

Social Tract

Module on

Caring for the caregiver

LEARNING OUTCOMES FOR ALL PARTICIPANTS

After completing this module the learner should:

1. Know which factors contribute to counsellor burnout.
2. Have an understanding of how proper mentorship and supervision can avoid counsellor burnout.

1. COUNSELLOR BURNOUT

Counsellors in the field of HIV/AIDS are at a high risk of burnout, especially in South Africa. Here is a list of some of the factors, which predispose (contribute) one towards burnout:

- Poorly defined or poorly maintained limits and boundaries with clients
- A need for skills or training to perform client-centred counselling
- Exaggerated expectations of oneself
- Repetition in job duties
- Stagnation in a position
- Accumulation of stress
- An absence of a supervision (mentoring) environment to deal with work challenges
- Poor monetary compensation (for non-volunteers)
- Feeling unappreciated
- A lack of personal interests
- A need for personal or professional support
- An absence of meaning or importance of a person's work
- Being in emotionally demanding interactions
- Being confronted with chronic illness, dying and death
- Working with clients who face numerous challenges and
- Working with clients who find it difficult to change unsafe behaviours.

FACTORS CONTRIBUTING TO BURNOUT/COMPASSION FATIGUE IN HIV/AIDS COUNSELLORS

Government's 5-year Operational Plan for HIV/AIDS includes:

- Promoting the uptake of VCT. This means that more counsellors will be required to do more pre-test counselling, HIV testing and post-test HIV counselling and, therefore, more likely to be providing HIV-positive diagnoses to a high number of people. Already many counsellors in busy sites state that in a full week's work they may give around 25 positive diagnoses to patients.
- Increasing the amount of counselling services offered to infected and affected children is an aim. This is often more difficult than providing positive results to adults as these children may be experiencing HIV-diagnosis as another trauma where previous traumas have been loss of parents, rape or sexual abuse.
- As an increasing number of patients are declining (particularly without ART) from WHO Stages 1 or 2 in the course of progression of the Virus, to Stages 3 or 4, counsellors are working with more patients who are sick, dying and experiencing opportunistic infections.
- Up until recently the operational plan has not included offering ART to patients. This has often meant that health care personnel are limited in terms of treatment options. The feeling of helplessness may lead to a sense of not being adequate as a health care professional. This is a factor that contributes to burnout.

2. BURNOUT AND COMPASSION FATIGUE

What is it?

Burnout, or cumulative stress, is a state of physical, emotional and mental exhaustion. You may experience burnout after a period of time during which your ability to cope with your work environment is lowered. This may be as a result of your responses to the ongoing demand characteristics of your daily lives (Maslach 1982). The high level of cumulative stress that you experience as counsellors is likely to negatively affect your resiliency.

Compassion fatigue is different to burnout. Burnout may make you more susceptible to compassion fatigue or you may experience it separately from burnout. Compassion fatigue results from a repeated preoccupation with the trauma of patients. The impact of hearing and seeing the trauma that patients experience accumulates and can carry emotional costs for you. Compassion fatigue is a state of tension that may manifest in the following ways:

- Re-experiencing the traumatic event
- Avoidance or numbing of reminders of the event, and
- Persistent arousal.

Ultimately, compassion fatigue results when counsellors' well being has been compromised.

South African counsellors bear witness to a multitude of traumatic events on a daily basis. Diagnosis of an HIV-positive patient may be only one in a multitude of traumas in that patient's life or in your duties of the day. Most of the patients who access public sector health care in South Africa are likely to be experiencing multiple demands and life challenges. VCT and the health care environment frequently provide a much-wanted context for patients to offload and talk about their problems. Counsellors report hearing stories about rape, incest, child abuse, domestic violence, hunger, substance abuse and the various other consequences that result from living in dire poverty. The level of empathy that you convey to the traumatized patient plays a significant role in transmitting a secondary traumatic stress to you. Unfortunately in order to be effective you need to be open emotionally and it is this which makes you vulnerable to compassion fatigue.

Some counsellors are more resilient than others to the transmission of traumatic stress. However, you are automatically at risk for compassion fatigue if you continually work with traumatized individuals.

How do we recognise burnout?

It is important that counsellors develop a heightened awareness of signs and symptoms of stress and burnout. It is helpful for the health care worker, your colleagues and management to look out for these signs and symptoms. If the signs are left unattended, burnout will not only have a negative impact on the service that is provided to patients, but may have far-reaching consequences for you as an individual.

There are many ways in which the stress of the health care worker can manifest itself. The key symptoms to look out for are:

- Feelings of inadequacy

- Feeling that you don't have the necessary skills to do the required job (which, in turn, contributes to burnout)
- Lack of self-confidence and diminished self-esteem
- Feelings of helplessness, guilt and loss of hope
- Depression, tearfulness and feelings of distress
- Avoidance of patients, minimising time spent with them and making early referrals
- Increase in self-destructive, self-soothing behaviours (such as use of alcohol or drugs, including sleeping tablets)
- Irritability, lower frustration tolerance and outbursts of anger
- Diminished sense of job purpose, reduced job satisfaction and decisions to leave the job or profession
- Lack of desire to go into work and perform work duties and, therefore, high levels of absenteeism
- No longer feeling fulfilled by your career, feeling disillusioned by the reality of what you face in your work and feeling that you have lost touch with your initial reasons for entering the profession.

How can we prevent burnout?

Burnout and compassion fatigue can be avoided, managed and reduced. There are numerous tasks that both managers and counsellors can perform in order to take charge of their vulnerability to burnout and compassion fatigue. They are as follows:

- **Acknowledge the stressful nature of this work:** Most importantly, both managers and counsellors need to formally acknowledge the stress factors that are inherent in this work. Feelings of distress in response to your experiences are legitimate and not signs of weakness or lack of professionalism.
- **Treat personal trauma:** Due to the high incidence of traumatic events in South Africa, it is not unlikely that you are experiencing your own personal traumas. If you do not acknowledge these first-hand traumas and receive the necessary counselling, you may become far more susceptible to vicarious or secondary traumatic stress.
- **Skills acquisition:** Counsellors need to learn, understand and develop personal strategies for coping with your professional challenges. Having insight into how and which difficult experiences diminish your hope and sense of empowerment is an imperative lead to resolving these experiences and accepting your own limitations. Frequently the skill of boundary setting is lacking and it is essential that you draw a line with regards to how far you will go to help your patients. Boundary setting is an essential skill that needs to be understood and developed in order to protect you from taking on too much responsibility, hence overwhelming yourself and leading to burnout. Part of this skills acquisition is also stress management.
- **Ongoing training:** Counsellors will immediately feel stressed when you are required to perform duties for which you do not have the necessary skills, knowledge and attitudes. Particularly in the ever-growing field of HIV/AIDS, ongoing training sessions that update and provide new information must take place. The incorporation of this into the clinical facility's training plan is an obligation of managers.
- **Self-care disciplines:** It is up to counsellors to develop and maintain good self-care behaviours. This involves developing a routine of exercise,

rest, time to yourself and good nutrition. You need to “allow” yourself to forget about your patients when you go home and permit yourself to not feel guilty about the suffering of others. Instead, it is important to acknowledge your achievements, however small. By instituting a pattern of self-care behaviours, you will be enhancing your future resiliency.

- **Periodic assessments of burnout:** Counsellors may choose to do this independently or managers, supervisors or mentors can facilitate it. There are various tools available for assessing the symptoms of stress, burnout or compassion fatigue. These tools may provide you with an external acknowledgment and validation of your feelings of stress. In the appendix of these Guidelines, you will find an easy-to-use tool to assess your level of compassion fatigue. Whether your results of the compassion fatigue test are high or low, it is still vital that you incorporate strategies into your daily life that will help you manage stress and reduce the chances of burnout and compassion fatigue.
- **Connecting with others:** In order to reduce stress, counsellors need to feel reconnected with the sense of hope and empowerment with which they entered their chosen field. This can be dealt with by your mentors or in supportive counselling. Such supportive counselling is helpful before you make the decision to leave your position or the profession. Frequently group sessions in which colleagues share the individual stressors of their work helps to achieve the “in-the-same-boat” phenomenon. The stressors become normalised, sharing of the stress is cathartic and the benefits of a sense of group support are gained. Where mentors are infrequently available or unavailable, peer mentoring is becoming more common. (See Mentorship and Supervision below).
- **Regular supervision and mentoring sessions:** (Please see Mentorship and Supervision section below).

Some easy tips to help you prevent burnout:

- Take regular leave and rotate your roles/duties
- Receive regular training
- Take regular breaks during the day
- Receive regular supervision, mentoring or group debriefings
- Recognise the achievements in your work
- Try to get constructive feedback about your work
- Establish support groups in your health care facility
- Do regular relaxation exercises.

Compassion Satisfaction and Fatigue (CSF) Test

Helping others puts you in direct contact with other people’s lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self-test helps you estimate your compassion status: How much at risk you are of burnout and compassion fatigue and also the degree of satisfaction with your helping others. Consider each of the following characteristics about you and your **current** situation. Write in the number that honestly reflects how frequently you experienced these characteristics in the last week. Then follow the scoring directions at the end of the self-test.

0=Never	1=Rarely	2=A Few Times	3=Somewhat Often	4=Often	5=Very Often
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Items About You

- _____ 1. I am happy.
- _____ 2. I find my life satisfying.
- _____ 3. I have beliefs that sustain me.
- _____ 4. I feel estranged from others.
- _____ 5. I find that I learn new things from those I care for.
- _____ 6. I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
- _____ 7. I find myself avoiding certain activities or situations because they remind me of a frightening experience.
- _____ 8. I have gaps in my memory about frightening events.
- _____ 9. I feel connected to others.
- _____ 10. I feel calm.
- _____ 11. I believe that I have a good balance between my work and my free time.
- _____ 12. I have difficulty falling or staying asleep.
- _____ 13. I have outbursts of anger or irritability with little provocation
- _____ 14. I am the person I always wanted to be.
- _____ 15. I startle easily.
- _____ 16. While working with a victim, I thought about violence against the perpetrator.
- _____ 17. I am a sensitive person.
- _____ 18. I have flashbacks connected to those I help.
- _____ 19. I have good peer support when I need to work through a highly stressful experience.
- _____ 20. I have had first-hand experience with traumatic events in my adult life.
- _____ 21. I have had first-hand experience with traumatic events in my childhood.
- _____ 22. I think that I need to "work through" a traumatic experience in my life.
- _____ 23. I think that I need more close friends.
- _____ 24. I think that there is no one to talk with about highly stressful experiences.
- _____ 25. I have concluded that I work too hard for my own good.
- _____ 26. Working with those I help brings me a great deal of satisfaction.
- _____ 27. I feel invigorated after working with those I help.
- _____ 28. I am frightened of things a person I helped has said or done to me.
- _____ 29. I experience troubling dreams similar to those I help.
- _____ 30. I have happy thoughts about those I help and how I could help them.
- _____ 31. I have experienced intrusive thoughts of times with especially difficult people I helped.
- _____ 32. I have suddenly and involuntarily recalled a frightening experience while working with a person I helped.
- _____ 33. I am pre-occupied with more than one person I help.
- _____ 34. I am losing sleep over a person I help's traumatic experiences.
- _____ 35. I have joyful feelings about how I can help the victims I work with.

- _____ 36. I think that I might have been “infected” by the traumatic stress of those I help.
- _____ 37. I think that I might be positively “inoculated” by the traumatic stress of those I help.
- _____ 38. I remind myself to be less concerned about the well being of those I help.
- _____ 39. I have felt trapped by my work as a helper.
- _____ 40. I have a sense of hopelessness associated with working with those I help.
- _____ 41. I have felt “on edge” about various things and I attribute this to working with certain people I help.
- _____ 42. I wish that I could avoid working with some people I help.
- _____ 43. Some people I help are particularly enjoyable to work with.
- _____ 44. I have been in danger working with people I help.
- _____ 45. I feel that some people I help dislike me personally.

Items About Being a Helper and Your Helping Environment

- _____ 46. I like my work as a helper.
- _____ 47. I feel like I have the tools and resources that I need to do my work as a helper.
- _____ 48. I have felt weak, tired, run down as a result of my work as helper.
- _____ 49. I have felt depressed as a result of my work as a helper.
- _____ 50. I have thoughts that I am a “success” as a helper.
- _____ 51. I am unsuccessful at separating helping from personal life.
- _____ 52. I enjoy my co-workers.
- _____ 53. I depend on my co-workers to help me when I need it.
- _____ 54. My co-workers can depend on me for help when they need it.
- _____ 55. I trust my co-workers.
- _____ 56. I feel little compassion toward most of my co-workers
- _____ 57. I am pleased with how I am able to keep up with helping technology.
- _____ 58. I feel I am working more for the money/prestige than for personal fulfillment.
- _____ 59. Although I have to do paperwork that I don't like, I still have time to work with those I help.
- _____ 60. I find it difficult separating my personal life from my helper life.
- _____ 61. I am pleased with how I am able to keep up with helping techniques and protocols.
- _____ 62. I have a sense of worthlessness/disillusionment/resentment associated with my role as a helper.
- _____ 63. I have thoughts that I am a “failure” as a helper.
- _____ 64. I have thoughts that I am not succeeding at achieving my life goals.
- _____ 65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.
- _____ 66. I plan to be a helper for a long time.

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Suggested Reference: *Stamm, B. H. & Figley, C. R. (1996). Compassion Satisfaction and Fatigue Test. Available on the World Wide Web: <http://www.isu.edu/~bhstamm/tests.htm>.*

Scoring Instructions

Please note that research is ongoing on this scale and the following scores should be used as a guide, not confirmatory information.

1. Be certain you respond to all items.
2. Mark the items for scoring:
 - a. Put an x by the following 26 items: 1-3, 5, 9-11, 14, 19, 26-27, 30, 35, 37, 43, 46-47, 50, 52-55, 57, 59, 61, 66.
 - b. Put a check by the following 16 items: 17, 23-25, 41, 42, 45, 48, 49, 51, 56, 58, 60, 62-65.
 - c. Circle the following 23 items: 4, 6-8, 12, 13, 15, 16, 18, 20-22, 28, 29, 31-34, 36, 38-40, 44.
3. Add the numbers you wrote next to the items for each set of items and note:
 - a. *Your potential for Compassion Satisfaction (x)*: 118 and above=extremely high potential; 100-117=high potential; 82-99=good potential; 64-81=modest potential; below 63=low potential.
 - b. *Your risk for Burnout (check)*: 36 or less=extremely low risk; 37-50=moderate risk; 51-75=high risk; 76-85=extremely high risk.
 - c. *Your risk for Compassion Fatigue (circle)*: 26 or less=extremely low risk, 27-30=low risk; 31-35=moderate risk; 36-40=high risk; 41 or more=extremely high risk.

3. MENTORSHIP AND SUPERVISION

In recent years wide support has been received for ideas concerning supervision and support for counsellors in the field of HIV and AIDS which were raised by the Department of Health. Although the new national mentorship programme is still in the process of its development, this section is guided by what has been established so far. If you would like further information on this programme, please see contact details in the resource section at the back of this manual.

What are 'mentoring' and 'supervision' and the difference between them?

The functions of mentoring and supervision need to be differentiated yet both are important to the effective functioning of counsellors.

Defining supervision

'Supervision' can be described as a relationship between the supervisor and the health care person that focuses primarily on the needs of the patient by enhancing your skills and knowledge to perform the required role. Supervision ensures that patients are cared for ethically and effectively by facilitating service to the patient. Its aim is not to be a counselling service for you.

Defining 'mentoring'

'Mentoring' is a relationship in which support, assistance, advocacy and guidance are offered by a more mature person who has had experiences similar to those which you are going through. The aim is that mentoring will help you to cope with your work and life challenges by encouraging ongoing learning and skill development and providing you with emotional support.

Types of Mentorship

Mentorship may take place in a variety of forms. These include:

- **Individual mentoring:** This is the ideal as the session can focus fully on the individual, his/her tasks, challenges, goals, issues and development. It is particularly valuable for new or inexperienced counsellors.
- **Group mentoring:** This is frequently more practical as the ratio of mentors to counsellors is very high until sufficient training of mentors has taken place. It is also more time efficient.
- **Peer mentoring:** This would be where counsellors run their own mentoring groups and those with more knowledge and experience try to assist and support those with particular needs. However, the experienced counsellors may not get their own needs met in such a group.
- **Case study driven:** This type of mentoring involves the presentation of difficult cases with the aim of brainstorming strategies for intervention or case management within the group. The presentation of cases would take place on a rotating basis.
- **Need-driven/Crisis groups:** Counsellors can share their experiences, gain mutual support from one another, mutual acceptance and the opportunity to talk about their own personal crises.

The "Minimum Standards for Counselling and Training" document differentiates between mentoring and supervision as follows:

Mentoring	<i>versus</i>	Supervision
■ Emotional support		Case management
■ Personal issues impacting work		Technical issues e.g. skills/theory
■ Counsellor's personal development		Accountability e.g. time, resources
■ No management functions		Management role

Why is supervision necessary?

While supervision should play a supportive role, its primary function is that of management. The supervisor has responsibilities for taking care of the health care worker, whilst they are both required to be accountable to each other and to the organisation. The supervisor can help to articulate the parameters/boundaries of the health care facility and is a channel through which the health care worker can report on how they are spending their time and resources, as well as discuss other work-related issues.

Each facility should have a protocol or policy that guides disciplinary procedures. Because the supervisor is legally responsible for the health care worker, confidentiality within the relationship cannot be ensured if there are implications for

the organisation. The supervisor, in consultation with the health care worker, can make recommendations to senior management on how to resolve the issue at hand.

What is the role of the supervisor?

According to the "Minimum Standards for Counselling and Training" document (no year), the supervisor is involved in providing the following roles:

- Case management of counsellors
- Dealing with the technical aspects of counselling of patients (such as skills development and theoretical understanding)
- Management role.

The supervisor may also be your line manager i.e. this is the person that you are directly accountable to for how they spend their time and resources. They may also be involved in the role of disciplining counsellors.

In the South African context, the term "supervisor" has tended to have negative connotations due to its emphasis on the hierarchical, accountability aspects of traditional health care work.

Why is mentoring necessary?

Mentorship may serve to fulfil many purposes. Amongst these is:

- **To prevent burnout and compassion fatigue:** through dealing with the health care worker's feelings of helplessness and despair by providing emotional support.
- **To assist with maintaining boundaries:** so that the risks of the health care worker becoming over involved with patients can be reduced.
- **To recognise constraints:** These may be constraints of the context, of the patient's situation or of the health care worker's skills and knowledge. Where these can be further developed through education and training, the mentor may facilitate this. Where these constraints are inherent in the patient's situation, the health care worker must be helped to acknowledge their own limitations.
- **To facilitate professional development:** Both through role modelling and by means of sharing new, relevant information with the health care worker, the health care worker's skills and knowledge can be developed. By assisting with this, the mentor enables the health care worker to feel more equipped to manage their work challenges.
- **To provide feedback:** Accurate and adequate self-evaluation can be created by the invaluable role of providing feedback. Counsellors are assisted to perceive the positive impact and quality of their work as well as come to terms with their limitations.
- **To help set realistic goals:** Many counsellors may be strongly idealistic about their caring roles. This can be a source of stress; easily leading to emotional depletion, especially there is exposure to a large amount of HIV-positive diagnoses or death. Many counsellors and managers set unrealistically high goals in relation to the work that must be performed. The mentor can help the health care worker to set more realistic goals in relation to their role as well as to set goals for receiving fulfilment outside of the work setting.

What is the role of the mentor?

The role of the mentor is differentiated through fulfilling the following roles:

- Providing emotional support to the health care worker
- Dealing with personal issues that impact on the health care worker's duties
- Facilitating the personal development of the health care worker as counsellor.

In order for the mentor to be able to play his/her role effectively, it is preferable that the mentor and the supervisor are separate people and that the mentor is not involved in the management of the health care worker.

In order to ensure the long-term sustainability of effective HIV and AIDS health care services in South Africa, it is crucial to implement systems of supervision and mentoring.

Practical strategies for providing mentorship

Health care facilities create a sense of security when they are clear about issues of accountability, setting standards for record-keeping and by putting in place a regular, formalised system of supervision and mentoring. It is necessary that managers and counsellors make a commitment to ensuring that mentoring and supervision take place. The following steps are a guide for implementing mentorship structures.

1. **Selection of mentor trainees:** If a decision is made to train up mentors from the internal staff component, these trainees must be carefully selected. The mentor needs to be someone who has extensive experience in the area of counselling with expertise in the HIV/AIDS field.
2. **Time for training:** managers will need to facilitate and commit time for trainees to attend the relevant course. Trainees should be selected who are motivated and enthusiastic about taking on this role.
3. **Clarity of role:** In order to function effectively in their new capacity, there needs to be a clear delineation between the time that is spent on their usual duties and time that is now allocated to providing mentorship.
4. **Insight into purpose of mentoring:** Counsellors need to have an understanding of the intended value of providing mentor. Clarity between mentorship and supervision may need to be established so that counsellors understand mentorship's role in providing support and facilitating personal and professional development.
5. **Ongoing support:** Mentors require ongoing support and training. It is both the role of managers and mentors to ensure that they are informed about the latest developments in the field as well as receiving their own support to prevent burnout.

Occasionally, secondary trauma does not need debriefing. Instead, you can ask the counsellor, "How is this experience re-shaping you?"

5. ACKNOWLEDGMENTS

- Brouard, P. HIV/AIDS Counselling Course: Trainer's and Participants' Manual. Centre for the Study of AIDS, University of Pretoria.
- Department of Health. Circular Minute on Prevention of Mother-To-Child Transmission of HIV: 16 April 2002. www.doh.gov.za
- Department of Health: Directorate: HIV/AIDS and STDs. Prevention of Mother-to-Child HIV Transmission and Management of HIV Positive Pregnant Women. Launched October 2000. www.doh.gov.za
- Department of Health. Recommendations for Managing HIV Infection in Children (Draft) (Launched October 2001). www.doh.gov.za
- Department of Health. Draft National Policy on Testing for HIV. www.doh.gov.za
- HIVCORE, School of Psychology, University of Kwa-Zulu/Natal, Pietermaritzburg and National Department of Health (2004). Mentorship for HIV/AIDS Counsellors: Discussion Document. Written by Ackhurst, J., Blom, S., Brouard, P., Moodley, T., Saloner, K., Solomon, V., Van der Watt, E., Van Rooyen, H. Partly funded by the Centre for Disease Control.
- Policy Project and Department of Health. Guidelines to establish and maintain support groups for people living with and/or affected by HIV and AIDS. (Final Draft – awaiting final approval). December 2003. For: Chief Directorate: HIV and AIDS and TB, National Department of Health.
- Saloner, K. (2002). A Training Programme to Enhance Fifth Year Medical Students' Ability to Manage the Challenges of HIV/AIDS Work. Completed towards Master of Arts (Social Work) degree by Coursework and Research Report in Industrial Social Work, University of the Witwatersrand (Wits), Johannesburg, South Africa.
- Saloner, K. (2003). Five-Day Course on Counselling for Anti-Retroviral Treatment Adherence. Centre for the Study of AIDS, University of Pretoria.
- SAfAIDS (2000). Counselling Guidelines on Disclosure of HIV Status. Zimbabwe: Southern African AIDS Training Programme.
- Treatment Action Campaign/AIDS Law Project (July 2001). Pregnancy and HIV/AIDS: A PRACTICAL GUIDE. Published by the AIDS Law Project and the Treatment Action Campaign. Written by F. Rahiman and D. Ewing; based upon *Pregnancy and HIV/AIDS: Recommended Code of Best Practice, October 1997*. www.tac.org.za
- Van Dyk, A. (2001). HIV/AIDS Care & Counselling: A Multidisciplinary Approach (Second edition). Cape Town: Pearson Education.

6. FURTHER READING

- Achmat, Z. (et al – no other names listed); editing: Fine, D., Heywood, M., Strode, A., (1997). HIV/AIDS and the Law: A resource manual. AIDS Law Project and Lawyers for Human Rights: Johannesburg.
- Allen, S., Karita, E., N'gandu, N. & Tichacek, A. (1999). "The Evolution of Voluntary Testing and Counselling as an HIV Prevention Strategy" in Gibney, L., Di Clement, R. & Vermund, S. (eds). Preventing HIV in Developing Countries: Biomedical and Behavioural Approaches. New York: Kluwer Academic/Plenum Publishers, 87-108.
- Anstey, M. (1983). Working with Groups. Cape Town: Juta.
- Burnard, P. (1994). Counselling Skills for Health Professionals (2nd ed). London: Chapman & Hall.

- Carkhuff, R. R. (1993). The Art of Helping (7th ed). Amherst, Massachusetts: Human Resource Development Press.
- Evian, C. (2003). Primary HIV/AIDS Care: A practical guide for primary health care personnel in the clinical and supportive care of people with HIV/AIDS (Fourth edition). Johannesburg: Jacana.
- Green, J. & McCreaner, A. (eds) (1996) Counselling in HIV Infection and AIDS (2nd edition). Oxford: Blackwell Science Ltd.
- Middleman, R. R. & Wood, G. (1990). Skills for Direct Practice in Social Work. New York: Columbia University Press.
- Miller, R. & Bor, R. (1988) AIDS: A Guide to Clinical Counselling. London: Science Press.
- Van Dyk, A. (2001). HIV/AIDS Care & Counselling: A Multidisciplinary Approach (Second edition). Cape Town: Pearson Education.