequate interest or commitment to therapy sessions. This produced further tension between the desire to help, but not being able to actualize such motivations. As such tensions and feelings were unresolved, some counselors felt like “I was overdoing and that it was me who needed help and not them (Male, 40, Moderate Group).” They mentioned a desire for further training from TP on how handle or have a breakthrough for families who were not appropriately engaged or committed:

“I felt in my heart that I wanted to help them, while to them they take it lightly [not very seriously] (Male, 40, Moderate Group).”

3.7 Coping and Resistance Mechanisms

3.7.1 Stress and Burnout Reduction

After discussing counselor experiences with stress and burnout, they were asked how they cope with both general stress and burnout. In both cases, counselors applied similar coping mechanisms.

For many counselors within all experience groups, stress relief came in the form of religious practices. These included praying or reading the Bible because it “makes the burden lighter (Female, 43, Minimal Group),” or “surrendering all this [disturbing

thoughts] at the foot of the cross (Female, 35, No TP Experience Group).” Music was seen as helpful, especially gospel music because, “the songs have encouraging words, advises, and after listening I feel inspired and lifted up from stress to happiness (Male, 40, Moderate Group),” or “help me remove my mind from the issues (Male, 47, Moderate Group).”

In addition, counselors also tried investing in personal relationships. This included talking to their family, spouse, or “a person you trust the most (Female, 35, Moderate Group),” “engaging yourself with [my] children like playing with them,” and through “sharing of ideas and brainstorming, also one can confide any secret issue (Male, 28, No TP Experience Group).”

For a few counselors, stress was also relieved by accessing support provided through TP, including supervisors and peers. This included reviewing the therapy manual to reassure themselves they knew what they were doing, calling their supervisor who could “give the way forward (Female, 43, Minimal Group)” and meeting with other counselors where, “we can share, then you realize that even what you go through is not as bad as what the other counselors are going through (Male, 47, Moderate Group).” If nothing else, some counselors mentioned returning to their other roles outside of counseling where “there are times that I also do my own stuff (Female, 55, Moderate Group),” and “catch up with my daily work (Female, 47, Moderate Group)” Such actions helped counselors distract and distance themselves from the situation or let them work through their feelings.

Some counselors also mentioned reframing stressors as a way to cope, alongside reminding themselves that they are likely temporary. One described, “I don’t call them stress. I see them as challenges that if you are committed and prayerful, just come to pass (Female, 57, Moderate Group).” As others put it, “I normally feel that the problems at hand

will get sorted out (Male, 40, Moderate Group),” and “the whole world encounters diverse challenges and stresses, for me I have decided to take it as a normal thing (Female, 47, Moderate Group).” A similar sentiment was shared by a counselor just beginning his experience: “I first must reason within myself and find out if I love this work. If I face challenges or when things go well...I have to accept all of it (Male, 44, Minimal Group).”

A few unique techniques, mentioned by the Minimally experienced group counseling their first families was finding ways to express or change their feelings. Examples included client family interactions where “I tried to lift up their spirits...[and] I also laugh with them (Female, 46, Minimal Group),” or “I cry, when I cry, I feel relieved (Female, 46, Minimal Group).” All of these stress reduction techniques were said to be effective by every counselor because they “set your mind free from all disturbing issues,” and provide encouragement or “strength renewal.”

While the above were mentioned specifically in response to questions related to stress, in instances where counselors experienced feelings of burnout, they applied similar coping methods. The difference is they tended to focus on techniques that renewed their motivation/faith and distracted them. These included religious practices described above because it “gives me the strength to go on (Female, 57, Moderate Group),” and “depend[ing] on God knowing that all things are possible (Male, 44, Minimal Group).” They also mentioned reviewing training documents and case files which restore feelings of self-efficacy and capability as a counselor. Beyond these strategies counselors themselves could perform, burnout also began to resolve if a family finally attend a session or showed positive progress; a counselor could feel renewed and relieved of their overwhelming stress:

“Now am feeling okay. You know when you help a family and they get healed, you feel even much better (Male, 47, Moderate Group).”

Even if such progress does not occur, counselors can remain actively engaged with their counseling roles despite feelings of burnout due to their strong convictions which led them to become a TP counselor or a strong sense of duty to TP:

“I used to feel bad. I wasn’t happy, it was really hurting. Though it was something that I had decided that I would do whether it be bad or good I would push through to the end (Male, 44, Minimal Group).”

“I felt that this work was difficult and was feeling like I can step aside. But I felt convicted not to because TP also spend their money on us so it would not be good if I stepped aside. I therefore encouraged myself and decided to be patient (Female, 47, Moderate Group).”

3.7.2 Counselors Not Experiencing Burnout

As counselors completed their interviews, it was encouraging to observe that eight reported not experiencing burnout. We therefore examined what may have protected them from this.

The first protective factor was a strong perceived sense of self-efficacy due to having gone through training, having their capacity widened, and being “built up” in counseling skills. This was connected to intrinsic confidence in one’s counseling capabilities. Some said phrases reflecting that they felt impervious to burnout, with one saying he “never felt that they [a family] could overwhelm me (Male, 50, Moderate Group).”

*“No, I didn’t feel like that [**an overstretched spring**]. You know when the program started, we underwent through a training where my knowledge and capacity was widened, I have learned how to handle a lot of issues and so, I am no longer the same as before the program where I used to harass people and used force (Male, 46, Moderate Group).”*

A second protective factor was using resources provided by TP, such as a supervisor in person or via phone. These resources allowed counselors to receive help when needed and made them feel part of a team. It also helped them to feel appreciated and recognized for their hard work:

“Okay, I haven’t seen any difficulties because we have all the resources we need to use during the process like the mobile phone. We are also given constant advice on challenges we face. The team is also doing good in checking on us through phone calls, so I’ll say I haven’t received any challenge that obstruct us from performing (Male, 63, Minimal Group).”

A third protective factor was having a strict schedule for activities so that they could best manage their time. This seems to help the counselor better balance their multiple responsibilities and roles and perhaps even compartmentalize stress:

*“No, I have not [**experienced overwhelming stress**]. Maybe. I always try to ensure that I have a schedule of work so that I don’t over stretch myself. And if I happen to have my own work on the same day with a day I am supposed to counsel I postpone to another day. There are days I have set for counseling and there are days that I have set for my own work (Female, 55, Moderate Group).”*

A fourth protective factor was the ability to press on due to the sense that a counselor was “fulfill[ing] the heart’s desire and goal of helping families improve and bring harmony to the community (Female, 53, Minimal Group).”

“What motivates me, is despite all these things, at the ended you get to achieve you goals of bringing families together, the other thing is the relationship between us and the supervisors is very good, so through them motivating and advising you constantly give me the morale to continue with this task as a TP counselor (Female, 57, Moderate Group).”

A final protective factor was observing the overall improvement in a counselor’s community and gaining motivation from such successes. They took pride in their community that is more welcoming and is living in increased harmony:

“What motivates me is the way people are in the village. It motivates me because I want people to live in harmony, to work hard, go to church...If all of them would change it would be very good. So it has given me a lot of motivation (Male, 44, Minimal Group).”

3.8 Dynamics Between Stress, Burnout, Motivation, and Self-Efficacy

After reviewing counselor experiences of identity role shifts and changes in stress, burnout, motivation, and self-efficacy, we examined how these domains interact with each other. We first identified a common cycle the counselors reported experiencing over time as a TP counselor. This cycle (described in Figure 2. TP Counselor Changes in Domains of Interest below) does not reflect all of the interactions observed between domains, but captures many of the connections described by the counselors.

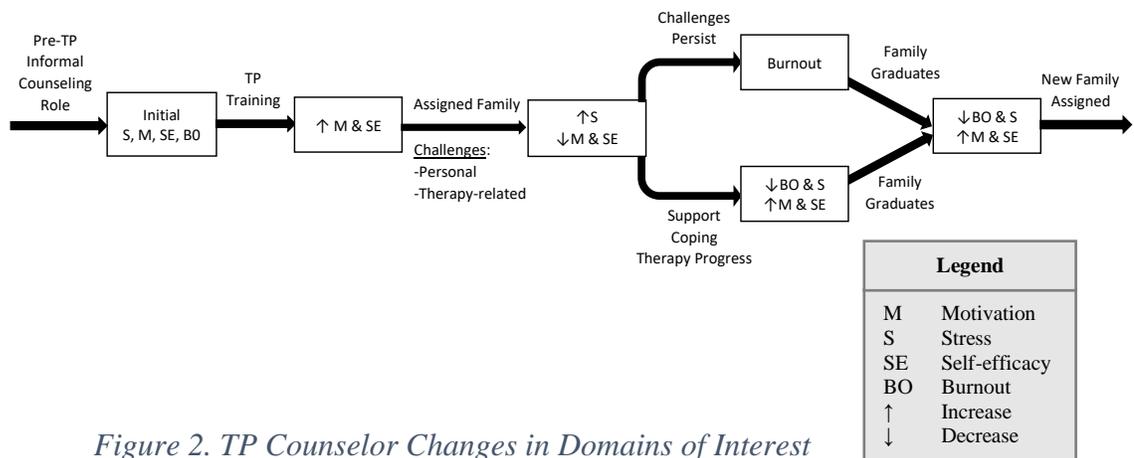


Figure 2. TP Counselor Changes in Domains of Interest

They began in their pre-TP informal counseling role with their individual levels of stress, motivation, self-efficacy, and burnout related to that informal role. They then received TP training, after which counselors expressed an increase in self-efficacy due to a sense of empowerment in their abilities as counselors. The TP skills and manual made them feel more systematic and that they had an expanded scope of situations they could help with. This removed the “guess work” they described for their previous therapy approaches and made it more “skillful” and “systematic.” Empowerment and self-

confidence were accompanied by an increase in motivation to counsel due to a sense of readiness and preparation.

After being assigned a family, the counselors began to experience the first challenges of formal counseling despite their preparations and increased self-efficacy. Two types of challenges emerged: personal and therapy-related. Examples of personal challenges primarily stemmed from the role balance tensions in trying to make time for counseling, but also taking care of their other roles. An example was the farmer who traveled to a session where the family did not attend, and they lost time they could have devoted to their fields. The most common therapy-related challenges included delayed or cancelled sessions, lack of progress in the early sessions (“refusal to change”), incomplete attendance of family members, or families “backsliding” after initial changes manifested. One example was the counselor who spent money on a motorbike for distant travel, both ways, due to heavy rains and mud, to have a session where the family refused to communicate and little progress was made. These types of challenges caused some counselors’ stress to increase while their motivation and self-efficacy decreased.

The branching point here was whether the counselor had access to, and engaged, support and coping strategies, or if the challenges persisted long-term without adequate support and coping. With persistent challenges, as shown in the upper pathway, the stress piled on and compounded more and more until the counselor could begin to experience symptoms of burnout. This was especially due to the accompanied decrease in motivation and self-efficacy as a counselor questioned the commitment of the family they were counseling and their own capabilities as a counselor. This decrease was further heightened as this negative cycle was accompanied by personal challenges of role balance with their

other non-counseling roles as parents, farmers, and public servants. A typical case was a counselor feeling they had “wasted or sacrificed” their time trying to counsel when they had other responsibilities to attend to.

However, as shown in the lower pathway, if a counselor found support in their challenges, or the counseled family finally made progress, the negative effects of the challenges could be reduced. This included reduction in stress and burnout and an upswing in motivation and self-efficacy. In addition to the stress coping and burnout resistance mechanisms described previously, this support often came in the form of supervisor guidance or peer group meetings with fellow counselors. Outside of TP, counselors also found support and positive changes through investing in their families and communities. Outlets for these interactions were described by many as arising due to “self-counseling”, which improved their interaction skills and social bonds with others. All of these positive outcomes led to improved sense of self-efficacy in multiple identity role areas and strengthened social status and networks. Importantly, sometimes this cycle repeated multiple times during the course of treatment for even one family.

Finally, in most cases, families graduated from treatment, having at least partially succeeded in reaching their treatment goals. At this point, both those who had experienced more support and coping, as well as those who had experienced more prolonged stress, often reported feeling a sense of accomplishment reflected in reduced feelings of stress and burnout, and restoration of motivation and self-efficacy.

4. Discussion

Following inquiry into the experiences of TP counselors providing counseling to distressed families, many challenges, pressures, and changes were discussed by individuals. Many started in a state of empowerment and elevated motivation, but were soon faced with the reality that counseling was not as easy as they expected and the need to continually work hard to help their families improve. Despite these challenges identified by participants, some counselors were observed to have unique characteristics that protected them, while others were simply able to endure due to other support networks. As counselors continued to work with their families, they would eventually find breakthroughs and the families would make progress. The progress would lead to improved motivation and self-efficacy and a reduction in the stress and burnout feelings.

The following sections provide a review and interpretation of what was found for this TP counselor population, relate it to the literature on similar topics, and propose future directions.

4.1 Identity Role Shifts

Although studies mentioned previously have focused on additional workloads and responsibilities taken on by lay providers in light of the socioeconomic inequalities they face, our population of TP counselors did not frequently touch on these topics. Many saw the added responsibilities as manageable and not inherently overwhelming. This was not unexpected since the implementation model explicitly recruited people already spending time on counseling, and included only small caseloads to mirror that existing routine. Instead, it was due to being overwhelmed from the struggles their responsibilities produced, such as mounting stress from scheduling or attendance issues and families not

improving. They also saw their new role and workload as an outlet to fulfill their intrinsic desires to help the community and achieve fulfillment.

Similar to the CHW population studied by Mlotshwa (2015) in South Africa delivering home-based care, a few TP counselors expressed an elevated sense of respect and status within their communities after taking on their counseling roles. However, a few counselors reported not experiencing this as much due to how discreet they needed to be about counseling families; others therefore did not know their new role. Given the tenants of role identity theory, it is not surprising that the counselors experienced shifts and changes in their non-counselor roles and relationships. As they integrated their new formal counselor role into their role set, with all of its skills, expectations, and responsibilities, its presence began to positively reshape their other role as parents, teachers, pastors, and community elders through the feedback and expectations they received from others. Their sense of identity and meaning within these new social spaces and interactions produced positive influences which further motivated them to embody their counselor roles.

4.2 Motivation and Self-Efficacy

Similar to findings from a study by Bhatnagar and colleagues (2017) of Nigerian primary care providers, the TP counselors' initial and sustaining motivations were often connected to individual factors (especially religious), organizational factors (like feeling part of a larger TP team), and the community recognition some received. Motivation is an important area on which to focus attention because it can determine how long a lay provider will remain engaged in the organization. It is also important to note how much it is influenced by stress, burnout, and self-efficacy feelings, which are continually fluctuating with a lay provider's day-to-day encounters. For the TP counselors, the most common route

to feeling burnout symptoms was due to continually mounting stress, diminished self-efficacy when they were not observing progress, and ultimately diminished motivation to continue as a result. Without continued motivation from intrinsic or extrinsic values, lay providers can succumb to burnout and lose the original spark they had for their work, leading to increased worker retention issues.

Alongside motivation, a driving force for TP counselor success was their sense of self-efficacy in their ability to complete their work. As with other lay provider populations, the TP counselors felt empowered by the training they received and desired to learn more in the future (Tilahun et al., 2017). This was also highly influenced by their perceived cohesiveness with the TP organization, their supervisors, and fellow counselors. In the face of all the challenges of the intensive TP therapy, namely family client attendance and cooperation, role balance issues, and internal struggles with stress, potentially leading to burnout, these self-efficacy improvement structures are key. Without the support structures in place and without continued training which sustain the counselors, it is difficult to see the counselors continuing to engage. They must trust in themselves that they can do the work, otherwise, no amount of intrinsic drive or motivation can help them effectively actualize their goals. A fostering balance must be maintained.

4.3 Stress and Burnout

Based on participant responses, the TP counselors have experienced classic physical and emotional symptoms associated with feelings of burnout (Traunmuller et al., 2019). Similar to Pandey and Singh (2016) findings, the TP counselors described a strong relationship between their emotional health, frustrations with their role, and burnout symptoms. Despite the difficult family cases the counselors worked with, none have

stopped engaging with their TP duties, even after several had experienced burnout symptoms. Even with the long-term TP counselors of two years, few were impacted or “drained of all compassion” as with Selamu’s (2017) Ethiopian study. This is an important factor to celebrate, but to also understand its origin to ensure it continues to happen. Important protective factors mentioned by TP counselors new and old included high self-efficacy feelings, which helped push a counselor through a tough case, returning to intrinsic motivations of a “calling” from God to help, and focusing on the positive changes happening in their lives and around them due to their counseling work. In other words, maintaining high levels of self-efficacy, motivation, and investing in the positive identity and social changes arising from taking on a lay provider role can help combat or resist burnout. However, it is unclear the full limitations, exact level, or combination that is necessary to fully enact these protective factors.

4.4 Approaches to Better Support Task-shift Volunteers

Despite inherent limitations of this study, given the design and special study population, the following section reviews key elements found from this study which may be applied to maintain lay provider engagement with a task-shifting program. They are organized into three key support areas (“Programmatic,” “Outside,” and “Self”) where resources can be explicitly invested during training and implementation to ensure sustainability and scaling. The overall message is that programs need to understand how these factors can influence their lay provider population and be proactive about preventing such negative and supporting such positive changes.

4.4.1 Programmatic Support

When TP counselors were describing their most stressful situations, which often led to feelings of burnout, what often reduced or removed burnout was finding internal support from their supervisor and fellow counselors. This was due to a feeling of being “part of a team” and “not being alone,” that such interactions produced. Their supervisors were able to help them keep the problem in perspective, give them advice on directions to try next, suggest areas for improvement, and invigorate motivation and self-efficacy. Their fellow counselors helped counselors realize they were not the only ones struggling with families, provided a creative space for problem solving through anecdotal experience, and bonded counselors in solidarity as a group.

In the case of TP, direct supervision over counselors was programmatically designed from the start. The inspiration for this model was due to the notion that, in order to be effective in their task-shifted duties, counselors would need higher collaborative support to provide such a challenging therapy than would be found from a few series of trainings or disparate supervision. With this in mind, we recommend that programs ensure proper supervision support for their lay providers as they transition into their new roles and continue to face struggles in their work. Other areas of support can come from nonmonetary incentives, as suggested by a few TP counselors regarding further training and help with travel. Such incentives have been used in other settings, like India, with provision of training opportunities, certificates, ID cards, bicycles, gumboots, and even uniforms (PressInformationBureau, 2015).

In the case of TP, the counselors’ support groups were an organic development that arose from the counselors taking it upon themselves to meet. This seems to have arisen

from solidarity found in being part of a training cohort and being fellow members of the community. These informal support groups were advocated for by all counselor experience groups for their positive impacts described previously. We recommend that TP and other programs with groups of lay providers do their best to create a collaborative, supportive atmosphere among their workforce. This can be through advocacy of physical support group meetings with lay providers, or general team building activities, or telecommunication media. A similar approach was adopted by the Karen Department of Health and Welfare (KDHW) in Myanmar through workshops for their trauma management medics to learn techniques to manage personal and peer mental wellbeing (Lim, Stock, Oo, & DJutte, 2013). Although successful in this context, admittedly, this may become difficult to coordinate as a program scales in size and personnel. However, efforts can still be made to ensure a team bond is felt by even the most disparate or isolated member within the chain. The positive impacts are too good to pass up.

Finally, a few counselors did mention the desire for monetary compensation in order to make their work “lighter” or “easier,” but the majority were more interested in other supportive measures, such as more training, or help with travel. This is not to say that they would not desire to be paid for their work but is encouragement that there are other avenues in which the TP counselors may be better supported. This is an important point given how essential maintenance of motivation is for ensuring positive counselor experiences and retention. Rather than only investing in those who have fiery initial motivations to do the work, organizations must invest in avenues to continually kindle and maintain worker motivation, financially or otherwise. To simply hire and replace counselors like freely exchangeable parts when one loses motivation is unsustainable for

complex interventions in terms of training and is exploitative of a potentially vulnerable population.

4.4.2 Outside Support: Family and Community

Outside of the influence of TP and its supervisor-counselor network, TP counselors often mentioned finding support from their non-counselor role social networks. This came in the form of talking to a spouse, family members, and friends or engaging with the community through religious services and events. This provided both a chance to express themselves as they transitioned into and balanced the new requirements of their old and new roles, and an outlet to escape their counseling role and perhaps return to a sense of normalcy. The best remedy for stress and negative feelings was often a full dive into one's non-counseling work, engaging in a social activity, or even just playing with children by "getting on their level."

We would recommend that TP and similar programs invest in ways to advocate for lay providers to engage in their extra-intervention support networks. This would be in the form of reminders during training and regular check-ins for lay providers to seek out support both from the organization and their own networks. It is important to keep lay providers engaged in their community outside of their provider role so that they can relieve negative feelings by taking a break from their provider role and reinvesting in their community they are trying to impact. This can reinvigorate the provider as they observe the impact they are making and are reminded of all the reasons they became a lay provider. The goal is to ensure they find the help they need from their new role's perspective within the organization and help from their non-provider role to maintain a healthy, positive balance. Continuing to engage in the community could also help with overall programmatic

success as the community becomes more aware of the lay health providers and their program. Community support for, and engagement with interventions is a key issue that has been explored in multiple studies (Davis et al., 2018; Ozano, Simkhada, Thann, & Khatri, 2018).

4.4.3 Self Support

4.4.3.1 Provider Buy-in and Self-Counseling

This “self-counseling” process described previously was a fascinating development in this TP counselor population. This is perhaps related to the “helper therapy principle” described by (Riesman, 1965; Riessman, 1990), whereby lay providers who share similar characteristics or problems of their clients may receive “helper benefits.” Previous studies have found these benefits could include increased self-confidence and personal effectiveness, greater social support, and improved status due to their associated role in the health system (Bond, 1979; Guinan, McCallum, Painter, Dykes, & Gold, 1991; Kahn & Fua, 1992; Wallston, McMinn, Katahn, & Pleas, 1983).

Similar to this discourse, as counselors honed and shaped their skills providing the TP therapy, many took it upon themselves to naturally integrate their learned TP counseling skills into their non-counseling roles as parents, pastors, and community leaders. This led to the positive spillover effects which improved their lives, self-efficacy, and motivation as counselors. As the counselors observed improvements in their own lives and families, it seems they strengthened their faith in the therapy’s ability to impact client families. This process appears to have produced an improved “provider buy-in” for the TP counselors by instilling motivation and faith in themselves and the program. To improve similar programs using task-shifted individuals, we would recommend program designers find ways to

increase this provider buy-in element to not only motivate their workforce, but also potentially enhance service fidelity.

In the case of mental health or behaviorally focused programs, this provider buy-in could be instilled during initial training by providing space for programmers and providers to discuss personal application of the skills and approaches learned. Admittedly, this process may not be applicable for all intervention programs, such as those focused on certain physical or infectious ailments, which may not have elements that providers can apply directly to their lives. However, to supplement, programs could offer alternative avenues to show providers the service's impact, such as sharing anecdotes, reports, or discussions during training or future workforce assemblies. The goal is to increase motivation, program faith, and provider self-efficacy by showing the connections between their on-the-ground work and the changes being produced.

4.4.3.2 Identity and Sense of Self Support

Given what we have learned from this TP counselor population, it is clear that taking on a new lay provider role is not always a simple increase in workload, stress, and time management challenges. It has impactful consequences on their social networks, behavioral approaches to life, and ultimately changes in their own sense of self related to their lay provider role and outside roles. Therefore, it is important for individuals to understand what to expect when taking on the role, beyond what is obvious about a new set of responsibilities.

We would recommend that, at the start, during recruitment and training, potential lay providers should be made aware that they may experience changes in their sense of self and interactions with others due to their new roles. They should be provided with examples

and case studies so that they can understand how the change may happen. A focus should be on the positive, but also addressing the negatives that may come. The goal is to ensure counselors have a smoother transition, rather than have them struggle alone or feel like they are not the right person for the job because they experience negative outcomes. Given the information at the start, the lay individuals could then be given space to problem solve how to handle these potential changes and create their own personal action plans. The organization as a whole could also provide suggested steps as well, informed by local contexts.

An approach that has been used in another setting is the provision of “Self-Management” (SM) training for health providers in South Africa (Majee et al., 2019). The goal is to provide methods to manage symptoms, treatments, lifestyle changes, and other consequences of health conditions. The emphasis is on the expectations a person has about being able to achieve a specific behavior (Richard & Shea, 2011). Although more focused on actual health outcomes or influences, a training could be modified to fit scenarios outside of physical health. An example of this would be teaching Emotional Intelligence (EI), which has been found to have protective influences on burnout (Antoniou & Koronaiou, 2018; Beauvais, Andreychik, & Henkel, 2017; Gorgens-Ekermans & Brand, 2012; Zysberg, Orenshtein, Gimmon, & Robinson, 2017)

4.4.4 Dynamics Between Domains

Following the starting understanding of the influences of stress, burnout, motivation, and self-efficacy on the TP counselors, a deeper understanding of their entire experience was reached by looking at how these domains interacted. Motivation and self-efficacy were often described as rising and falling together, typically in response to

challenges or stress. Burnout started to make an appearance once a certain threshold of sustained high stress and diminished motivation and self-efficacy was reached.

This threshold effect points to a lesson that programs must intervene and address multiple domains in tandem to be successful in maintaining positive lay provider experiences. In the case of TP, it was not enough to provide training and supervision as programmatic support, although they did help with self-efficacy and motivation building. As the TP counselors struggled with their role challenges, which brought on compounding stress, they often sought out coping and support from their existing social networks outside of TP. An important step for TP and other lay provider programs is to obtain a deeper understanding of the full work lifecycle of their lay provider experiences which would allow for identification of potential areas that produce increases or decreases in key domains. With this understanding, a tailored set of support networks to combat declines and promote increases to sustain lay providers could be created.

With the identification of TP counselor outside social networks as an important support structure, a potential avenue to begin formulating better support for lay providers could be an adaptation of “Support Network Mapping” as used in social work cases, such as for foster care youth (Jennifer E. Blakeslee, 2015; J. E. Blakeslee & Best, 2019). The goal of the mapping is to assess the structure and function personal social networks, strength of relationships, and types of support offered (Tracy & Whittaker, 1990). This process would help engage lay providers and their existing outside support. By linking lay provider social networks and programmatic support structures to problem areas found in their work lifecycle, more comprehensive lay provider support could be reached. This

could help with short term fidelity and retention, and be an optimal way to further evaluate how well program activities are being fulfilled from the lay provider perspective.

4.5 Study Strengths and Limitations

Key strengths for this study include inclusion of majority of the eligible counselors from this specific intervention (22 of 27 trained counselors), rigorous interview guide preparation through multiple translation/back-translation rounds with local collaborators and piloting, and a FGD “member checking” procedure to verify data collected and missingness with participants. Other strengths include the inclusion of stress mapping, an innovative method to triangulate purely qualitative data, and looking at a new implementation method which begin to fill the literature gap described previously.

Two key limitations are due to sample size and translation approaches. Although a study strength was inclusion of almost all counselors for this intervention, a limitation is not having a larger sample of counselors from different interventions. Future research will be essential for exploring whether these findings hold and are influenced by other interventions and implementation models. Translation from Kiswahili to English for analysis, and lack of a Kenyan coder, also could have led to potential loss of contextual depth of interview data.

4.6 Implications for Further Research

A focus on roles and associated changes in identity, sense of self, and social networks provided a unique insight into the lives of lay counselor providers. With a lot of literature, it seems researchers and program designers focus on the negative impacts of becoming a lay provider by focusing on the impact due to workload, low-to-no-pay volunteerism, and increased stress. However, by looking at these new avenues, we found

that accompanying these negative influences, by taking on this new role, lay providers may also experience just as many, or even more, positive influences which counterbalance the negatives. While the current study similarly included many questions on burnout, stressors, and problems, future studies could take a positive mental health approach, conceptualized as positive emotions paired with good psychological and social functioning (Keyes, 2002, 2005). These could help identify even more protective factors that did not surface from this study.

The lesson learned here is that future researchers and program designers for task-shift models and lay providers need to look beyond the negative influences of taking on responsibilities and increased workload, and into the other influences on lay provider experiences. They are humans, not “magic bullets,” who are integrating these new skills and experiences into all aspects of their lives, not simply being a lay provider in discrete, controlled instances. As such, a focus must be on both the positive and negative spillover effects which may occur outside of the lay provider role as individuals integrate new roles into their initial role set and social networks.

5. Conclusion

In this study, we have reviewed common pathways a population of lay counselors follow as they transition into a formal counseling role. Important influences on their lives included changes and interactions between the domains of stress, motivation, burnout, and self-efficacy in relation to their unique challenges and support networks. Role Identity Theory offered a unique lens to further understand how these changes emerged and coping mechanisms the lay counselors utilized to maintain their counselor role. An important lesson learned is that assessing the impact of a provider role on lay individuals is not a simple balancing of scales between positive and negative influences. There are multiple intertwining events which produce positive and negative changes in lay provider lives which contribute to their overall outlook on their role. With this comes a need to approach development of support networks for lay providers that synergistically intervene in these multiple influential areas.

As health systems and global health initiatives continue to use lay providers, especially in rural areas of LMICs, it is important to understand their experiences fulfilling their roles so that they can be adequately supported and retained. Using the information from this study, and others which focus on the professional, personal, and social challenges of lay providers, future initiatives can better formulate and implement more holistic support networks to intervene when lay providers need them most. In doing so, we can ensure that the positive outcomes lay providers are able to produce in their communities are maintained in an ethical manner which is not exploitative of their valiant efforts.

Appendix A: Data Collection Materials

A1. Interview Question Protocol (Regular)

Primary research question:

In what ways do role and identity shifts experienced by people who are trained as community-based lay counselors affect their levels of stress, burnout, motivation, and self-efficacy?

Pre-Interview:

1. Fill out initial “Interview Cover Sheet,” and “Informant Demographics” tables.
2. Review Consent Form and obtain written consent.

Probe Technique Reminder: Try to always make a connection between “before” or “after” becoming a Tuko Pamoja counselor for participant responses

*****BEFORE STARTING*****

“Before starting, I would like to emphasize that we are not sharing any of your responses with your supervisor or anyone on the Tuko Pamoja team. Any information that is shared will not be associated with you. Your responses will remain confidential and will not stop you from continuing to be a Tuko Pamoja Counselor”

“Now, I am going to ask a couple simple questions to help us start our discussion.”

1. Could you describe your family structure? [**Spouse and children**]
2. How long have you been counseling as a Tuko Pamoja counselor?
3. How many families have you counseled with the Tuko Pamoja program?
4. What do you like most about being a Tuko Pamoja counselor?

“Now, I would like to change the conversation towards our first topic. For the next few questions, think back to the time before you started training with Tuko Pamoja.”

1. Before becoming a counselor for Tuko Pamoja, what was your role in the community?
 - i. What was your role in the church, your family?
 - b. What caused you to take on this role in your community?
 - c. Can you tell me a little bit about your counseling approach before Tuko Pamoja?
 - i. Where did you learn these techniques, advices, etc.?
2. When you were approached about becoming a Tuko Pamoja counselor, how did you decide to do it? [**What steps did you take to make the decision?**]
 - a. What was your personal goal for your position as a counselor before Tuko Pamjo?

“Thank you so much for your responses so far. Now, I would like to ask you about your time as a counselor since you started using your training from Tuko Pamoja.”

1. What does it mean to you to be a Tuko Pamoja counselor?
 - a. What are the qualities of being a Tuko Pamoja counselor?
 - b. How have you started to use the Tuko Pamoja training skills in your counseling sessions?
2. Now that you are a counselor for Tuko Pamoja, how has your role in the community changed?
 - a. In what ways is it different from when you were counseling before Tuko Pamoja training?
 - b. What do other people in the community think is your role? **[Have others noticed this change you have mentioned?]**

“Thank you for your responses. Now, when people take on new responsibilities, sometimes it can also change the way they feel and think about themselves, families, friends, or other things. I’d like to talk about anything that’s happened like that for you.”

1. In what ways has your counseling role changed your day-to-day life?
[Community, family, spouse, etc.]
 - a. Can you give an example of this change?
 - b. How have these changes made you feel?
2. Have your relationships with other people changed since becoming a Tuko Pamoja counselor? **[i.e. family members, spouse, church members]**
 - a. In what ways have they changed in a **good** way?
 - b. In what ways have they changed in a **bad** way?
 - c. Do people treat you differently now that you are a Tuko Pamoja counselor?
 - i. In what ways do they treat you differently?

“Before continuing, I would like to again emphasize that we are not sharing any of your responses with your supervisor. Your responses will remain confidential and have no bearing on you continuing to be a Tuko Pamoja Counselor”

“Now, I would like to talk about your stressful experiences while being a Tuko Pamoja counselor, and how these experiences made you feel.”

1. What are some things that are stressful about being a Tuko Pamoja counselor?
 - a. What makes these things stressful? **[Why are they stressful?]**
 - b. What’s the hardest thing about being a Tuko Pamoja counselor?
2. Do you feel more stress in life since becoming a Tuko Pamoja counselor **[completed training]**?
 - a. In what ways has your stress changed? Can you give an example?
 - i. **[If they say they are not more stressed even though they listed a lot of stressors, ask how that works or how is that possible]**
 1. **[Relist the stressors to them in your probe]**
3. What are ways that you help reduce or relieve your stress?

- a. How effective [**helpful, useful**] are those?
 - b. What else might be helpful for relieving stress?
 - i. What have you heard others do to relieve stress that you haven't tried to do?
4. How is your relationship with your supervisor? [**Emphasize confidentiality here**]
- a. Who was your supervisor? [**Helping them remember**]
 - b. How is your communication with them?
 - c. Are there ways they could better support you?
5. How is your relationship with other Tuko Pamoja counselors?
- a. How is your communication with them?
 - b. Are there ways they could better support you?

“Thank you so much for your responses so far. Now, the next section is similar to the last, but this time, I will be asking about your experiences with larger, extreme, or overwhelming feelings of stress related to your tasks as a Tuko Pamoja counselor. Imagine a time when you were counseling a family as a Tuko Pamoja counselor, and you felt like a spring. Sometimes your work caused you to feel stretched, but you were able to bounce back and return to your original shape. However, imagine a time when you felt stretched too far and couldn't come back.”

1. What brought on these feelings of overwhelming stress? [**What caused these feelings?**]
 - a. Do you ever feel like you have too many responsibilities or are taking on more than you initially thought you would? [**Do you have an example?**]
2. Can you describe how this situation made you feel?
 - a. How do these situations make you feel in your heart?
 - i. What do they make you feel in your head?
 - ii. How do they make your body feel?
 - iii. [**Other areas?**]
3. How do you relieve these feelings of overwhelming stress?
 - a. [**If they say “nothing” or “don't know”, ask about community and support relationships**]
4. Although you have these feelings of overwhelming stress, what keeps you motivated to continue being a Tuko Pamoja counselor?
 - a. Are there things your supervisor or others in Tuko Pamoja could do to help relieve these feelings of stress or [**insert vocabulary participant has used**]?

“Now, this final section will be related to topics of your feelings about your preparation and training to become a Tuko Pamoja counselor, and how capable you feel as a Tuko Pamoja counselor”

1. At the start of becoming a Tuko Pamoja counselor, did you feel you were prepared to take on these responsibilities?
 - a. Has this feeling changed since then, now that you have some experience?
2. Were the trainings helpful in preparing you for your responsibilities as a Tuko Pamoja counselor?

- a. In what ways were they helpful? Ways trainings were unhelpful?
- b. What did you learn from the trainings compared to what you used to do?
- 3. What are your own personal expectations for yourself in your role as a Tuko Pamoja counselor?
 - a. **[If not understood: What is your goal for being a Tuko Pamoja counselor?]**
 - b. Do you meet these personal expectations?
 - i. In what ways do you meet them?
 - ii. In what ways do you **NOT** meet them?
- 4. What are the expectations others place on you as a Tuko Pamoja counselor?
 - a. **[Families you counsel, your family, your spouse, your community]**
 - b. Do you feel you are able to meet their expectations?
 - i. In what ways do you meet them?
 - ii. In what ways do you **NOT** meet them?

Closing Questions: Never Skip these

- 1. If you met someone who was considering becoming a Tuko Pamoja counselor, how would you describe the responsibilities to them?
 - a. What advice would you give them?
 - i. Advice on making the decision?
 - ii. Advice on performing the responsibilities?
- 2. Are there ways in which you think Tuko Pamoja could better support future counselors?
 - a. How would such things help Tuko Pamoja counselors with their day-to-day tasks?
- 3. Was there anything that you would like to mention or discuss that was not mentioned so far in our conversation?
- 4. Demographic Questions
 - a. Age, Gender/Sex, Primary Church Location, Education, Informal Training, Home/Village of Origin, Number of families counseled?

Closing: “Thank you so much for your time and participation in this interview. Your time is very much appreciated and your insights have been helpful.”

A2. Interview Protocol/Guide (TP No Experience Group)

Primary research question:

In what ways do role and identity shifts experienced by people who are trained as community-based lay counselors affect their levels of stress, burnout, motivation, and self-efficacy?

Pre-Interview:

- 1. Fill out initial “Interview Cover Sheet,” and “Informant Demographics” tables.
- 2. Review Consent Form and obtain written consent.

*****BEFORE STARTING*****

“Before starting, I would like to emphasize that we are not sharing any of your responses with anyone affiliated with Tuko Pamoja. Any information that is shared will be anonymous without any connection to you. Your responses will remain confidential.”

“Now, I am going to ask a couple simple questions to help us settle into our discussion.”

1. Could you describe your family structure? [**Spouse and children**]
2. How long have you been counseling and giving advice to others in your community?
3. What do you like most about counseling and giving advice to others in your community?
4. What did you like most about the Tuko Pamoja counselor trainings?

“Now, I would like to direct the conversation towards our first topic. For the next few questions, think back to the time before you started training with Tuko Pamoja.”

1. Before starting training to be a counselor for Tuko Pamoja, what was your role in the community?
 - i. What was your role in the church, your family?
 - b. What caused you to take on this role in your community?
 - c. Can you yell me a little bit about your counseling approach before Tuko Pamoja training?
2. When you were approached about taking the Tuko Pamoja counselor training, how did you decide to do it? [**What steps did you take to make the decision?**]
 - a. What was your personal goal for your position as a counselor before the Tuko Pamoja training?

“Thank you so much for your responses so far. Now, I would like to ask you about your time since you completed training with Tuko Pamoja.”

1. Have you been assigned a family to work with using the Tuko Pamoja counseling skills?
 - a. **IF YES:** [**Exit the interview and seek our clarification from the PI. They should not be interviewed using this guide**]
 - b. **IF NO:** Have you used any Tuko Pamoja counseling skills with a family in the community?
 - i. **IF YES:** What skills have you used?
2. In what ways were the skills you learned from the Tuko Pamoja training different from when you were counseling before the training?
3. How has your role in the community changed since your counselor training with Tuko Pamoja?
 - a. In what ways has it changed?
 - b. What do other people think your role is in the community? [**Have others noticed this change you have mentioned?**]

IF THEY MENTION A CHANGE IN ROLE/POSITION SINCE TRAINING WITH TUKO PAMOJA, ASK THIS SET OF QUESTIONS CONCERNING THE NEW ROLE THEY MENTIONED

“Thank you for your responses. Now, when people take on new responsibilities, sometimes it can also change the way they feel and think about themselves, families, friends, or other things. I’d like to talk about anything that’s happened like that for you.”

4. In what ways has your role changed your day-to-day life? [**Community, family, spouse**]
 - a. Can you give an example of this change?
 - b. How have these changes made you feel?
5. Have your relationships with other people changed since becoming a [**role**]? [**i.e. family members, spouse, church members**]
 - c. In what ways have they changed in a **good** way?
 - d. In what ways have they changed in a **bad** way?
 - e. Do people treat you differently now that you have this role?
 - i. In what ways do they treat you differently?

“Now, I would like to talk about your stressful experiences while working as a [role], and how these experiences made you feel.”

1. What are some things that are stressful about working as a [**role**]?
 - a. What makes these things stressful? [**Why are they stressful?**]
 - b. What’s the hardest thing about being a [**role**]?
2. Do you feel more stress in life since becoming a [**role**]?
 - a. In what ways has your stress changed? Can you give an example?
 - i. [**If they say they are not more stressed despite listing a lot of stressors, ask how that works or how is that possible**]
 1. [**Relist the stressors to them in your probe**]
3. What are ways that you help reduce or relieve your stress?
 - a. How effective [**helpful, useful**] are those?
 - b. What else might be helpful for relieving stress?
 - i. Maybe something you haven’t tried to do?
4. How is your relationship with your [**pick most appropriate: community OR family**]?
 - a. How is your communication with them?
 - b. Are there ways they could better support your work?

“Thank you so much for your responses so far. Now, the next section is similar to the last, but this time, I will be asking about your experiences with larger, extreme, or overwhelming feelings of stress related to your work as a [role]. Imagine a time when you were working as a [role], and you felt like a spring. Sometimes your work caused you to feel stretched, but you were able to bounce back and return to your original shape. However, imagine a time when you felt stretched too far and couldn’t come back.”

1. What brought on these feelings of overwhelming stress? [**What caused these feelings?**]

- a. Do you ever feel like you have too many responsibilities or are taking on more than you initially thought you would? [**Do you have an example?**]
2. Can you describe how this situation made you feel?
 - a. How do these situations make you feel in your heart?
 - i. What do they make you feel in your head?
 - ii. How do they make your body feel?
 - iii. [**Other areas?**]
3. How do you relieve these feelings of overwhelming stress?
 - a. [**If they say “nothing” or “don’t know”, ask about community and support relationships**]
4. Despite these feelings of overwhelming stress, what keeps you motivated to continue being a [role]?
 - a. Are there things your family or community could do to help relieve these feelings of stress or dread?

“Now, this final section will be related to topics of your feelings about your preparation and training to become a [role], and how capable you feel as a [role]”

1. At the start of becoming a [role], did you feel you were prepared to take on these responsibilities?
 - a. Has this feeling changed since then, now that you have some experience?
2. Were there any trainings involved in preparing you for becoming a [role]?
 - a. **IF YES**
 - i. Were the trainings helpful in preparing you for your responsibilities as a [role]?
 - ii. In what ways were they helpful?
 - iii. What did you learn from the trainings?
3. What are your own personal expectations for yourself in your role as a [role]?
 - a. [**If not understood: What is your goal for being a [role]?**]
 - b. Do you meet these personal expectations?
 - i. In what ways **do** you meet them?
 - ii. In what ways do you **NOT** meet them?
4. What are the expectations others place on you as a [role]?
 - a. [**People you work with, your family, your spouse, your community**]
 - b. Do you feel you are able to meet their expectations?
 - i. In what ways **do** you meet them?
 - ii. In what ways do you **NOT** meet them?

Closing Questions

1. If you met someone who was considering becoming a [role], how would you describe the responsibilities to them?
 - a. What advice would you give them?
 - i. Advice on making the decision?
 - ii. Advice on performing the responsibilities?
2. Are there ways in which you think your community could better support future [role(s)]?
 - a. How would such things help a [role(s)] with their day-to-day work?

3. Was there anything that you would like to mention or discuss that was not mentioned so far in our conversation?
4. Demographic Questions
 - a. Age, Gender/Sex, Primary Church Location, Education, Informal Training, Home/Village of Origin, Number of families counseled?

Closing: “Thank you so much for your time and participation in this interview. Your time is very much appreciated and your insights have been helpful.”

A3. Interview Free-Listing Activity Instructions

At the **START** of the Stress section of the interview, you will be leading an activity to try to delve deeper into participant experiences with stress. Follow these steps to lead the activity:

1. **Announce**: “I will now pause the recorder so that we can complete an interview activity”
2. **PAUSE THE RECORDER: DO NOT STOP OR SAVE THE RECORDING**
3. Pass out a piece of paper and pen to the participant
4. Introduce the activity as:
 - a. “Now we are going to perform a small activity to better understand your experiences with stress. To do so, we will be making a list of things that you find stressful or make you feel stressed as a [role].”
5. Listing Stressors:
 - a. “To start, use the paper and pen given to you to make a list of as many things that you can think of that you find stressful or that make you feel stressed as a [role].”
6. Encouraging exhaustive lists
 - a. [Encourage participants to write down **EVERYTHING** that makes them feel stressed. Use any relevant probes or questions]
 - i. Ex. “What things make you feel stressed when you...[insert example]?”
7. Ranking the Stressors
 - a. “Now that you have your list, I want you to put the items in order by placing a number beside them. We will be ordering them from most stressful to least stressful.”
 - b. “Please mark a number one beside the most stressful item and then count upward until all items have a number beside them. Feel free to mark multiple items with the same number if you think they cause the same amount of stress for you. However, be sure

that your number markings are a fair and accurate representation of how you feel.

8. Post-Activity Discussion [**Take note of responses**]
 - a. “How did you feel about this activity?”
 - b. “Did you learn or realize anything from this activity?” [**If so, what?**]
 - c. “What was the hardest thing about this activity?”
9. “**Thank you so much for your participation in this activity. Now, we will continue with the remaining sections of the interview**”
10. **RESTART THE RECORDER**

Announce: “**We have completed the activity and will continue the interview**”

A4. FOCUS GROUP Guide (Regular)

Jonathan Wall, PI
Joyce Jeptum, Interviewer

As people are arriving to the focus group, I will welcome them and note their names. Once everyone has arrived, we will start the introduction.

Introduction:

“Good morning and welcome. Thank you for taking the time to join us in our discussion of the experiences of Tuko Pamoja counselors in their daily work counseling families. My name is Joyce Jeptum and I am an interviewer with Tuko Pamoja whom you all have met with individually. Lydia here will be taking notes on our discussion. We are collaborating with Taylor Wall, who is a student from Duke who also works with Tuko Pamoja. Taylor is interested in learning about your experiences, challenges, and perceptions of the work you do with counseling families. The goal is to use this information to improve the Tuko Pamoja training and support for both current and future counselors. As such, we encourage you to tell us both positive and negative experiences you have had so that we can work to improve the program. Your responses will be kept confidential, without your name attached to them, and will have no bearing on your status as a Tuko Pamoja counselor. Following your individual interviews, we wanted to host a group discussion focused on these topics to gain further insight into these issues. I would like to remind everyone that there are no right or wrong answers. I expect that you will have differing points of view. Please feel free to share your point of view even if it differs from what others in the group have said – everything you have to say is relevant! I want to understand your experiences and opinions about your time as a Tuko Pamoja counselor and activities involved in counseling.”

“We are recording the session because we do not want to miss any of your comments. We will be the only ones to listen to this recording, and it will be destroyed after the data analysis. **Is everyone okay with that?** Before we begin, let me suggest some things that will make our discussion more productive. First, please speak up so that everyone may understand you. Second, only one person should talk at a time, so we should not interrupt each other. Please feel free however to respond to what other people have said, but please help us to foster a comfortable and respectful atmosphere of sharing. We

will be on first name basis, and in our later reports there will not be any names attached to comments. Your comments are confidential. I also request that everyone please keep all of today's discussions confidential and do not discuss anything others in the group talk about outside of this group. Also, if you feel uncomfortable or wish to leave at any time, you are free to leave."

"If you want to follow up on something that someone has said, or agree or disagree, or give an example, feel free to do that. Remember there are no wrong answers, only potentially differing points of view. Also, do not feel like you have to respond to me directly the entire time. Feel free to have a conversation with each other in the room about these questions. My job as moderator is to simply guide the discussion. I am here to ask questions, listen, and make sure everyone has a chance to share. I am interested in hearing from each of you. So, if you are talking a lot, I may ask you to give others a chance to speak. We just want to make sure that we hear from all of you. We will be done by *[insert time that is 2 hours from now]*."

[Be sure to take a break with the provided refreshment snacks at the one-hour mark!]

Opening questions: "To begin, we will start with some simple introductions."

- 1) I would like to start out by learning more about all of you. Could we please go around the room and each of you give a brief introduction of who you are? Please state your name, role in the community, and something you like to do in your free time.

"Thank you for your introductions. The goal of this next set of questions is to review information we have learned from your individual interviews to make sure we have understood you all correctly and have not missed anything. These questions will relate to if you all agree or disagree with what we have found, if you all think there is anything missing or that should be added, or any reflections or reactions you all have on information we have gathered from your individual interviews. These are summaries of individual interview responses that have had individual names removed for confidentiality."

Main questions:

1. COUNSELOR IDENTITY: "We will now review your individual responses for differences you all have experienced in your counseling roles compared to before and after your Tuko Pamoja training."

- 1) What does it mean to be a Tuko Pamoja counselor?
 - a) In what ways do you feel you embody the qualities necessary to be a Tuko Pamoja counselor?
- 2) How do the ways others view your role as a counselor compare to how you wish they viewed your role as a counselor?
 - a) Do you wish others viewed your role as a counselor differently?
- 3) How does your reputation in the community influence your work as a Tuko Pamoja counselor?
- 4) Compared to before your training with Tuko Pamoja, do you all feel you make more sacrifices to fulfill your responsibilities as a Tuko Pamoja counselor?
 - a) If so, what things do you have to sacrifice more of?

2. STRESS AND BURNOUT: *“We will now review a compiled list of stressors gathered from your individual interviews [see Focus Group Activity instructions].”*

- 1) Do you agree with this list?
 - a) Are there any very important stressors that are missing?
- 2) What are things that cause overwhelming stress, like the spring metaphor I asked you about in your interviews?
- 3) Are there ways you could be better supported to help with your stress?

3. MOTIVATION: *“We will now review responses for your individual motivations for being a Tuko Pamoja counselor. These are both things that motivate you and things that decrease your motivation.”*

- 1) Which of these motivations are the most influential in keeping you working as a Tuko Pamoja counselor?
 - a) Have we missed any important motivators?
- 2) Which of these items listed that decrease your motivation are most influential?
 - a) Have we missed any important items that decrease your motivation to work as a Tuko Pamoja counselor?

4. SELF-EFFICACY: *“For this final section, we will review your responses to questions about your feelings of preparedness and capabilities in being a Tuko Pamoja counselor.”*

- 1) What things influence how effective you feel as a counselor?
- 2) Have you all ever had a breakthrough experience, or epiphany, where you finally felt you could adequately do your job as a counselor? [*What events caused this moment to happen?*]
- 3) What are ways Tuko Pamoja could improve their trainings for counselors to help you all feel more effective as counselors?

In conclusion: *“Now, I have a final question before we are finished for this session.”*

- 1) Is there anything that we should have talked about but did not during our discussion today?

“Thank you all so much for attending today’s discussion. This will help us to work to better improve Tuko Pamoja’s support of future counselors. This was also a time to assure you all that we have been listening to you and have heard your ideas and voices.”

“Following this session, we would like to invite you all to a small debriefing meeting on August _____ at 2pm. This will be a time where the leader of this small research project, Taylor Wall, will present preliminary findings from your responses. It should last about an hour and will have snacks and refreshments. This is a time for you to see the outcome of your time invested in this project.”

A5. FOCUS GROUP Guide (No TP Experience Group)

As people are arriving to the focus group, I will welcome them and note their names. Once everyone has arrived, we will start the introduction.

Introduction:

“Good morning and welcome. Thank you for taking the time to join us in our discussion of the experiences of those trained to become Tuko Pamoja. My name is Joyce Jeptum and I am an interviewer with Tuko Pamoja whom you all have met with individually. Lydia here will be taking notes on our discussion. We are collaborating with Taylor Wall, who is a student from Duke who also works with Tuko Pamoja. Taylor is interested in learning about your experiences, challenges, and perceptions of the work you do with counseling families now that you are trained as Tuko Pamoja counselors. The goal is to use this information to improve the Tuko Pamoja training and support for both current and future counselors. As such, we encourage you to tell us both positive and negative experiences you have had so that we can work to improve the program. Your responses will be kept confidential, without your name attached to them, and will have no bearing on your status as a Tuko Pamoja counselor. Following your individual interviews, we wanted to host a group discussion focused on these topics to gain further insight into these issues. I would like to remind everyone that there are no right or wrong answers. I expect that you will have differing points of view. Please feel free to share your point of view even if it differs from what others in the group have said – everything you have to say is relevant! I want to understand your experiences and opinions about your time since completing the Tuko Pamoja training and activities involved in counseling.”

“We are recording the session because we do not want to miss any of your comments. We will be the only ones to listen to this recording, and it will be destroyed after the data analysis. **Is everyone okay with that?** Before we begin, let me suggest some things that will make our discussion more productive. First, please speak up so that everyone may understand you. Second, only one person should talk at a time, so we should not interrupt each other. Please feel free however to respond to what other people have said, but please help us to foster a comfortable and respectful atmosphere of sharing. We will be on first name basis, and in our later reports there will not be any names attached to comments. Your comments are confidential. I also request that everyone please keep all of today’s discussions confidential and do not discuss anything others in the group talk about outside of this group. Also, if you feel uncomfortable or wish to leave at any time, you are free to leave.”

“If you want to follow up on something that someone has said, or agree or disagree, or give an example, feel free to do that. Remember there are no wrong answers, only potentially differing points of view. Also, do not feel like you have to respond to me directly the entire time. Feel free to have a conversation with each other in the room about these questions. My job as moderator is to simply guide the discussion. I am here to ask questions, listen, and make sure everyone has a chance to share. I am interested in hearing from each of you. So, if you are talking a lot, I may ask you to give others a chance to speak. We just want to make sure that we hear from all of you. We will be done by *[insert time that is 2 hours from now]*.”

[Be sure to take a break with the provided refreshment snacks at the one-hour mark!]

Opening questions: “To begin, we will start with some simple introductions.”

- 1) I would like to start out by learning more about all of you. Could we please go around the room and each of you give a brief introduction of who you are? Please state your **name, role in the community, and something you like to do in your free time.**

“Thank you for your introductions. The goal of this next set of questions is to review information we have learned from your individual interviews to make sure we have understood you all correctly and have not missed anything. These questions will relate to if you all agree or disagree with what we have found, if you all think there is anything missing or that should be added, or any reflections or reactions you all have on information we have gathered from your individual interviews. These are summaries of individual interview responses that have had individual names removed for confidentiality.”

Main questions:

1. COUNSELOR IDENTITY: *“We will now review your individual responses for differences you all have experienced in your counseling roles compared to before and after your Tuko Pamoja training.”*

- 1) What does it mean to be a trained Tuko Pamoja counselor?
 - a) In what ways do you feel you embody the qualities necessary to be a Tuko Pamoja counselor?
- 2) How do the ways others view your role as a counselor compare to how you wish they viewed your role as a counselor?
 - a) Do you wish others viewed your role as a counselor differently?
- 3) How does your reputation in the community influence your work as a person who counsels families?
- 4) Compared to before your training with Tuko Pamoja, do you all feel you make more sacrifices to fulfill your responsibilities as a counselor?
 - a) If so, what things do you have to sacrifice more of?

2. STRESS AND BURNOUT: *“We will now review a compiled list of stressors gathered from individual interviews [see Focus Group Activity instructions].”*

- 1) Do you agree with this list?
 - a) Are there any very important stressors that are missing?
- 2) What are things that cause overwhelming stress, like the spring metaphor I asked you about in your interviews?
- 3) Are there ways you could be better supported to help with your stress?

3. MOTIVATION: *“We will now review responses for your individual motivations for being a counselor. These are both things that motivate you and things that decrease your motivation.”*

- 1) Which of these motivations are the most influential in keeping you working as a counselor?
 - a) Have we missed any important motivators?
- 2) Which of these items listed that decrease your motivation are most influential?
 - a) Have we missed any important items that decrease your motivation to work as a counselor?

4. SELF-EFFICACY: *“For this final section, we will review your responses to questions about your feelings of preparedness and capabilities in being a counselor.”*

- 1) What things influence how effective you feel as a counselor?

- 2) Have you ever had breakthrough experience, or epiphany, where you finally felt you could adequately do your job as a counselor? [*What events caused this moment to happen?*]
- 3) Have you counseled families using the Tuko Pamoja skills outside of those assigned to you by Tuko Pamoja?
 - a) In what ways do you use Tuko Pamoja skills in counseling trainings outside of those assigned to you by Tuko Pamoja? [*Ask for specific examples or stories*]
- 4) What are ways Tuko Pamoja could improve their trainings for counselors to help you all feel more effective as counselors?

In conclusion: “Now, I have a final question before we are finished for this session.”

- 1) Is there anything that we should have talked about but did not during our discussion today?

“Thank you all so much for attending today’s discussion. This will help us to work to better improve Tuko Pamoja’s support of future counselors. This was also a time to assure you all that we have been listening to you and have heard your ideas and voices.”

“Following this session, we would like to invite you all to a small debriefing meeting on August ____ at 2pm. This will be a time where the leader of this small research project, Taylor Wall, will present preliminary findings from your responses. It should last about an hour and will have snacks and refreshments. This is a time for you to see the outcome of your time invested in this project.”

A6. FGD Pile-Sorting Activity Instructions

At the **START** of the **Stress Section of the Focus Group Discussion Guide**, you will be leading an activity to try to delve deeper into participant experiences with stress.

11. **Announce**: “I will now pause the recorder so that we can complete an activity”
12. **PAUSE THE RECORDER: DO NOT STOP OR SAVE THE RECORDING**
13. Spread out the slips of paper listing the stressors and the blank labeling cards on the table
14. Introduce the activity as:
 - a. “Now we are going to perform a sorting activity using the responses from your individual interviews. We would like your help in combining and sorting the stressors into smaller categories and groups.”
15. Sorting Stressors:
 - a. “To start, discuss with each other which stressors need to go together in one group. Keep adding, subtracting, and rearranging

the groupings until you all are satisfied that the stressors are appropriately grouped together. If there is disagreement, discuss your views until a decision is reached. Remember, there are no limits on how many stressors can go into a group. A group could have only 1 stressor or could have many stressors.”

16. Checking Stressor Sorting:

- a. **“Now that we have sorted the groups, I would like to review each stressor in each group to make sure you all agree on its group assignment. If something should be moved, let me know and we will discuss where it should go.”**

17. Naming the Groups

- a. **“Now that we have organized the stressors into groups, I want you to help in naming each group using no more than 5-6 words. Please discuss with each other what phrase best explains what stressors are found within each group.”**

18. Review of groups

- a. **“Would anyone like to summarize the groups we have created today? [*help them summarize what each group contains and represents*]”**

19. Post-Activity Discussion [**Take note of responses**]

- a. “How did you feel about this activity?”
- b. “Did you learn or realize anything from this activity?” [**If so, what?**]
- c. “What was the hardest thing about this activity?”

20. **“Thank you so much for your participation in this activity. We will leave the cards where they are until we are finished. Now, we will continue with the remaining sections of the discussion”**

21. **RESTART THE RECORDER**

22. **Announce: “We have completed the activity and will continue the discussion”**

Appendix B: Reporting Guidelines Checklist

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:

Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality Health Care*. 2007. 19(6): 349-357.

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
<i>Personal Characteristics</i>		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	Joyce Jeptum
2. Credentials	What were the researcher's credentials? e.g. PhD, MD	Jonathan Wall BSc. Bio, BA Anthropology, MSc. Global Health Candidate
3. Occupation	What was the occupation at the time of the study?	MSc. Global Health student, Research Assistant
4. Gender	Was the researcher male or female?	Male
5. Experience and training	What experience or training did the researcher have?	Methods - The researcher gathered data from interviews and focus groups in Chapel Hill in a study at the University of North Carolina at Chapel Hill in 2016. He participated in qualitative research and analysis courses at Duke University, Durham, NC in 2018.
<i>Relationship with participants</i>		
6. Relationship Established	Was a relationship established prior to study commencement?	Yes – Prior communication with study participants through Skype calls to describe the study and answer questions.

7. Participant knowledge of the interviewer	What did the participants know about the researcher? E.g. personal goals, reasons for doing the research	Participant information sheet and Consent Form
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Methods (2.5.1 <i>Study Personnel</i>)
Domain 2: study design		
<i>Theoretical framework</i>		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Methods (2.7 <i>Analysis</i>)
<i>Participant selection</i>		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Methods (2.3 <i>Participants</i>)
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Methods (2.3 <i>Participants</i>)
12. Sample Size	How many participants were in the study?	Methods and Results (2.3 <i>Participants</i> , 3.1 <i>Description of Sample</i>)
13. Non-participation	How many people refused to participate or dropped out? Reasons?	Results (3.1 <i>Description of Sample</i>)
<i>Setting</i>		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	Methods (2.1 <i>Setting</i> , 2.5.2 <i>Individual Interviews and Stress-Map Free-Listing</i> , 2.5.3 <i>Focus Group Discussion</i>)
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	No
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Results (3.1 <i>Description of Sample</i>)

<i>Data collection</i>		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Methods (2.4.1 Interview Guide)
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	No – offered, but not used.
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Methods (2.5.2 Individual Interviews and Stress-Map Free-Listing, 2.5.3 Focus Group Discussion)
20. Field notes	Were field notes made during and/or after the interview or focus group?	Methods (2.7 Analysis)
21. Duration	What was the duration of the interviews or focus group?	Methods (2.5.2 Individual Interviews and Stress-Map Free-Listing, 2.5.3 Focus Group Discussion)
22. Data saturation	Was data saturation discussed?	No
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	No – but findings were discussed and commented on in FGD sessions
Domain 3: analysis and findings		
<i>Data analysis</i>		
24. Number of data coders	How many coders coded the data	Methods (2.7 Analysis)
25. Description of coding tree	Did authors provide a description of the coding tree?	Methods (2.7 Analysis)
26. Derivation of themes	Were themes identified in advance or derived from the data?	Methods (2.7 Analysis) – A mix of both, but primarily from the data
27. Software	What software, if applicable, was used to manage the data?	Methods (2.7 Analysis)
28. Participant checking	Did participants provide feedback on the findings?	Methods (2.5.3 Focus Group Discussion)
<i>Reporting</i>		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Results – Each quote was identified using sex, age, and Counselor Experience group number

30. Data and findings consistent	Was there consistency between the data presented and the findings?	Yes – Discussion
31. Clarity of major themes	Were major themes clearly presented in the findings?	Yes – Results
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Mix of both – Results

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