

Running head, Compassion Stress volunteer care givers

Compassion Stress among HIV Infected Peoples' Volunteer Caregivers in Addis ketema

(The case of NGOs' volunteers)

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Table of content

Contents -----page

Acknowledgement-----ii

Table of content-----iii

Acronyms-----x

Abstract -----xi

Organization of the thesis -----xii

 I Overview of the Study-----1

Background-----1

Statement of the Problem-----3

Objectives of the Study-----6

 General objective-----6

 Specific objectives-----6

Assumption in this study-----6

Research questions-----6

Research hypotheses-----7

Scope and limitations of the study-----7

 II Literature review-----9

Caring Role and its Effect-----9

Compassion Stress volunteer care givers	v
Compassion -----	13
Compassion and its Barriers-----	14
Stress Related to Care giving for HIV Infected people-----	15
Spirituality as an Intervention Strategy for Care giving-----	17
Attachment, Altruism and Care giving-----	18
Ways of helping caregivers Combat Stress-----	19
Age and coping skill of Stress-----	20
Volunteerism-----	22
Gap in Literature on the study area-----	23
Theoretical frame work-----	24
Resiliency Model-----	24
Conceptual Framework-----	26
III Methodology-----	27
Study Area and Population -----	27
Study population-----	28
Research design-----	28
Sample size determination-----	29
Sampling Techniques-----	30
Procedures and techniques of data collection and analysis-----	30
Data collection tools and Procedure-----	30
Description of variables-----	31

Data Analysis plan-----	33
Ethical issues of the study-----	33
Operational Definition of terms-----	34
IV Data presentation and discussion-----	35
Data presentation-----	35
Demographic variable-----	35
Dependent variable-----	52
Compassion stress -----	52
Hypothesis testing-----	53
Hypothesis one-----	53
Hypothesis two-----	54
Hypothesis three-----	57
Discussions-----	58
Respondents' characteristics-----	59
Age Category of respondents-----	59
Sex of respondent-----	61
Educational level in a wider category-----	62
Marital status-----	62
Range of family member in a household-----	63

Religious affiliation where respondent belong-----	63
Monthly income level of respondent-----	64
Protective factor variables-----	64
Acceptability of the work performed by respondents-----	65
Belief of oneself on successfully caring out ones' responsibility-----	65
Positive expectation of respondents about things-----	66
Level of religious practice of respondents-----	67
Number of training taken by care givers-----	67
Risk factor variables-----	68
Role strain (Failure of volunteer care givers to discharge ones' role)-----	68
Fear of attack of respondent by care recipients-----	69
Observation of caregivers when care recipients isolate themselves from others-----	69
Dependent variable-----	70
Compassion stress -----	70
Hypothesis testing-----	70
Hypothesis one-----	70
Hypothesis two-----	71
Hypothesis three-----	72
V Summary Conclusion and Implication of the study-----	73
Summary-----	73
Conclusions -----	82
Implications to Social work, policy and Research -----	86
Appendix I -----	i

Appendix II-----ii

Appendix III-----vii

Declaration -----xii

List of tables

tables-----	-----page
Table 1: Operationalisation of major variables-----	31
4.1.1. Age Category of respondents -----	36
Table 4.1.2 Score of compassion stress experienced by caregivers and age category of respondents Cross tabulation-----	37
Table 4.1.3 Paired Samples Correlations -----	37
Table 4.1.4 sex of respondent -----	38
Table 4.1.5 score of compassion stress experienced by caregivers and sex of respondent Cross tabulation-----	38
Table 4.1.6 educational level in a wider category-----	39
Table 4.1.7 Paired Samples Correlations -----	39
Table 4.1.8 marital status-----	40
Table 4.1.9 Paired Samples Correlations-----	40
Table 4.1.10 range of family member in a household-----	41
Table 4.1.11 Paired Samples Correlations -----	41
Table 4.1.12 religious affiliation where respondent belong -----	42
Table 4.1.13 religious affiliation where respondent belong and score of compassion stress experienced by caregivers Cross tabulation-----	42
Table 4.1.14 monthly income level of respondent-----	43

Table 4.1.15 Monthly income level of respondent and score of compassion stress experienced by caregivers Cross tabulation-----	43
Table 4.1.16 Paired Samples Correlations-----	44
Table 4.2.1 acceptability of the work performed by respondents -----	44
Table 4.2.2 Paired Samples Correlations-----	45
Table 4.2.3 belief of oneself on successfully caring out ones' responsibility-----	45
Table 4.2.4 Paired Samples Correlations-----	46
Table 4.2.4 positive expectation of respondents about things-----	46
Table 4.2.5 Paired Samples Correlations -----	47
Table 4.2.6 level of religious practice of respondents-----	47
Table 4.2.7 Paired Samples Correlations-----	48
Table 4.2.8 number of training taken by care givers-----	48
Table 4.2.9 Paired Samples Correlations-----	49
Table 4.3.1 Role strain (failure of respondents to discharge ones role)-----	49
Table 4.3.2 Paired Samples Correlations-----	50
Table 4.3.3 fear of attack of respondent by care recipients-----	50
Table 4.3.4 Paired Samples Correlations-----	51
Table 4.3.5 Observation of caregivers when care recipients isolate themselves from others-----	51
Table 4.3.6 Risk factor variables-----	52
Table 4.3.6 Paired Samples Correlations-----	52
Table 4.4.1 Score of compassion stress experienced by caregivers-----	53
Table 4.5.1.1 score of compassion stress experienced by caregivers-----	53
Table 4.5.2.1 Paired Samples Correlations -----	54

Table 4.5.2.2 Paired Samples Correlations-----	54
Table 4.5.1.2 Test Statistics -----	54
Table 4.5.2.3 Model Summary -----	55
Table 4.5.2.4.Coefficients -----	55
Table 4.5.2.5 Model Summary -----	55
Table 4.5.2.6 Coefficients -----	56
Table 4.5.3 1 Correlation-----	57

Acronyms

HIV Human's Immune Virus

AIDS Acquired Immune Deficiency Syndrome

PLWHA People Living With HIV/AIDS

CS Compassion Stress

(IRI) Inter personal Reactivity Index

(PSMS), Physical Self Maintenance Scale

(IADL) Instrumental Activities of Daily Living Scale,

(NARS) Neuropsychiatric AIDS Rating Scale

Compassion Fatigue (CF).

(PTSD) Post Traumatic stress Disorder

SPSS Statistical Package for Social Science

NGO Non-Governmental Organizations

Abstract

The study describes the situation compassion stress among volunteer care givers as it was designed to describe how volunteer caregivers cope with and fail to compassion stress. Social factors or personal qualities to the susceptibility or non susceptibility to CS prevailed on volunteer caregivers and the respective actual and perceived difficulties of the failure to compassion stress to care givers in the study area were examined. The study took a strictly designed survey to view the objective reality of respondents as it is. In this study, cross sectional survey for descriptive analysis method were employed with the intent of investigating the current condition and level of susceptibility among care givers. The data collected was analyzed through a soft ware known as statistical package for social science (SPSS) version 16 to generate descriptive statistics and to measure the association and relationship between the identified independent and dependent variables. The study used models called linear regression, paired correlation and bi-variant correlation matrix in the analysis. The extent to which a caregiver experiences psychological burden including compassion stress depends up on their personal protective or precipitating characteristics. To state some example, Compassion stress has a significant variation among different age group. With regard to marital status, as it goes from unmarried to married, divorced and widow compassion stress experienced by care givers decreases. Again, Self efficacy is found to be one of the protective factors of CS.

Organization of Thesis

The thesis comprises five chapters. The first chapter introduces, describes and locates the overall condition and the need for the study over the title “Compassion stress among HIV infected peoples’ volunteer care givers”. It highlights the problems and the key research objectives and questions which are intended to address and demonstrate the significance and the limitation of the study. The second chapter encompasses reviewed related literatures, on issues such as with compassion, compassion and its barriers, Stress related to care giving for HIV infected people, Spirituality in Caregivers of Family Members, Attachment, Care giving, and Altruism, Ways of helping caregivers combat stress, Age and coping skill of stress, Volunteerism, The Compassionate Care giving System and its Interplay with the Attachment System and conceptual frame work with its description. Chapter three provides the methods and methodological approaches used to undertake the research. The fourth chapter presents and discusses the data. The last chapter provides summary, conclusion and interpret main findings into concrete implications to social work, policy and research.

I Overview of the study

Background

Human beings are innately equipped with care giving behavioral systems, among other important behavioral systems (e.g., exploration, sexuality) Phillip R. et al 2005. According to attachment theory of Phillip R. et al 2005, the function of the caring system is to protect a person from danger by assuring that he or she maintains proximity to caring and supportive others (attachment figures) who provide protection, support, and relief in times of adversity (Phillip R. et al, 2005). Care giving is a way of getting human species survives. But, care giving has been found to adversely affect the psychological well-being of informal caregivers (Pearlin et al., 1994; p, 128). Specially, Informal caregivers to persons with HIV/AIDS report experiencing problems with psychological burden as a result of their care responsibilities (Raveis & Siegel, 1991, p. 215).

Compassion stress is natural to occur and it is healthy to feel alike if there has to be compassion. Here the question is who is occupationally susceptible to compassion stresses? According to Figley & Nelson, (1989) Professional caregivers and others in the helping professions are most likely to develop compassion stress.

Specifically, research findings have observed high levels of compassion stress amongst volunteer care givers possibly higher than qualified caregivers (Maidment.J, 2003; Barlow and Collins, 2008). (Debra L. Stang, 2010, p.12). In the state of compassion stress, volunteer Caregivers are no longer able to maintain a balance of empathy and objectivity.

The cost of living with Compassion stress can be quite high in terms of functionality, family, work, community and most of all; self. However, it varies from person to person.

Caregiver psychological and economical burdens have been described as the secondary epidemic associated with the HIV/AIDS crisis (Rait, 1991, p. 271).

There is a great deal of researches done on care giving regarding compassion fatigue and burnout. But, there is still a gap on how care giving affect people and why caregivers experience compassion stress differently. Such and other issues need to be studied in countries where HIV epidemic is prevalent like in our country. Adequate literatures on compassion stress affecting compassionate and altruistic volunteer care giving couldn't be found. Given this, it is legitimate to say researchers have given less emphasis to the study of compassion stress. In fact it is healthy for caregivers to have compassion associated stress. But, like compassion fatigue, compassion stress has destructive effect on care givers' life if it is not managed properly. Given that, the intention of this researcher is to contribute some part on a new look at to compassion stress among volunteer care givers.

Statement of the problem

Since HIV/AIDS was discovered in 1981, more than 20 million people have lost their lives to the virus. Tiaji. S (2005) has been stating that nearly 40 million are currently living with HIV/AIDS. (Tiaji S, 2005, p.87) Sub-Saharan Africa remains the most affected region with 25.4 million people living with HIV/AIDS until the end of 2004. Ethiopia is one of the countries severely affected by the pandemic in the region. According to Tewabe Yizengaw, 2007, the prevalence of HIV/AIDS in Addis ketema; a sub-city Addis Ababa is the highest among all the sub-cities of Addis Ababa where 49,135 people were estimated to live with the virus out of the general estimated population of 336,541. (Tewabe Yizengaw, 2007, p. 31). Beside to the infection, there is a great deal of need for care as it causes bereavement among the patients.

Among PLWHA in the sub city, it is likely that a significant number of patients need permanent or temporary care from volunteers as HIV/AIDS causes bereavement among patients. Because there would no a family member who can take the care giving role. Of course, there are local NGOs working on providing home based care to PLWHA with the help of volunteers in Addis ketema sub city.

However, care giving becomes heavier over time, making caregiver burden, stress, strain, and depression common. We don't have to underscore the necessity of recognizing contemporary social conditions that create stressors for people and decrease their ability to cope effectively with transitions. One example in modern society is the increasing number of persons caught in the "sandwich generation" those who care for both children and elderly parents and any people in adversity as well. Although this may be sequential rather than concurrent, it is nonetheless a stressor, and disproportionately so for women who are usually the primary care providers (Hunter & Sundel, 1989, p.219)

Research evidence suggests quality care giving is possible so long as caregivers have ample resources to withstand compassion stress (Schulz et al 1995 p.167). Phillip R. et al, 2005, also states that compassionately stressed individuals tend to focus more on their own distress and need for greater attachment security (Phillip R. et al, 2005, p. 818). But, literature said nothing on how volunteer caregivers cope with or fail to compassion stress, is there social factors or personal qualities to the susceptibility or non susceptibility to CS prevailed on volunteer caregivers and the respective actual and/or perceived difficulties of the failure to compassion stress to care givers. While there is all rounded study on compassion fatigue.

It might be thought that it is healthy for caregivers to have compassion associated stress. But, like compassion fatigue, compassion stress has unnoticeable effect on care givers'

particularly volunteers' life if it is not managed properly. This can also be a barrier for the retention of Volunteering and Pro-Social Attitudes and helping professionals as well. Gillath, 2005, p.182, has argued that the altruistic, innate tendency to attend empathically to others' distress and provide care when needed can be interfered with, suppressed, or overridden by psychological insecurity due to compassion stress (Gillath, et,al, 2005, p.89).

Under conditions of threat, adults often think first of turning to oneself for support and comfort rather than providing support to others. At such times they are likely to be so focused on their own needs that they lack the mental resources necessary to attend empathically to others' distress and to engage in altruistic behavior (Gillath, et,al, 2005, p.89). Only when relief is attained and a sense of security is restored can many people easily direct attention and energy to other behavioral systems, such as care giving. Only a relatively secure person can easily perceive others not only as sources of security and support, but also as suffering human beings who have important needs and therefore deserve support. (Kunce & Shaver, 1994, p. 72)

Therefore, in the area of care giving, studies need to be done on how volunteer care givers would be free from compassion caused stress. Because, researches have shown that the long-range emotional impact of working with trauma clients is pathogenic and can be transmitted through the process of compassion (Catherall, 1995; Figley, et al, 1995). As a result of vicarious exposure to traumatic events, care givers especially volunteers have reported to have emotional unrest and distress (Bell *et al.*, 2003, p.216).

Research findings have observed high levels of compassion-related stress amongst nonprofessional volunteer caregivers possibly higher than qualified staff (Barlow and Collins, 2008, p.10).But, it happened to be hard to find literatures on compassion stress associated with why and how volunteer caregivers are vulnerable to it and how they can cope up with it. A study

on these questions need to be conducted so that it is possible to rescue volunteer caregivers from the negative effects of CS by designing intervention to volunteers based on the findings of the inquiry.

Given that, the intention of this enquiry is to assess the general compassion induced susceptibility and personal psycho-socio-spiritual resources to lessen and risk factors worsening the compassion stress and burden on volunteer caregiver providing constant and demanding care to PLWHA (people living with HIV/AIDS) in the study area perceiving themselves as sources of security and support.

Assumption in this study

In this study it was expected that subjects would be comfortable to be part of the inquiry. And was assumed that volunteer care giver would demonstrate some sort of compassion better than any other professionals. Interpersonal reactivity outcome between care giver and care recipients is thought to demonstrate compassion associated stress among caregivers and as a compassion stress scale, interpersonal reactivity index (IRI) would measure the compassion level experienced by the care givers.

Objectives of the study

General objective

The study was designed to describe how volunteer caregivers cope with and fail to compassion stress. Social factors or personal qualities to the susceptibility or non susceptibility to CS prevailed on volunteer caregivers and the respective actual and perceived difficulties of the failure to compassion stress to care givers in the study area were described.

Specific Objectives

In line with the above general objective the study could specifically met concerns below

1. To describe protective factors and resources used by caregivers to combat CS.
2. To assess Situation based factors to forget self care.
3. To describe the influence and l experience of compassion stress among volunteer caregivers.
4. To examine Caregivers' resilience to compassion stress.

Research questions

1. How could care givers be able to experience one of the psychological problems; compassion stress differently out of the same circumstance?
2. What are protective resources used by caregivers to combat CS?
3. What are the Situation based factors that get forget self care?
4. How is the perceived and actual influence of compassion stress to volunteer caregivers?
5. What are Caregivers' personal resiliencies to cope compassion stress?

Research hypotheses

1. Voluntary care giving does lead to compassion stress.
2. Self efficacy, optimism and religiosity are some personal factors which lead to compassion stress.
3. There social approval is social coping resources which helps volunteer caregivers combat compassion stress.

Scope and Limitations of the Study

As tried to specify in objective part, the study is confined on describing and understanding the vulnerability of volunteer caregivers and adaptive resources of care givers to CS in the study area. In the study, risk and protective factors which get caregivers unable/able to give self care will be revealed.

As to limitations of the study related to the designed method, it is difficult to conduct stress related research in a normal condition. Respondents may face difficulty in putting the exact emotional feeling of stress as they are feeling at the event even if the researcher will try his best by developing and adopting questioner which is universally accepted and raise the internal validity and reliability. The population of the study subjects is mostly females and this would have some effect on the generalization of the analysis regarding gender dimension. In addition to this, there would be situations to be controlled so that I can say that the recorded stress is resulted from compassionate care giving. For example, prior to the study, participant Care givers' health status would have been tested by the Physical Self Maintenance Scale (PSMS), Instrumental Activities of Daily Living Scale (IADL), and the Neuropsychiatric HIV Rating Scale (NARS). But, due to time and financial constraint the paper couldn't control the above mentioned probabilities not to influence the result and the study couldn't incorporate some other social, biological and other essential precipitating and controlling variables affecting compassion stress.

II Literature review

This chapter is organized to support the study and show the gap of literatures on the research title “Compassion stress among HIV infected peoples’ volunteer caregivers” by reviewing various publications. In order to address related issues regarding the study, titles including Compassion, Compassion and its barriers, Stress related to care giving for HIV infected people, Spirituality in Caregivers of Family Members, Attachment, Care giving, and Altruism, Ways of helping caregivers combat stress, Age and coping skill of stress, Volunteerism, care giving, and the need for care on the side of PLWH and compassion stress could be retrieved.

The Compassionate Care giving System and Its Interplay with the Attachment System

According to Bowlby, (1982, p.46), the care giving system is designed to provide protection and support to others who are either chronically dependent or temporarily in need. It is inherently altruistic in nature, being aimed at the alleviation of others’ distress, although the system itself presumably evolved because it increased the inclusive fitness of individuals by making it more likely that children and tribe members with whom the individual shared genes would survive and reproduce (Hamilton, 1964, p.742).

Within attachment theory, the care giving system provides an entree to the study of compassion and altruism; moreover, understanding this system provides a foundation for devising ways of increasing people’s compassion and effective altruism. Care giving refers to a broad array of behaviors that complement a relationship partner’s attachment behaviors or signals of need. The set goal of such behaviors is reduction of the partner’s suffering (which Bowlby, 1982, p.183) called providing a “safe haven”) or fostering the partner’s growth and development (which Bowlby called providing a “secure base” for exploration). The key mechanism for achieving these goals is the adoption of what Batson (1991, p.12) called an

empathic stance toward others' suffering taking the perspective of the distressed person to sensitively and effectively help him or her reduce suffering and distress. That is, the care giving system is focused on the other's welfare and therefore directs attention to the other's distress rather than to one's own emotional state. In its prototypical form that is, in the parent-child relationship the set goal of the child's attachment system (proximity that fosters protection, reduces distress, increases safety, and establishes a secure base) is also the aim of the parent's care giving system. Extending this conceptualization to the broader realm of compassion and altruism, one can view the care giving system as being activated by the presence of a distressed person, even a stranger in need, and its aim as being to alter the needy person's condition until signs of increased safety, wellbeing, and security are evident.

Beyond explaining this complementarity between the support seeker's attachment system and the support provider's care giving system, (Bowlby, 1982, p.3487) also conceptualized the interplay between these two systems within the mind of a potential support provider. Just as (Ainsworth et al. 1978, p.452) argued that a child's exploration system is inhibited or distorted by an urgent need for attachment security in strange or threatening situations.

Attachment, Altruism and Care giving

Recent studies based on Mario Mikulincer, et.al, (2005) attachment theory reveal that dispositional attachment security facilitate cognitive openness and empathy, strengthen self-transcendent values, and foster tolerance of out-group members. Moreover, dispositional attachment security is associated with volunteering to help others in everyday life and to unselfish motives for volunteering. Dispositional attachment-related anxiety and avoidance adversely influenced compassion, personal distress, and altruistic behavior in theoretically

predictable ways. As expected, attachment security provides a foundation for care-oriented feelings and care giving behaviors, whereas various forms of insecurity suppress or interfere with compassionate care giving.

In light of this situation, researchers have begun to explore some of the risk factors involved in the development of distress on the one hand, and some buffering factors that help reduce distress on the other hand. Among the risk factors identified are intensity of exposure to HIV related issues, age and professional experience, supervision and training. Evidently, the more time social workers spend with traumatized clients and the more trauma cases they have under their care the greater the risk of developing secondary stress reactions (Pearlman and MacIain, 1995, p.498). Other researchers, however (e.g. Follette *et al.*, 1994), have argued that secondary trauma may emerge unexpectedly, as a sudden flood of symptoms accompanied by a sense of helplessness, confusion and disassociation.

Under the above title, it could be reviewed that intensity of exposure to HIV related issues, age and professional experience, supervision and training are some of the identified buffering factors for general distress. But, it has nothing to say about compassion caused stress. as compassion stress has significantly different from general stress, the above literature may not sound alike to it.

Compassion

According to attachment theory (Mario Mikulincer, et.al, 2005, p.287) during evolution becoming emotionally attached to caregivers (e.g., parents) and providing care for dependent or injured individuals (e.g., infants, children, injured family members) enhanced the chances of survival, reproduction, and successful parenting (i.e., genetic success or inclusive fitness).

According to (Mario Mikulincer, et.al, 2005, p.287), the function of the attachment system is to protect a person from danger by assuring that he or she maintains proximity to caring and supportive others (attachment figures) who provide protection, support, and relief in times of adversity. The attachment system is most evident during infancy and childhood but continues to be important across the life span. Its innate parameters are gradually shaped and altered by social experiences with attachment figures, resulting eventually in fairly stable individual differences in attachment style a systematic pattern of relational expectations, emotions, and behaviors that increases Compassion and Helping.

Literatures on the above title still shows a gap on answering how the innate parameters of compassion are shaped and altered in their experiences of it which are resulting eventually in fairly stable individual differences in expectations, emotions, and behaviors that causes stress due to the variation in experiencing compassion?

Compassion and its Barriers

Compassion is an innate behavior but, it might not occur due to various reasons. (Gillath, et al, 2005, p.314) has argued that the altruistic, innate tendency to attend empathically to others' distress and provide care when needed can be interfered with, suppressed, or overridden by insecurity. Under conditions of threat, adults often think first of turning to others for support and comfort rather than providing support to others. At such times they are likely to be so focused on their own needs that they lack the mental resources necessary to attend empathically to others' distress and to engage in altruistic behavior. Only when relief is attained and a sense of security is restored can many people easily direct attention and energy to other behavioral systems, such as care giving. Only a relatively secure person can easily perceive others not only as sources of

security and support, but also as suffering human beings who have important needs and therefore deserve support.

In short, the aim of the care giving system is more likely to become salient and be realized in behavior when a person is secure enough to allow for an empathic focus on someone else's needs. This ability to help others is a consequence of having witnessed and benefited from good care provided by one's own attachment figures, which both increases one's sense of security and provides models of good care giving (Kunze & Shaver, 1994, p.723). Furthermore, the sense of attachment security reduces needs for self-protection and self-enhancement (Mikulincer & Shaver, 2005, p.260) and allows a person to shift resources to other behavioral systems, including care giving, and to take the other's perspective (Mikulincer et al., 2002, p.296) the key mechanism underlying altruistic helping (Batson, 1991, p.185). According to our current understanding of the process, attachment security does not activate the care giving system directly but rather provides a solid and stable psychological foundation for a form of empathy that is not overwhelmed by others' suffering or threatened by the interdependence entailed by care giving. In other words, attachment security facilitates helping behavior that is truly aimed at benefiting another person even when there is no egoistic reason for helping.

We don't have to underscore the necessity of recognizing contemporary social conditions that create stressors for people and decrease their ability to cope effectively with transitions. One example in modern society is the increasing number of persons caught in the "sandwich generation" "those who care for both children and elderly parents. Although this may be sequential rather than concurrent, it is nonetheless a stressor, and disproportionately so for women who are usually the primary care providers (Hunter & Sundel, 1989, p.219)

Under this title, it had been sought to review literatures on how role strain caused by role overload change compassion in to stress. But, there is still a gap of publication on it.

Care giving caused stress

Although research findings suggest that care givers gain considerable satisfaction from their work, they tend to report higher levels of work related stress and burnout than many other occupational groups (Lloyd et al., 2002; Rose, 2003; Johnson et al., 2005; Collins, 2008). Work-related stress has serious implications for the mental and physical well-being of care givers; the provision of care may also be compromised via impaired performance at work and sickness absence (Wright and Cropanzano, 1998; Horder, 1999; Morris, 2005; Nissly et al., 2005). The high levels of stress and burnout experienced by care givers have also been found to contribute to the growing retention problems within the profession. A recent study by the Local Government Association (LGA, 2009) reported that 60 per cent of local authorities experience difficulty in retaining care givers, representing an increase of 20 per cent in the previous twelve months. Moreover, a study conducted by Curtis, Moriarty and Netten (2009) found that the longevity of a newly qualified social worker was around eight years considerably less than those working in similar professions such as doctors and nurses. One of the most common reasons cited by care givers for leaving the profession is the stressful nature of the job (LGA, 2009). Perceptions of care givers as an emotionally demanding and stressful career have also been found to contribute to the current recruitment problems in the UK (Eborall and Garmeson, 2001). In order to guide the development of interventions to enhance the well-being of care givers and maximize retention in the profession, it is important to identify the factors that may protect staff from the negative impact of the demands that they face. This paper focuses on one such factor: stress resilience. More specifically, it examined the emotional and social competencies that predict

resilience to stress in the social care context, relationships between resilience and psychological well-being and the mechanisms by which resilience might reduce psychological distress and enhance well-being.

Resilience

Resilience is a complex and multi-faceted construct, referring to a person's capacity to handle environmental difficulties, demands and high pressure without experiencing negative effects.

Within the psychological literature, resilience is defined as 'the general capacity for flexible and resourceful adaptation to external and internal stressors' (Klohen, 1996, p. 1068). Resilience has most frequently been examined as a protective resource that might help children 'bounce back' after experiencing major life changes, deprivation and stress (e.g. Haggerty et al., 1996). Less frequently, studies have investigated the role played by stress resilience in protecting the psychological well-being of adults who have experienced traumatic or life threatening events such as bereavement, war and terrorism (e.g. Bonanno, 2004). Some aspects of resilience, such as temperament, are believed to have a strong genetic component (Kagan, 1994). Nonetheless, research findings suggest that environmental factors such as the quality of family and peer relationships and attachment style in childhood are major predictors of resilience to stress in later life (Buckner et al., 2003).

Resilience may not only be a stress resistance resource for people who experience traumatic life circumstances. It has been suggested that resilience might buffer the negative impact of work stress, especially in intrinsically challenging working environments (Howard, 2008). The concept of resilience might explain why some employees who experience chronically high levels of stress at work not only fail to burn out, but may even thrive, resulting in a greater ability to manage future challenges. It has been recently suggested that resilience may be a

particularly important quality for social workers, as it may help them adapt positively to stressful situations and enhance their professional growth (Collins, 2008; Morrison, 2007; Howe, 2008). The need for social workers to develop the emotional resilience required to manage the challenges they face was also emphasized by Lord Laming in a report commissioned to examine child protection in England (Laming, 2009). Despite its relevance as a potential resource for managing work-related stress in the context of social care, the extent to which resilience enhances well-being has not yet been examined. Moreover, little is known about the individual difference factors that promote stress resilience in social workers.

This paper examined several emotional and social competencies as predictors of stress resilience in volunteer care givers. Research findings have observed high levels of work-related stress amongst volunteers possibly higher than qualified staff (Maidment, 2003; Barlow and Hall, 2007; Collins, 2008). It is clearly important to help trainees enhance their resistance to work-related stress at an early stage in their social work career. It is anticipated that the findings of this study will inform the development of interventions to enhance the stress resilience of trainee and early career social workers.

Resilience and emotional competencies

Based on interviews with members of different occupational groups, several factors have been highlighted as having the potential to foster stress resilience at work. Amongst other qualities, Klarreich (1998) emphasised an internal locus of control, optimism, social support and the effective regulation of cognitions and beliefs as particularly important qualities in enhancing resilience to stress. Interviews conducted with family physicians by Jensen et al. (2008) highlighted the importance of a range of factors, such as: valuing the work role, but setting clear boundaries between work and non-work demands; developing well structured work routines;

effective communication skills and successful peer-support mechanisms; and enhancing self-awareness and acceptance by reflecting upon personal strengths and limitations. Howe (2008) has argued that the successful management of emotions is likely to underpin resilience in social care workers. As yet, however, little is known about the specific emotional competencies that predict resilience to stress in this occupational context. This study examines emotional intelligence and associated inter-personal and intra-personal resources, namely reflective ability, empathy and social competence, as predictors of stress resilience in trainee social workers. It is argued that trainees who are more emotionally intelligent, who are more socially competent and empathetic and whose reflective abilities are more developed will be more resilient to stress. Whilst a negative relationship between resilience and psychological distress is anticipated, it was predicted that resilience would mediate the relationship between emotional intelligence and psychological distress. More specifically, trainee social workers who are more emotionally intelligent will be more resilient to life stressors, which, in turn, would protect their emotional well-being.

Emotional intelligence has been conceptualized in various ways. The concept is defined broadly by Goleman (1996, p. 34) as 'being able to motivate oneself and persist in the face of frustrations; to control impulse and delay gratification; to regulate one's moods and keep distress from swamping the ability to think; to empathize and to hope'. A number of studies have highlighted emotional intelligence as a key predictor of adaptive coping and interpersonal success in the workplace and other life domains; it has also been related to enhanced life satisfaction and psychological and physical health (Salovey et al., 2002; Mikolajczak et al., 2006; Carmeli and Josman, 2006). Poor emotion management skills are likely to have a negative impact on colleagues and clients as well as the individual social worker.

The capacity to manage the emotions of oneself and others effectively, frequently in complex care settings, is central to the role of a social worker. Emotional intelligence has important implications for job performance, as it has been associated with enhanced judgment and decision-making abilities, greater flexibility in negotiation and the generation and maintenance of enthusiasm, confidence, optimism, co-operation and trust in others (George, 2000).

Reflective thinking ability is believed to be a key component of emotional intelligence (Schon, 1983). Personal reflection is fundamental to the acquisition, maintenance and enhancement of professional development in care settings; it has also been found to underlie successful coping in this context (Collins, 2007; Ruch, 2009). Based on research conducted with medical students, Aukes et al. (2007) propose that personal reflection in care settings has three elements: self-reflection, empathetic reflection and reflective communication.

Feelings of competence in social situations are also considered to be important aspects of emotional intelligence. Clearly, care givers require well developed social skills if they are to communicate effectively with service users from different backgrounds, as well as forge and maintain effective social support networks amongst peers, family and friends. If social skills are under-developed, attempts to enhance supportive networks as stress management tools are likely to fail (Sarason et al., 1985). The present study therefore also considered the role of social competence as a potential predictor of stress resilience.

Finally, the role played by empathy in predicting resilience was also examined. Empathy is a key component of all helping relationships; it has been found to have strong positive therapeutic effects on service users' physical, mental and social well-being (Morrison, 2007). Nonetheless, it remains under-explored in social work settings (Barlow and Hall, 2008). Early

definitions of empathy considered it to be the ability to adopt the perspective of others in order to understand their feelings, thoughts or actions (Hogan, 1969). As with reflective ability, however, later conceptualizations consider empathy to be a multidimensional construct that encompasses perspective taking (spontaneous attempts to adopt the perspectives of other people), empathic concern (feelings of warmth, compassion and concern for others) and personal distress (feelings of anxiety and discomfort resulting from the negative experiences of others) (Davis, 1983). All three components of empathy were examined in this study.

Ways of helping caregivers combat stress

Adequate supervision is conducive to a relationship in which the worker feels safe about expressing fears, concerns and inadequacies (Welfel, 1998). Thus, a responsive and supportive supervisory relationship may enable workers to process traumatic experiences, and thus mitigate the personal effect of those experiences. Supervision may also help alleviate stress by encouraging the worker to take on a smaller or more diverse caseload, and by increasing the worker's awareness of boundaries and professional margins (Sexton, 1999, p.864). Pearlman and MacIan (1995) found that workers who were exposed to personal trauma and did not receive supervision experienced higher levels of distress than did those who were exposed to trauma and received supervision. (Pearlman and MacIan, 1995, p.741)

An additional personal disposition that has been identified as a resource in coping with stress situations is optimism. Optimism is defined as a relatively stable, generalized expectation that good outcomes will occur across important life domains (Scheier and Carver, 1985, p.319). People tend to maintain their optimism over time and across different situations. Studies have confirmed cross-sectional and longitudinal relationships between optimism and subjective well-being (Khoo and Bishop, 1997, p.821), self-esteem (Dunn, 1996, p.18), low depression (Marshall

and Lang, 1990, p.193), low negative emotions (King *et al.*, 1998, p.56) and high life satisfaction (Chang1998). A few studies have examined the relationship between optimism and risk of job burnout or distress. A study of employed students revealed that lack of optimism is a risk factor for job burnout, independently of stress (Rachel Dekel, et. al,2006, p.1250) Another study, conducted among information service workers whose jobs require them to deal with serious global computer programming problems, found that optimism has both direct and moderating effects (Riulli and Savicki, 2003).

Spirituality as an intervention strategy for Care giving

Researchers have implemented various intervention strategies and evaluated their impact on the negative aspects of care giving. Yet, many of these strategies have failed to show reductions in the burden of care giving. However, caregivers sometimes report that these same intervention strategies were extremely helpful. Perhaps those strategies are helping caregivers find spiritual meaning in their lives that empowers them to transcend their care giving difficulties.

To assist care givers to cope with the burden of care giving, researchers have implemented various intervention strategies testing their effects on the social, emotional, and physical consequences of care giving (Acton &Winter). However, to date, researchers have reported conflicting effects on care giving outcomes such as stress, anxiety, depression, coping, and support (Acton & Kang, 2001, p. 714), and a meta-analysis showed that few interventions significantly reduced caregiver burden (Acton & Kang, 2001, p.531).

Contrary to these findings, however, caregivers often report high levels of satisfaction with various intervention strategies such as education/support or counseling, and in some cases, caregivers report that the interventions have been instrumental in their being able to remain in

the care giving role. Yet, empirically, these same interventions showed little or no effect on the negative outcomes of care giving such as burden and stress (Acton & Miller, 1996, p.378).

Statements from caregivers regarding the helpfulness of the interventions indicate that the intervention strategies may be more successful than quantitative outcomes suggest.

In the process of the whole review, it was strived to see if religiosity has any relation with compassion stress. But, it could be hard to find a paper which states about compassion stress. This shows that there is a gap in literature on the area.

Age and coping skill of stress

Even though, there is no one related to compassion stress, many ligatures have tried to relate age and traumatic stress experience. Even, it can be said that age differences of workers gain increasing importance because of demographic changes in most industrialized countries, age differences in stress experience and resistance have been rarely addressed. According to Rauschenbach & Guido Hertel,2010, In this initial empirical study, we explore the general relationship of age and strain as a function of three processes: (1) older workers might experience less strain because of better coping strategies; (2) older workers might experience more strain because of higher vulnerability; or (3) age and strain might be curvilinear related with highest strain reported by middle age workers. Using both general and experience-based measures, strain and emotional reactivity to stressful job events were reported by 274 workers aged between 18 and 65 years. Results showed an inverted U-shaped relationship between age and strain experience. (Rauschenbach & Guido Hertel,2010, p.1248).

Moreover, findings have revealed that age and professional experience correlate inversely with the development of secondary traumatization. The less experienced the workers, the more they are at risk when they treat traumatized clients. Notably, they have less time to develop their

professional identity and effective coping strategies than do experienced workers. In addition, they have fewer opportunities to integrate their clients' traumatic stories into their system of beliefs and to balance their own personal safety. They are overwhelmed by a sense of futility due to violence around them, tend to be suspicious of others, and lack confidence in their ability to contribute to their clients' well-being (Neumann and Gamble, 1995, p.532). By contrast, findings indicate that older and more experienced social workers have a stronger sense of self-efficacy and are better able to separate their professional role from their private life. In this connection, several studies have found a correlation between inexperience and high levels of distress (e.g. Adams *et al.*, 2001; Baird and Jenkins, 2003). In addition, trauma-specific training and effective supervision have been found to diminish the potential for distress among social workers.

Literatures gap on the study area

Through the review, there is a great deal of researches done on compassion fatigue and burnout. However, adequate literatures on compassion stress affecting compassionate and altruistic volunteer care giving couldn't be found.

Literatures on the topic still shows a gap on answering how the innate parameters of compassion are shaped and altered in their experiences of it which result eventually in fairly stable individual differences in expectations, emotions, and behaviors that causes stress due to the variation in experiencing compassion? In the process, it had also been sought to review literatures on how role strain caused by role overload change compassion in to stress. But, there is still a gap of publication on it.

It was exhaustively searched to see the association between self stigma of care recipients and fear of attack of care givers and compassion stress. But, it could be hard to find. In addition

to this, it was strived to see if religiosity has any relation with compassion stress. But, it could be hard to find a paper which states about compassion stress.

Again, it could be reviewed that intensity of exposure to HIV related issues, age and professional experience, supervision and training are some of the identified buffering factors for general distress. But, it has nothing to say about compassion caused stress. As compassion stress has significantly different from general stress, the literature retrieved related to fatigue may not sound alike to it. This shows that there is a gap in literature on the area.

Given all these, it is legitimate to say researchers have given less emphasis to the study of compassion stress particularly to volunteer care givers. According to the enquirer's view, it is over looked. Yes it is. In fact it is healthy for caregivers to have compassion associated stress. But, like compassion fatigue, compassion stress has unnoticeable effect on care givers' life if it is not managed properly. Therefore, intention of this study is to contribute some part on a new look at to compassion stress particularly on the issues framed under the study objective.

Theoretical frame work

Resiliency Model

By relying on stress and coping models, the primary focus in care giving research has been on how individual characteristics and coping processes interact with stress and result in burden and distress. Resilience as a conceptual framework is relevant to understanding how caregivers' capabilities can buffer them from the disruptions of excessive demands (Walsh, 200, p.79).

Resilience is defined here as the behavioral patterns, functional competence and cultural capacities that individuals, families and communities utilize under adverse circumstances, and the ability to integrate adversity as a catalyst for growth and development. Some individuals are resilient because of adversity, not despite adversity. Thus, a conceptual model of care giving

resilience is applicable for examining care giving processes and outcomes within historically disadvantaged communities, such as among people living with HIV/AIDS and their formal/informal caregivers. Four factors are salient:

1) Demographic characteristics; like Sex, age, religion, Family size, Marital status, Income level, Educational status

(2) Risk factors, Role strain, Self stigma of care recipient, Care givers' fear of attack by care recipient

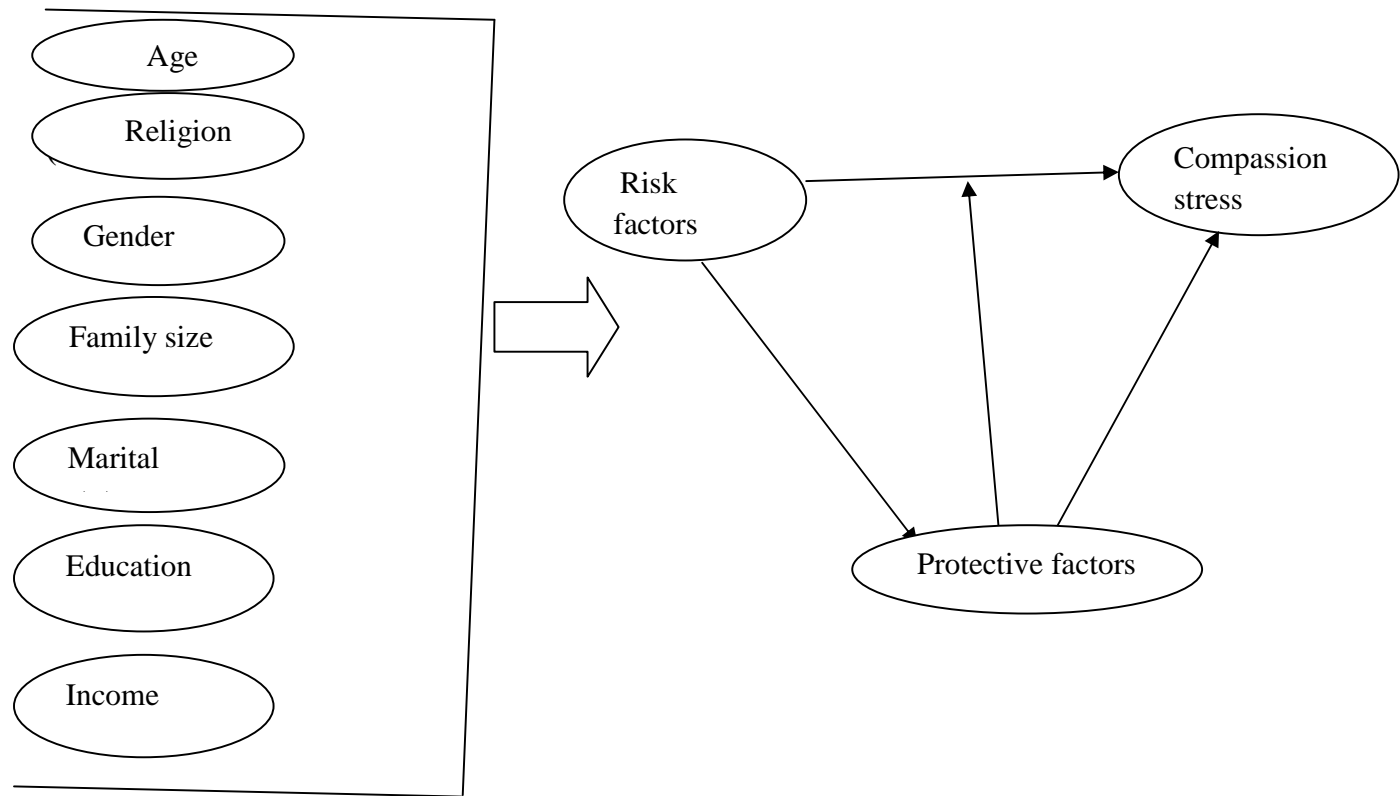
(3) Protective factors; Self efficacy, Social approval, Optimism, religiosity of caregivers, Training level And

(4) Compassion stress. The conceptual framework is illustrated in Figure 1 and described below.

This study also utilized a model of emotional intelligence developed by Schutte et al.(1998, p.72). The model, emotional intelligence rubric originally conceptualized by Goleman (1996), were assessed in the present study

Conceptual framework

Figure1. The Care giving Resilience and Model



Description of variables

The study variables of this research are

Table 1: Operationalisation of major variables

Concepts	Variables	indicators
Demographic Characteristics	Independent variables	
	Sex	Whether the subject is male or female
	age	Number of years the subject lived
	religion	Religious affiliation of subjects

	Family size	The total household member
	Marital status	The marital status of subjects
	Income level	Monthly income
	Educational status	Academic level in grade
Protective factors	Self efficacy	Level of confidence on oneself to carry out a work successfully
	Social approval	frequency of appreciation that society express to the service they provide (less frequent-more frequent) 1, 2, 3...
	Optimism	Frequency of positive thought and expectation, 1-5, pessimist-optimist
	religiosity of caregivers	number of time spent on spiritual activities like meditation, yoga or other ritual activities (per day-per month
risk factors	Role strain	Number of experiences of unmet social expectations (per week)
	Self stigma of care recipient	Frequency of cases experienced by care giver when the care recipients prefer to be alone while visiting to serve.

	Care givers' fear of attack by care recipient	Number of absents or interruption of services because of fear of attack
	Training level	Number of care giving related training taken
Dependant variable	Compassion stress	Level of stress experienced due to interpersonal interaction between care giver and care recipients (IRI)

Operational Definition of terms

Care giving refers to a broad array of behaviors that complement a relationship partner's attachment behaviors or signals of need. The set goal of such behaviors is reducing the partner's suffering or fostering the partner's growth and development. Compassion and real care giving are inseparable because, care giving is effective so long as there is compassion in the heart of the care giver. The attachment theory of Phillip R. et al, 2005, states that the care giving system provides an entree to the study of compassion and altruism.

Compassion can be defined simply as the ability and willingness to help others who are suffering. This means that we need to hear another's suffering, not just imagine it or think about it. Hearing another's suffering, or sitting with their suffering, involves empathy. Both empathy and compassion are relational phenomenon, which means that we come to learn about them through our relationships with others and ourselves. (Dr. David Hoisington May, 2007)

Compassion stress can be defined as "a state of feeling resulting from a challenge appraised as opportunity to help others but, the likelihood of the condition demanding greater adaptive resource than the helper has". (Lazarus & Lazarus, 1994, pp.254)

Compassion fatigue is the natural consequence of stress resulting from caring for and helping traumatized or suffering people or animals (Figley 1993,pp. 82).

Optimism is a positive expectation (thought) of people to events and the future.

Religiosity is defined as "a comply cumulative tradition composed from myriad beliefs and practices that have expressed and formed the faith of persons" (Fowler, 1996, p. 21, 56).

Spirituality is defined as the "pattern of our relatedness to self, others, and our world in light of our relatedness to ultimacy"(Fowler, 1996, p. 21).

Self efficacy; Level of confidence on oneself to carry out a work successfully

Self stigma; the degree of social exclusion experienced by the person be alone while the care giver need to serve

Social approval; Frequency of appreciation that society express to the service they provide

Strain refers to a person's physiological and/or psychological response to stressors (Cornelia Rauschenbach & Guido Hertel, 2010, p. 1), leading to job dissatisfaction, psychological distress, burnout or low mental well-being.

III Methodology

It is tried to explain in the first section, the intention of the study is to discover the condition of compassion stress in the study area particularly, the protective and risk factors, affecting caregivers to compassion stress. Throughout the enquiry process, the study took a strictly designed tool for grant to view the objective reality of respondents as it is. Because, in the inquiry it was believed that the realities that are sought to be viewed (care giving and compassion stress) can be reliably identified so long as it is approached rigorously and view as a series of logically related steps, and here in this study, it is believed that rigorous methods of quantitative data collection and analysis approach is decisive to reach tangible reality. In this research, it is also believed that reality can be seen as an objective knowledge if it is approached in a systematically structured manner and if it is successfully demonstrated the phenomenon under study.

Study Area and Population

The area where the research is proposed to conduct is in Addis Ababa particularly Addis Ketema Sub-city cares giving NGOs' Volunteers for HIV infected people where there is high prevalence of HIV/AIDS among all the sub-cities of Addis Ababa where 49,135 people were estimated to live with the virus out of the general estimated population of 336,541. (Tewabe Yizengaw, 2007) The focal point of the research is specifically on three local NGOs; Wogen Aden Ethiopians Association, Beza Lehiwot orphan caring association, Hiwot HIV/AIDS Association; which work on HIV/AIDS. These NGOs undertake home based care in collaboration with community volunteer caregivers.

Study population

Subjects of this study were all those who have been voluntarily giving care for people living with HIV/AIDS under the aforementioned NGO since 2009/10. There are also volunteers selected from Kolfe sub-city administered under Beza Lehiwot. This segment of people was selected to be part of the study because voluntary care giving people are assumed to be closer to compassion stress and I had adequate observation on them while I was placed for field practice.

Research design

In this study, cross sectional survey (the survey is conducted at a time and a place) for descriptive analysis method were employed with the intent of investigating the current condition and level of susceptibility among care givers. According to Deribie Debela, 2010, survey design is appropriate to collect diversified types of data on situation that exists, opinions that are prevailed, trends that are developed and preferences that are sought. (Deribie, 2010, pp,39) so, the preferred design is thought to achieve the enquiry on answering research questions associated with influence of compassion stress, risk factors of compassion stress and respective affording resources.

Sample size determination

Since each organization has a personnel inventory for all volunteers who have been serving, the desired types of data is known. According to information obtained from the three local NGOs, there are 320 volunteer caregivers in the sub-city. A sample of 178 individuals is found to be reasonable, and fair. According to Israel, & Glenn D. 1992, p.5, Size n of a simple random sample required for a 95 % confidence level the estimate can be fixed with the formula below.

$$N = \text{population size} \quad n = \frac{N}{1 + N(e)^2}$$

$$n = \text{sample size:} \quad n = \frac{320}{1 + 320(0.05)^2}$$

$$e = \text{margin of error} \quad n = \frac{320}{1.8}$$

$$n = 178$$

Based on their proportion, out of 44, 230 and 46 volunteer care givers, survey participants were selected from Wogen Aden Ethiopian Association, Besa Lehiwot orphan caring association, and Hiwot HIV/AIDS respectively. This makes the sample size to be 178 volunteers. The list of members of volunteer care givers is obtained from each NGO and used to prepare sampling frame. To draw the samples, a proportionate organization based stratified systematic sampling technique was employed. The volunteer care givers were stratified by the agency to which they work

The sampling frame contains a list of stratified volunteer caregivers. Then number 20 selected from the summative list of individuals through lottery method and every 20th of the list was included in the sample (20th, 2*20th, 3*20th...). This continues until the sample size 178 is met.

Sampling Techniques

The project will take random sampling techniques as a quantitative approach was used. The sample was selected by systematic random sampling by clustering subjects based on the

organizations under which they are administered. Attempts were made to systematically diversify subjects in order to assure the data representativeness for the quantitative data. Given this, 24, 128, 26 study participants were selected from Wogen Aden Ethiopian Association, Besa Lehiwot orphan caring association, and Hiwot HIV/AIDS respectively.

Procedures and techniques of data collection and analysis

Data collection tools and procedure

Since the nature of the data required by the study is quantitative. Therefore, structured questioner was used to answer the research questions. Part IV of the questioner which is a twenty item scale that deals with compassion stress was adapted from a measure developed by Davis (1983) while the rest is developed by the researcher. This scale has three dimensions: perspective taking, empathetic concern and personal distress. The survey questioner was tested on community worker and supervisors of volunteer caregivers in the NGO before using it for the actual purpose at real respondents. Then the questioner was refined by the conductor and six questioner administrators were trained. Finally, prior to the distribution of questioner the objective of the study and ethical clarification were made to the respondents and then appropriate time and situation was considered in the distribution and collection of the questioner to avoid lack of concentration at the data collection process.

Data Analysis plan

The data collected had a nature of quantitative one and questioner was self administered which was analyzed through a soft ware known as statistical package for social science (SPSS) version 16. In presenting descriptive data and testing hypothesis in the study, both descriptive and inferential statistics were used. Among descriptive statistics, frequencies and cross tabulation

were used. From inferential statistics applied to this study were models like linear regression, paired correlation and bi-variant correlation matrix in the analysis with which it could be possible to see the linear relationship between the risk factors and protective factors and compassion stress.. Regression test was used to determine and measure the extent, direction of association and relationship forecasted between independent variables and the dependant variable.

Ethical issues of the study

While dealing with subjects, there were some ethical issues considered as customary research. Of course, some of the ethical issues were clarified to the respondents in the form of informed consent and the promise in the form will be kept. In addition to this, the issue of confidentiality and anonymity were insured by the questioner preparation as it didn't ask any private data like address and name. In the data collection process, community workers who are familiar to them were used to make subjects comfortable with the participation.

IV Data presentation and discussion

Data presentation

This chapter focuses on presenting and discussing the data resulted from the survey when it is analyzed with the SPSS. In presenting descriptive data and testing hypothesis in the study, both descriptive and inferential statistics were used. Among descriptive statistics, frequencies and cross tabulation are reported. From inferential statistics applied to this study, regression test, chi-square test, Pearson's correlation coefficient and paired test are reported. Regression test was used to determine forecasted relationship between independent variables and the dependant variable.

Demographic variables

There are about seven demographic variables that are sought to be tested if they are factors to the dependant variable, compassion stress. These variables are age, gender, educational status, marital status, family size, religion and monthly income of volunteer care givers. Statistically described data of the above variables are reported relating to the dependent variable, compassion stress.

Age category of respondents

In order to gather data about age region of volunteer care givers, the respondents are asked to which age category they do belong. Table 4.1 summarizes the information as follows

Table 4.1.1 Age Category of respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
child		2.7	2.7	2.7
young	67	37.8	7.8	40.5
Adult	106	59.5	9.5	56.8
old				
Total	178	100.0	100.0	100.0

Adults and youths are the dominant care givers of the three NGOs who are working in Addis ketema sub city related to People living with HIV/AIDS. 97.3% of the total 178 respondents are adults and youths, (59.5% & 37.8%) respectively. The child and aged segment of the respondents accounts only 2.7% of the total number of respondents while there is no one whose age is above 60 years of old. The graph in appendix III shows this percentage precisely.

Table 4.1.2 Score of compassion stress experienced by caregivers and age category of respondents
Cross tabulation

score of compassion stress experienced by caregivers	Category of age region where respondent belong			Total
	child	young	adult	
<60	0	27	43	70
>60	5	38	65	108
Total	5	65	108	178

As table 4.2 shows that more than 50 % of all the age category has experienced compassion stress greater than 60 IRI score.60 % (n=65) of adult respondents are stressed. And 100% of children are stressed. all the five children are in >60 compassion stress category.

The variable (category of age region where respondent belong)

Table 4.1.3 Paired Samples Correlations

			Correlation	sig.
Pair 1	age category of respondents & score of compassion stress experienced by caregivers	178	-.078	.509

As the Paired Samples Correlations table shows there is statistically inconsistent relationship between category of age region where respondent belong & score of compassion stress experienced by caregivers. The variables are also inversely related. $r(178)=-0.078$, $p>0,05$

Table 4.1.4 sex of respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	female	152	85.1	85.1	85.1
	male	26	14.9	14.9	100.0
	Total	178	100.0	100.0	

As it can be seen in table 4.4, the female gender takes a higher proportion of the total respondent. 85.1 % of the respondent is female while the rest 14.9 % is male. Out of the total respondents only 14.9% of them are male. Here it can be said that gender based division of labor is manifested in the caring role.

Table 4.1.5 score of compassion stress experienced by caregivers and sex of respondent Cross tabulation

	sex of respondent		Total
	female	Male	
score of compassion stress experienced by caregivers <60	63	7	70
>60	89	19	108
Total	152	26	78

58% (n=89) of female respondents are >60 compassion stress level of IRI while males in this category accounts about 73%. This implies those females are relatively less compassionately stressed than male.

Table 4.1.6 educational level in a wider category

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid elementary	65	36.5	36.5	36.5
High school	103	58.1	58.1	94.6
graduate	10	5.4	5.4	100.0
Total	178	100.0	100.0	

From the total number of respondents (178) only 5.4 % of them are graduates. The rest 94.6 % (36.5 % and 58.1 %) of them are in elementary and high school level of education respectively. Table 4.6 shows that more than half of the population of the total respondents is in the wider category of educational level of high school.

Table 4.1.7 Paired Samples Correlations

		Correlation	Sig.
Pair 1	educational level in a wider category & score of compassion stress experienced by caregivers	-.049	.676

The table of Paired Samples Correlations indicates that there is an inverse relation between educational level and score of compassion stress. As educational level increases score of compassion stress scale of IRI decreases. But, the relationship is statistically insignificant.

$r(178)=-0.049, p>0.05$

Table 4.1.8 marital status

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid married	111	62.2	62.2	62.2
unmarried	43	24.3	24.3	86.5
divorced	14	8.1	8.1	94.6
widow	10	5.4	5.4	100.0
Total	178	100.0	100.0	

Table 4.12 displays that 62.2 % (n=111) of the care givers participated in the survey are married. According to the above table, 5.4 % of the respondents are widow. The rest 24.3% and 8.1 % are unmarried and divorced respectively.

Table 4.1.9 Paired Samples Correlations

		Correlation	Sig.
Pair 1 marital status & score of compassion stress experienced by caregivers	178	-.050	.673

The correlation table, table 4.13 tried to compare score of compassion stress scale with marital statuses. It shows that as it goes from unmarried to married, divorced and widow compassion stress experienced by caregivers decreases. But, the correlation is statistically less strong $r(178)=-0.050, p>0.05$. This might have been caused by multitude of exposures to stressing condition. But, there is statistical evidence to this idea.

For the question posed to know how many family member he/she is living with, respondents have answered a valid category of (1-4), (5-7) and (>7)

Table 4.1.10 range of family member in a household

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	(1-4)	63	35.1	35.1	35.1
	(5-7)	79	44.6	44.6	79.7
	above 7	36	20.3	20.3	100.0
	Total	178	100.0	100.0	

According to table 4.10 more than 79.7 % of the survey respondents are living in medium and lower family size of a household. 44.6 % of the respondents are living with five to six member of a household. There as 35.1 % of them are (1-4) member in a family. The remaining 20.3 % of the respondents have >7 family members in the household.

Table 4.1.11 Paired Samples Correlations

			Correlation	Sig.
Pair 1	range of family member in a household & score of compassion stress experienced by caregivers	178	-.012	.921

Even if it is statistically insignificant, there is a correlation between the two variables.

The sign of correlation shows that range of family member in a household & score of compassion stress experienced by caregivers are inversely related. $r(178) = -0.012$, $p > 0.05$. This might be due to the fact that respondents take family members as a social capital which is a buffering factor for compassion stress. This guess is not supported by statistical evidences.

Table 4.1.12 religious affiliation where respondent belong

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Christian	154	86.5	87.7	87.7
	Muslim	16	9.5	9.6	97.3
	others		2.7	2.7	100.0
	Total	177	98.6	100.0	
Missing	System		1.4		
Total		178	100.0		

Table 4.13 displays that the majority of the respondents (154 out of 178) are Christians. They are 87, 7 % of the general sample population while the rest of the respondents are Muslim and other religious followers who takes 9.6 % and 2.7 % respectively.

Table 4.1.13 religious affiliation where respondent belong and score of compassion stress experienced by caregivers Cross tabulation

religious affiliation where respondents belong	score of compassion stress experienced by caregivers					total
	unstressed	less stressed	stressed	much stressed	quit stressed	
Christian	24	19	44	48	19	154
Muslim						16
others						
Total	24	28	49	52	24	177

72 % of the Christian respondents are above the normal stress level of IRI (interpersonal reactivity index). 68.7 % of Muslim respondents are stressed and beyond. And 42.8 % of other

religious followers are in a stressful condition and above that. This might have been influenced by the proportion of participants in the survey.

Table 4.1.14 monthly income level of respondent

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid below 500 br	135	75.7	75.7	75.7
(500-1000) br	38	21.6	21.6	97.3
(1000-2000) br		2.7	2.7	100.0
Total	178	100.0	100.0	

Majority of the respondents were low monthly income earners (<500). About 75.7 % of them have less than 500 birr income. 21.6% of the respondents are in a medium income level (100-2000).

Table 4.1.15 Monthly income level of respondent and score of compassion stress experienced by caregivers Cross tabulation

monthly income level of respondent	score of compassion stress experienced by caregivers					Total
	unstressed	less stressed	tressed	much stressed	quit stressed	
below 500 br	19	19	12	44	31	135
(500-1000) br	0	5	12	21	0	38
(1000-2000) br	0	0	5	0	0	5
Total	19	24	29	65	31	178

Table 4.15 shows those 87 respondents or 64.4 % of low income earners are above the normal stress level of IRI. High income earners are in stressed level while there is no high income earner in other scale of IRI. There is no respondent who is unstressed, much stressed or quit stressed. Whereas 33 of the respondents who are in middle income level are stressed and much stressed.

Table 4.1.16 Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	monthly income level of respondent & score of compassion stress experienced by caregivers	178	-.064	.587

However it is statistically insignificant, Table 4.16 of Paired Samples Correlation depict there is a relatively weaker inverse relationship between income level and compassion stress. $r(178)=-0.064, p>0.05$ As monthly income level increases, compassion stress experienced decreases.

Protective factor variables

Table 4.2.1 acceptability of the work performed by respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	always	118	66.2	66.2	66.2
	often	37	20.3	20.3	86.5
	sometimes		4.1	4.1	90.5
	occasionally	9	5.4	5.4	95.9
	never	7	4.1	4.1	100.0
	Total	178	100.0	100.0	

For the question how often do you get appreciation for the work you performed? 118 respondents have replied that they always get appreciation from the community members. This figure takes 66.2 %. 20.3 % of the respondents are often appreciated for the caring activity they engaged. 9.5 % of the volunteer care givers receive approval from the community. And 4.1 % of the respondents have never got any appreciation from anybody.

Table 4.18 Paired Samples Correlation depicts that there is statistically significant positive relationship between the two variables; acceptability of the work performed by respondents & score of compassion stress experienced by caregivers. $r(178)=0.225, p<0.05$

Table 4.2.2 Paired Samples Correlations

	N	Correlation	Sig.
Pair 1 acceptability of the work performed by respondents & score of compassion stress experienced by caregivers	178	.225	.049

Table 4.2.2, Paired Samples Correlation shows that acceptability of the work performed by respondents & score of compassion stress experienced by caregivers have statistically significant and direct relationship the correlation show that the variables are positively related $r(178)=0.225, p<0.05, CI=95\%$

Table 4.2.3 belief of oneself on successfully caring out ones' responsibility

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid always	140	78.4	78.4	78.4
often	29	16.2	16.2	94.6
sometimes	2	1.4	1.4	95.9
occasionally	5	2.7	2.7	98.6
never	2	1.4	1.4	100.0
otal	178	100.0	100.0	

Table 4.2.3 shows that 94.6 % the respondents gave an answer always or often to the question how often they do feel confidence on successfully caring out one's responsibility while the remaining 5.4 % of the respondents said that they feel confident sometimes, occasionally or have never felt self efficacy.

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	belief of oneself on successfully caring out ones' responsibility & score of compassion stress experienced by caregivers	178	-.042	.722

However statistically insignificant there is an inverse relationship between belief of oneself on successfully caring out ones' responsibility & score of compassion stress experienced by caregivers which means score of compassion stress experienced by caregiver decreases as belief of oneself on successfully caring out ones' responsibility increases.

Table 4.2.4 positive expectation of respondents about things

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	always	123	68.9	68.9	68.9
	often	39	21.6	21.6	90.5
	sometimes	7	4.1	4.1	94.6
	occasionally	2	1.4	1.4	95.9
	never	7	4.1	4.1	100.0
	Total	178	100.0	100.0	

Respondents were asked “how often do you feel that it is natural normal to expect that clients would face some adversity & behave differently?” 68.9 % of the respondents replied they always take it as it is okay. And 21.6% of the survey participants answered the question that they often feel it is natural. The rest 9.5% of the respondents answered sometimes, occasionally and never.

Table 4.2.5 Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	positive expectation of respondents about things & score of compassion stress experienced by caregivers	178	.044	.711

As table 4.2.5 Paired Samples Correlation shows positive expectation of respondents about things & score of compassion stress experienced by caregivers are directly correlated but, it is statistically insignificant $r(178)=0,044$, $p>0.05$, $CI=95\%$.

Table 4.2.6 level of religious practice of respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always	89	50.0	50.0	50.0
	often	53	29.7	29.7	79.7
	ometimes	12.2	12.2	12.2	91.9
	occasionally	5	2.7	2.7	94.6
	never	9	5.4	5.4	100.0
Total		178	100.0	100.0	

As table 4.2.6 shows 50% of the respondents always undertake religious practices like praying, attending preach, hearing religious songs and the like while 29.7% carryout oftentimes and 12.2%, 2.7% of the respondents conduct some religious practices sometimes, occasionally respectively. The remaining 5.4% of the survey respondents never do such practices.

Table 4.2.7 Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	level of religious practice of respondents & score of compassion stress experienced by caregivers	178	-.080	.498

The correlation column of Table 4.2.7 shows that there is an inverse relationship between level of religious practices and compassion stress. According to the table above score of compassion stress of IRI scale decrease as the level of religious practice increase. But, the relationship is statistically insignificant. $r(178)=0.080$, $p>0.05$, $CI=95\%$

Table 4.2.8 number of training taken by care givers

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Once	26	14.9	14.9	14.9
	Twice	20	10.8	10.8	25.7
	Three times	17	9.5	9.5	35.1
	Four times	31	17.6	17.6	52.7
	five and more	84	47.3	47.3	100.0
	Total	178	100.0	100.0	

The above table show that 47.3 % (n=84) of the respondents have taken five and more training about care giving. Other 14.9%, 10.8%, 9.5% and 17.6 % of the respondents takes once, twice, three times and four times respectively.

Table 4.2.9 Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	number of training taken by care givers & score of compassion stress experienced by caregivers	178	.309	.007

The table above shows that there is a statistically strong relationship between the two variables: number of training taken by care givers & score of compassion stress experienced by caregivers. Higher level of training tends to precipitate compassion stress. $r(178)=0.309$, $p<0.01$

Risk factor variables

Role strain (Failure of volunteer care givers to discharge ones' role)

Table 4.3.1 Role strain (failure of respondents to discharge ones role)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	always	22	12.2	12.2	12.2
	often	94	52.7	52.7	64.9
	sometimes	24	13.5	13.5	78.4
	occasionally	10	5.4	5.4	83.8
	never	28	16.2	16.2	100.0
Total		178	100.0	100.0	

64.9 % (n=94, often, n=22 always,) of the total respondents face role strain because of the additional role of voluntary care giving. The remaining 18.9 % (13.5 %, sometimes, 5.4%, occasionally) of the survey participants face role strain sometimes and occasionally. There are

also 16.2 % participants who say that they never face role strain due to the additional role of care giving.

Table 4.3.2 Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	Role strain failure of respondents to discharge ones role & score of compassion stress experienced by caregivers	178	.324	.005

The above table shows a positive correlation $r(178)=0.324$, $p<0.01$, $CI=95\%$. between failure of respondents to discharge ones role & score of compassion stress experienced by caregivers. This implies that as score of compassion stress increase whenever failure of respondents to discharge one's own role increases.

Table 4.3.3 fear of attack of respondent by care recipients

		Frequency	Percent	Valid Percent	umulative Percent
Valid	always	14	8.1	8.1	.1
	often	29	16.2	16.2	4.3
	sometimes	10	5.4	5.4	9.7
	occasionally	12	6.8	6.8	6.5
	never	113	63.5	63.5	00.0
	Total	178	100.0	100.0	

The above table depicts that majority of the respondents (63.5 %) answered for the question how many times did you absent or interrupt services because of fear of attack since you start to give service? that they do not afraid of attack by the care recipients. There as 8.1

%, 16.2 %, 5.4% and 6.8 % of the survey participants answered always, often, sometimes and occasionally respectively.

.3.4 Paired Samples Correlations

	N	Correlation	Sig.
Pair 1 fear of attack of respondent by care recipients & score of compassion stress experienced by caregivers	178	.431	.000

The table above shows that there is a very strong positive correlation between fear of attack of respondent by care recipients & score of compassion stress experienced by caregivers. $r(178)=0.431$, $p<0.01$ the correlation implies score of compassion stress experienced by caregivers increases as fear of attack of respondent by care recipients increases.

Observation of caregivers when care recipients isolate themselves from others

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	always	32	17.6	17.6	17.6
	often	48	27.0	27.0	44.6
	sometimes	32	17.6	17.6	62.2
	occasionally	33	18.9	18.9	81.1
	never	33	18.9	18.9	100.0
	Total	178	100.0	100.0	

Table shows that 81.1% of the survey participants (17.6 %, always, 27% often, 17.6% sometimes and 18.9%, occasionally) have observed clients while they are isolating themselves. Whereas 18.9% of the respondents have never seen clients while they are isolating themselves.

4.3.6 Paired Samples Correlations

	N	Correlation	ig.
Pair 1 observation of care givers when recipients isolate themselves from others & score of compassion stress experienced by caregivers	178	.009	.942

The correlation table shows that there is no correlation between observation of care givers when recipients isolate themselves from others & score of compassion stress experienced by caregivers $r(178)=0.009$, $p>0.005$, $CI=95\%$.

Dependent variable

Compassion stress

To measure the compassion stress level and identify the score experienced by each respondent, interpersonal reactivity index (IRI) is used. Based on the index, scale is qualified as unstressed for the compassion stress score 1-20, less stressed for score 21-40, stressed for score 41-60, much stressed for score 61-80, and quit stressed for the score 81-100.

The table below shows that the score of compassion stress experienced by caregivers is relatively high. It is only 24.3 % of the respondent unstressed and less stressed. The rest 75.7% of the survey participants are in stressed much stressed and quit stressed category of the index (interpersonal reactivity index).

4.4.1 score of compassion stress experienced by caregivers

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	unstressed	17	9.5	9.5	9.5
	less stressed	26	14.9	14.9	24.3
	stressed	29	16.2	16.2	40.5
	much stressed	75	41.9	41.9	82.4
	quit stressed	31	17.6	17.6	100.0
	Total	178	100.0	100.0	

Hypothesis testing**Hypothesis one**

Research hypothesis: Voluntary care giving is compassionately stressful.

Null hypothesis: voluntary care giving is not stressful

Table 4.5.1.1 score of compassion stress experienced by caregivers

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	unstressed	17	9.5	9.5	9.5
	less stressed	26	14.9	14.9	24.3
	stressed	29	16.2	16.2	40.5
	much stressed	75	41.9	41.9	82.4
	quit stressed	31	17.6	17.6	100.0
	Total	178	100.0	100.0	

In order to answer the above research question and test the null hypothesis the dependent variable score of compassion stress experienced by caregivers is tested by chi-square to know as to how the frequency of score of compassion stress is statistically significant, as it is shown in

the table below, the chi-square test affirms that the frequency data of the above table is reliable with the test. $\chi^2(178) = 23.56, df=4, p<0.01$

Table 4.5.1.2 Test Statistics

	score of compassion stress experienced by caregivers
Chi-Square	23.568 ^a
df	
Asymp. Sig.	.000

.0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 14.8.

Hypothesis two

Research hypotheses: There are social/personal factors such as role strain and fear of attack by care recipients which lead to compassion stress.

Null hypothesis: Social or personal factors like role strain and fear of attack by care recipients do not cause compassion stress to occur among volunteer care givers.

Table 4.5.2.1 Paired Samples Correlations

	N	Correlation	Sig.
Pair 1 failure of respondents to discharge ones role & score of compassion stress experienced by caregivers	178	.324	.005

Table 4.5.2.2 Paired Samples Correlations

	N	Correlation	Sig.
Pair 1 fear of attack of respondent by care recipients & score of compassion stress experienced by caregivers	178	.431	.000

In order to test this null hypothesis, the statistical significance of correlation risk factor predictor variables are tested by paired correlations test and role strain and fear of attack by care recipients are proved to be statistically significant as $p < 0.05$. Having done this, the cause and effect relationship between the two risk factors and the outcome variable is tested by regression.

Table 4.5.2.3 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.243 ^a	.059	.046	1.210

. Predictors: (Constant), failure of respondents to discharge ones role

Table 4.5.2.4.Coefficients

Model	Unstandardized Coefficients		Standardized Coefficients	Sig.
		Std. Error	Beta	
(Constant)	2.537	.325		.000
failure of respondents to discharge ones role	.240	.113	.243	.037

. Dependent Variable: score of compassion stress experienced by caregivers

Table 4.5.2.5 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.411 ^a	.169	.158	1.137

. Predictors: (Constant), fear of attack of respondent by care recipients

Table 4.5.2.6 Coefficients

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	1.750	.392		4.464	.000
fear of attack of respondent by care recipients	.352	.092	.411	3.828	.000

. Dependent Variable: score of compassion stress experienced by caregivers

According to the regression test, role strain (failure of respondents to discharge ones role) seems to predict score of compassion stress, $B=2.537$, $t(178)=7.797$, $R^2 = 0.059$ $p<0.01$. The coefficient of determination for role strain to determine score of compassion stress varies with about 4.6 %. This implies that score of compassion stress tend to increases as failure of care givers to discharge one's own role increases.

The above two tables show that the variable, fear of attack of caregivers by care recipients determines the score of compassion stress to be experienced by them, $B=1.750$, $t(178)=4.464$, $R^2 = .0169$ $p<0.01$. The coefficient of determination for fear of attack to determine score of compassion stress varies with about 15.8 %.

According to the test undertaken by regression, there is no reason to accept the null hypothesis. In other words the research hypothesis is proved to be true that there are social/personal factors. Particularly, role strain and fear of attack by care recipients are the risk factors which lead to compassion stress.

Hypothesis three

Research hypothesis: There are some personal coping resources like optimism and self efficacy which help volunteer caregivers combat compassion stress

Null hypothesis: personal resources like optimism and self efficacy do not help volunteer caregivers combat compassion stress.

Like the above two hypothesis testing process, hypothesized control variables were first tested with paired correlation test and then treated with bivariate correlation.

Table 4.5.3 1 Correlation

score of compassion stress experienced by caregivers	Pearson Correlation	1	.139	-.042
	Sig. (2-tailed)		.238	.722
		178	178	178
positive expectation of respondents about things	earson Correlation	.139	1	.170
	Sig. (2-tailed)	.238		.148
		178	178	178
belief of oneself on successfully caring out ones' responsibility	Pearson Correlation	.042	.170	1
	Sig. (2-tailed)	.722	.148	
		178	178	178

The above correlation matrix table shows that both hypothesized protective variables are not statistically significant and the Pearson correlation sign of the relation between the dependent variable, score of compassion stress experienced by caregivers and predictor variable, positive expectation of care givers about things (optimism) indicates that they are positively related,

$r(178)=0.139$, $p>0.05$, $CI=95\%$, and (self efficacy) belief of oneself on successfully caring out ones' responsibility $r(178)=-0.042$, $p<0.05$, $CI=95\%$.

According to the test result, the null hypothesis couldn't be rejected or the research hypothesis needs to be rejected and the null hypothesis is accepted. The result shows optimism and self efficacy do not help volunteer caregivers combat compassion stress.

Discussions

Caregiver psychological and economical burdens have been described as the secondary epidemic associated with the HIV/AIDS crisis (Rait, 1991, p. 271). Care giving has been found to adversely affect the psychological well-being of informal (volunteer) caregivers (Pearlin et al., 1994; p, 128). Informal caregivers to persons with HIV/AIDS report experiencing problems with psychological burden as a result of their care responsibilities (Raveis & Siegel, 1991, p. 215). But the extent to which a caregiver experience psychological burden depends up on their personal protective or precipitating characteristics. Some informal caregivers to persons with HIV/AIDS report experiencing problems with psychological burden as a result of their care responsibilities (Raveis & Siegel, 1991, p. 215). And other HIV/AIDS caregivers also report salutary consequences associated with the provision of care (Callery, 2000, p.412) as they have developed their ability to create meaning out of adverse life circumstances and personal growth resulting from their care responsibilities (Folkman et al., 1994, p. 293).

“How could people be able to experience one of the psychological problems; compassion stress differently out of the same conduct; caregiving?” was the general question of the study. To answer this, about fifteen variables are tested if they are factors to the dependant variable, compassion stress. These variables were hypothetically clustered in to respondent characteristics,

risk factors and protective factors variables. Statistically described data of the above variables are discussed relating to the dependent variable, compassion stress.

Respondents' characteristics

Age Category of respondents

When exploring age differences in the work context, it is important to specify which aspect of age is focused upon, given the wide variety of potential dimensions (Cornelia R. & Guido H, 2010). According to Cornelia R. & Guido H. , 2010 five aspects of age in the workplace are identified as, (1) chronological age, which refers to one's calendar age; (2) functional age, based on a worker's performance; (3) psychosocial age, based on the social perception of age (including self-perception); (4) organizational age, which refers to the experience of individuals in their jobs and organizations; and (5) the lifespan concept of age, which refers to the life stage and family status of an individual. However, apart from important theoretical differences, the empirical effects of the different conceptualizations are often quite similar because the different age concepts are highly interrelated (Cornelia R. & Guido H. , 2010). Whatever, age in the context of this study is the chronological age, which refers to one's calendar age.

In order to gather data about age category of volunteer care givers, the respondents are asked to which age category they do belong: Child, young, adult or old. Table 4.1 summarizes the information as follows

Adults and youths are the dominant care givers of the three NGOs who are working in Addis ketema sub city related to People living with HIV/AIDS. 97.3% of the total 178 respondents are adults and youths, (59.5% & 37.8%) respectively. The child and aged segment of

the respondents accounts only 2.7% of the total number of respondents while there is no one whose age is above 60 years of old. The level of participation might have happened like this because, the resource acquisition among the age groups vary considerably. The chart in appendix III shows this percentage.

To assess the relationship between age group and score of compassion stress, Table 4.1.2, a cross tabulation table shows that more than 50 % of all the age category has experienced compassion stress greater than 60 IRI score. 60 % (n=65) of adult respondents are stressed where as 38 % of youth survey participants are above the normal stress scale of IRI. And 100% of children are stressed. All the five children appeared in the survey are in >60 compassion stress category.

This implies that compassion stress has a significant variation among different age group. Even if it is not specific to compassion stress, the prevailing literature findings confirm this result. a research conducted in 2010 by Cornelia Rauschenbach & Guido Hertel on Age Differences in Strain and Emotional Reactivity to Stressors in Professional Careers says there is non-linear relationship between age and stress. it has an inverted U-shaped pattern because of contextual demands that are highest for middle-age workers (Cornelia R. & Guido H. , 2010).

The same is true for this study because, the present study provides an insight to the three different age-related compassion caused stress condition similar to the above description. First, youths might be more resilient to daily stressors compared to children because of better emotion regulation. Second, adults might be more vulnerable to stressors compared to youths because of higher trend in depletion and decrease in physical resources. Finally, children are highly stressed because of both physical and emotional deficiency they have.

In addition to the above descriptive statistics finding about age and compassion stress, the correlation test has undertaken. The result of this test points that even if it is statistically insignificant, the Paired Samples Correlations table 4.1.3 shows there is relationship between category of age region where respondent belong & score of compassion stress experienced by caregivers. The variables are also inversely related. $r(178) = -0.078$, $\text{sig} = .509$, $p > 0,05$ this weaker relationship is supported by Some researchers conducted on development of secondary traumatization. These findings have revealed that age and professional experience correlates inversely with the development of secondary traumatization. The younger the workers, the more they are at risk when they treat traumatized clients. Notably, they have less time to develop their professional identity and effective coping strategies than do aged workers. In addition, they have fewer opportunities to integrate their clients' traumatic stories into their system of beliefs and to balance their own personal safety. They are overwhelmed by a sense of futility due to violence around them, tend to be suspicious of others, and lack confidence in their ability to contribute to their clients' well-being (Neumann and Gamble, 1995).

Sex of respondent

As it can be seen in table 4.1.4, the female gender takes a higher proportion of the total respondent. 85.1 % of the respondent is female while the rest 14.9 % is male. Out of the total respondents only 14.9% of them are male. Here it can be said that gender based division of labor is manifested in the caring role. Care giving seems to be given to females in the study area. As nursing has been reserved for female for a long, care giving also tends to be one gender role

Table 4.1.5 score of compassion stress experienced by caregivers and sex of respondent Cross tabulation shows that 58% (n=89) of female respondents are >60 compassion stress level of IRI while males in this category accounts about 73%. This implies those females are relatively

less compassionately stressed than male. This variation between both genders might have occurred due to perceived role conflict on the side of male. This is said because; it could be seen in the above analysis that there is a tendency of pushing care giving role to females in the community.

Educational level in a wider category

From the total number of respondents (178) only 5.4 % of them are graduates. The rest 94.6 % (36.5 % and 58.1 %) of them are in elementary and high school level of education respectively. Table 4.6 shows that more than half of the population of the total respondents is in the wider category of educational level of high school.

Table 4.1.7 of Paired Samples Correlations indicates that there is an inverse relation between educational level and score of compassion stress. As educational level increases score of compassion stress scale of IRI decreases. Education level determines the level of stress one experience. But, the relationship shown in Table 4.1.7 of Paired Samples Correlations is statistically insignificant $r(178)=-0.049$, $p>0.05$.

Marital status

Table 4.1.8 displays that 62.2 % (n=111) of the care givers participated in the survey are married. According to the above table, 5.4 % of the respondents are widow. The rest 24.3% and 8.1 % are unmarried and divorced respectively. And the correlation table, table 4.1.9 tried to compare score of compassion stress scale with marital statuses. It shows that as it goes from unmarried to married, divorced and widow compassion stress experienced by caregivers decreases. But, the correlation is statistically less strong $r(178)=-0.050$, $p>0.05$. This might have been caused by multitude of various exposures to stressing condition. But, there is statistical evidence to this idea.

Range of family member in a household

For the question posed to know how many family member he/she is living with, respondents have answered a valid category of (1-4), (5-7) and (>7). According to table 4.1.10 more than 79.7 % of the survey respondents are living in medium and lower family size of a household. 44.6 % of the respondents are living with five to six member of a household. There as 35.1 % of them are (1-4) member in a family. The remaining 20.3 % of the respondents have >7 family members in the household.

Even if it is statistically weak, Table 4.1.11 Paired Samples Correlations shows that there is a very weak correlation between the two variables. The sign of correlation shows that range of family member in a household & score of compassion stress experienced by caregivers are inversely related. $r(178)=-0.012$, $p>0.05$. This might be due to the fact that respondents take family members as a social capital which is a buffering factor for any form of stress. This guess is not supported by statistical evidences.

Religious affiliation where respondent belong

Table 4.1.12 displays the majority of the respondents (154 out of 178) are Christians. They are 87, 7 % of the general sample population while the rest of the respondents are Muslim and other religious followers who takes 9.6 % and 2.7 % respectively. The above data is not adequate to say Christian voluntary to provide care giving service. Because, recruited by Iddir counsels in the first place. Second of all, it might have been influenced by the demographic structure of the general population.

Table 4.1.13 religious affiliation where respondent belong and score of compassion stress experienced by caregivers Cross tabulation depicts 72 % of the Christian respondents are above the normal stress level of IRI (interpersonal reactivity index). 68.7 % of Muslim respondents are

stressed and beyond. And 42.8 % of other religious followers are in a stressful condition and above that. This might have occurred due to the proportion of participants in the survey.

Monthly income level of respondent

Majority of the respondents were low monthly income earners (<500). About 75.7 % of them have less than 500 birr income. 21.6% of the respondents is in a medium income level (100-2000).

Table 4.15 shows those 87 respondents or 64.4 % of low income earners are above the normal stress level of IRI. High income earners are in stressed level while there is no high income earner in other scale of IRI. There is no respondent who is unstressed, much stressed or quit stressed. Whereas 33 of the respondents who are in middle income level are stressed and much stressed.

However it is statistically insignificant, Table 4.16 of Paired Samples Correlation depict there is a relatively weaker inverse relationship between income level and compassion stress. $r(178)=-0.064, p>0.05$ As monthly income level increases, score of compassion stress experienced decreases.

Protective factor variables

Research findings obtained support the claim that lack of protective resources puts the caregiver at risk for burden. Previous studies have emphasized the role of personal and social resources as moderators of stress and have found them to be related to greater levels of caregiving (Stoller & Pugliesi 1991, Skaff et al. 1996, Miller et al. 2001). Resources have also been noted as significant correlates of positive psychological health of care givers. (Muhlenkamp & Sayles 1986, Palank 1992).

Acceptability of the work performed by respondents

For the question how often do you get appreciation for the work you performed? 118 respondents have replied that they always get appreciation from the community members. This figure takes 66.2 %. 20.3 % of the respondents are often appreciated for the caring activity they engaged. 9.5 % of the volunteer care givers receive approval from the community. And 4.1 % of the respondents have never got any appreciation from anybody.

Table 4.2.2 Paired Samples Correlation depicts that there is statistically significant positive relationship between the two variables; acceptability of the work performed by respondents & score of compassion stress experienced by caregivers. $r(178)=0.225, p<0.05$

Table 4.2.2, Paired Samples Correlation shows that acceptability of the work performed by respondents & score of compassion stress experienced by caregivers have statistically significant and direct relationship the correlation show that the variables are positively related. $r(178)=0.225, p<0.05, CI=95\%$ this might have occurred due to an increase in burdensome commitment resulted from social approval.

This result is consistent with Haya Greenberger's finding of the study conducted entitled as 'Can burdened caregivers be effective facilitators of elder care-recipient health care?' in 2001. It says social approval emerged as weakly but positively related to compassion stress. Perhaps burdened caregivers are more motivated to seek out formal support. They may also more readily gain the attention and empathy of professionals. On the one hand, caregivers may be satisfied, gratified and energized through caregiving yet, on the other hand, they may experience substantial burden. They may, for example, perceive role overload and role captivity while still expressing feelings of role competence (Haya G. ,2001).

Belief of oneself on successfully caring out ones' responsibility

Table 4.2.3 shows that 94.6 % the respondents gave an answer always or often to the question how often they do feel confidence on successfully caring out one's responsibility while the remaining 5.4 % of the respondents said that they feel confident sometimes, occasionally or have never felt self efficacy.

However statistically less strong, table 4.2.4 stipulates there is an inverse relationship between belief of oneself on successfully caring out ones' responsibility (self efficacy) & score of compassion stress experienced by caregivers which means score of compassion stress experienced by caregiver decreases as self efficacy or belief of oneself on successfully caring out ones' responsibility increases $r(178) = -.042, p > 0.05, CI = 95\%$.

Parelal to this result, Haya G, 2001 found that caregivers with high levels of mastery and self-esteem tended to have high levels of caregiving competence, which may also be considered a role-specific resource to cope up caring stress. Second, higher compassion stress levels were related to lower levels of self worth. Perhaps resources protect against burden, or perhaps burdened caregivers are vulnerable to loss of resources (Haya G, 2001).

Positive expectation of respondents about things

The variable, Positive expectation of respondents about things here refers to Optimism is defined as a relatively stable, generalized expectation that good outcomes will occur across important life domains (Scheier and Carver, 1985).

Respondents were asked "how often do you feel that it natural normal to expect that clients would face some adversity & behave differently?" to get the optimisticcity data. Table 4.2.4 positive expectation of respondents about things displays 68.9 % of the respondents replied they always take it as it is okay. And 21.6% of the survey participants answered the question that

they often feel it is natural. The rest 9.5% of the respondents answered sometimes, occasionally and never.

As table 4.2.5 Paired Samples Correlation shows positive expectation of respondents about things & score of compassion stress experienced by caregivers are directly correlated but, it is statistically insignificant $r(178)=0,044$, $p>0.05$, $CI=95\%$.

This result with regard to the direction of relationship is contrary to a study done about distress among care givers in England by Perkins, Elizabeth A. in 2006, which have shown that optimism has beneficial effects on protecting caregivers' distress. According to Perkins, Elizabeth A. in 2006, optimism emerges as protective factors positively associated with caregiver well-being.

Level of religious practice of respondents

As table 4.2.6 shows 50% of the respondents always undertake religious practices like praying, attending preach, hearing religious songs and the like while 29.7% carryout oftentimes and 12.2%, 2.7% of the respondents conduct some religious practices sometimes, occasionally respectively. The remaining 5.4% of the survey respondents never do such practices.

The correlation column of Table 4.2.7 shows that there is an inverse relationship between level of religious practices and compassion stress. According to the table above score of compassion stress of IRI scale decrease as the level of religious practice increase. But, the relationship is statistically insignificant $r(178)=0.080$, $p>0.05$, $CI=95\%$.based on the level of correlation, it is possible say religious orientation is not associated with caregiver compassion stress or well-being in this study.

Number of training taken by care givers

Table 4.2.8 number of training taken by care givers show that 47.3 % (n=84) of the respondents have taken five and more training about care giving. Other 14.9%, 10.8%, 9.5% and 17.6 % of the respondents takes once, twice, three times and four times respectively.

Table 4.2.9 shows that there is a statistically strong relationship between the two variables: number of training taken by care givers & score of compassion stress experienced by caregivers. Higher level of training tends to precipitate compassion stress. $r(178)=0.309$, $p<0.01$

Risk factor variables

Role strain (failure of volunteer care givers to discharge ones' role)

Table 4.3.1 Role strain (failure of respondents to discharge ones role) shows that 64.9 % (n=94, often, n=22 always,) of the total respondents face role strain because of the additional role of voluntary care giving. The remaining 18.9 % (13.5 %, sometimes, 5.4%, occasionally) of the survey participants face role strain sometimes and occasionally. There are also 16.2 % participants who say that they never face role strain due to the additional role of care giving.

Table 4.3.2 Paired Samples Correlations shows a positive correlation $r(178)=0.324$, $p<0.01$, CI=95%. between failure of respondents to discharge ones role & score of compassion stress experienced by caregivers. This implies that as score of compassion stress increase whenever failures of respondents to discharge one's own role increase.

The result is supported by studies like Fredriksen-Goldsen & Karen I.(2007), which says role strain is repeatedly associated with decreased psychological health among caregivers, including increased levels of caregiver compassion stress and depression. (Fredriksen.G & Karen I., 2007)

Fear of attack of respondent by care recipients

Table 4.3.3 fear of attack of respondent by care recipients depicts that majority of the respondents (63.5 %) answered for the question how many times did you absent or interrupt services because of fear of attack since you start to give service? that they do not afraid of attack by the care recipients. There as 8.1 %, 16.2 %, 5.4% and 6.8 % of the survey participants answered always, often, sometimes and occasionally respectively.

Table 4.3.4 Paired Samples Correlations shows that there is a very strong positive correlation between fear of attack of respondent by care recipients & score of compassion stress experienced by caregivers. $r(178)=0.431$, $p<0.01$ the correlation implies score of compassion stress experienced by caregivers increases as fear of attack of respondent by care recipients increases.

Observation of caregivers when care recipients isolate themselves from others

Table 4.3.5 shows that 81.1% of the survey participants (17.6 %, always, 27% often, 17.6% sometimes and 18.9%, occasionally) have observed clients while they are isolating themselves. Whereas 18.9% of the respondents have never seen clients while they are isolating themselves.

The correlation table 4.3.6 shows that there is no correlation between observation of care givers when recipients isolate themselves from others & score of compassion stress experienced by caregivers $r(178)=0.009$, $p>0.05$, $CI=95\%$. The absence of association between the two variables may be related to the understanding of caregivers about self stigma and the extent to which it imply.

Compassion stress

Compassion stress was measured by a twenty item scale adapted from a measure developed by Davis (1983). This scale has three dimensions: perspective taking, empathetic concern and personal distress.

To measure the compassion stress level and identify the score experienced by each respondent, interpersonal reactivity index (IRI) is used. Based on the index, scale is qualified as unstressed for the compassion stress score 1-20, less stressed for score 21-40, stressed for score 41-60, much stressed for score 61-80, and quit stressed for the score 81-100.

The table 4.4.1 shows that the score of compassion stress experienced by caregivers is relatively high. It is only 24.3 % of the respondent unstressed and less stressed. The rest 75.7% of the survey participants are in stressed much stressed and quit stressed category of the index (interpersonal reactivity index).

Hypothesis testing

Hypothesis one

Research hypothesis: Voluntary care giving is compassionately stressful.

Null hypothesis: voluntary care giving is not stressful

In order to answer the research questions and test the above null hypothesis, the dependent variable score of compassion stress experienced by caregivers is tested by chi-square to know as to how the frequency of score of compassion stress is statistically significant, as it is shown in the table below, the chi-square test affirms that the frequency data of the above table is reliable with the test. $\chi^2(178) = 23.56, df=4, p<0.01$.

The finding is consistent with other studies' results as Caregiver distress has been described as the secondary epidemic associated with the HIV/AIDS crisis. Caregiving has been found to adversely affect the psychological well-being of informal caregivers and to result in the restriction of opportunities for personal, social and economic development. Informal caregivers to persons with HIV/AIDS report experiencing problems with economic burden as a result of their care responsibilities. (Perkins, Elizabeth A.(2010)

Hypothesis two

Research hypotheses: There are social/personal factors such as role strain and fear of attack by care recipients which lead to compassion stress.

Null hypothesis: Social or personal factors like role strain and fear of attack by care recipients do not cause compassion stress to occur among volunteer care givers.

In order to test this null hypothesis, the statistical significance of correlation risk factor predictor variables are tested by paired correlations test and role strain and fear of attack by care recipients are proved to be statistically significant as $p < 0.05$. Having done this, the cause and effect relationship between the two risk factors and the outcome variable is tested by regression

According to the regression test, role strain (failure of respondents to discharge ones role) seems to predict score of compassion stress, $B=2.537$, $t(178)=7.797$, $x^2 = 0.059$ $p < 0.01$. The coefficient of determination for role strain to determine score of compassion stress varies with about 4.6 %. This implies that score of compassion stress tend to increases as failure of care givers to discharge one's own role increases. The above two tables show that the variable, fear of attack of caregivers by care recipients determines the score of compassion stress to be

experienced by them, $B=1.750$, $t(178)=4.464$, $x^2 = .0169$ $p<0.01$. The coefficient of determination for fear of attack to determine score of compassion stress varies with about 15.8%.

According to the test undertaken by regression, there is no reason to accept the null hypothesis. In other words the research hypothesis is proved to be true that there are social/personal factors. Particularly, role strain and fear of attack by care recipients are the risk factors which lead to compassion stress.

Hypothesis three

Research hypothesis: There are some personal coping resources like optimism and self efficacy which help volunteer caregivers combat compassion stress

Null hypothesis: personal resources like optimism and self efficacy do not help volunteer caregivers combat compassion stress.

Like the above two hypothesis testing process, hypothesized control variables were first tested with paired correlation test and then treated with bi variant correlation.

Table 4.5.3 1 the correlation matrix table shows that both hypothesized protective variables are not statistically significant and the correlation sign indicates that the dependent variable, score of compassion stress experienced by caregivers and predictor variable, positive expectation of care givers about things (optimism) are positively related, $r(178)=0.139$, $p>0.05$, $CI=95\%$ and (self efficacy) belief of oneself on successfully caring out ones' responsibility and score of compassion stress are not significantly correlated, $r(178)=-0.042$, $p<0.05$, $CI=95\%$.

According to the test result, the null hypothesis couldn't be rejected or the research hypothesis needs to be rejected and the null hypothesis is accepted. The result shows optimism

and self efficacy do not help volunteer caregivers combat compassion stress. Even the sign of the correlation indicates that as optimism increase, the score of compassion stress tend to increases.

Contrary to the above finding, literatures say that optimism and self-efficacy may play important roles in how positive meaning is created through the care giving experience (Land&Long, 2000), as well as how caregivers balance the costs of providing care with personal rewards. Perkins, Elizabeth A. (2006) has stated about optimism as one of the personal dispositions that has been identified as a resource in coping with stress situations (Perkins, Elizabeth A. (2006).

This contradiction might have occurred because compassion stress is somewhat different form of stress which is induced by positively rated stressors like compassion, empathy, pity and the like feelings. The above literatures are telling about the general stress.

V Summary Conclusion and Implication of the study

Summary

Generally speaking, caregiver psychological and economical burdens have been described as the secondary epidemic associated with the HIV/AIDS crisis (Rait, 1991, p. 271). Care giving has been found to adversely affect the psychological well-being of informal (volunteer) caregivers (Pearlin et al., 1994; p, 128). Informal caregivers to persons with HIV/AIDS report experiencing problems with psychological burden as a result of their care responsibilities (Raveis & Siegel, 1991, p. 215). But according to the result of this study and others too, the extent to which a caregiver experience psychological burden depends up on their personal protective or precipitating characteristics. Some informal caregivers to persons with HIV/AIDS report experiencing problems with psychological burden as a result of their care responsibilities (Raveis & Siegel, 1991, p. 215). And other HIV/AIDS caregivers also report salutary consequences associated with the provision of care (Callery, 2000, p.412) as they have developed their ability to create meaning out of adverse life circumstances and personal growth resulting from their care responsibilities (Folkman et al., 1994, p. 293).

“How could people be able to experience one of the psychological problems; compassion stress differently out of the same circumstance; care giving?” was the general research question of the study. Under this question there were four sub questions like what are protective factors and resources used by caregivers to combat CS?, what are the Situation based factors that get forget self care? How is the perceived influence and actual experience of compassion stress to volunteer caregivers? And what are Caregivers’ personal resiliencies to compassion stress? And there were three research hypotheses such as Voluntary care giving is compassionately stressful,

There are some personal factors which lead to compassion stress There are social/personal coping resources which help volunteer caregivers combat compassion stress

To answer these questions and hypotheses, about fifteen variables are tested if they are factors to the dependant variable, compassion stress. These variables were clustered in to respondent characteristics, risk factors and protective factors variables. Statistically described data of the above variables are discussed relating to the dependent variable, score of compassion stress and summarized as follow.

From Respondents characteristics: chronological age Category of respondents was one of the variables. In order to gather data about age category of volunteer care givers, the respondents are asked to which age category they do belong: Child, young, adult or old and the relationship between age group and score of compassion stress was described with cross tabulation table and it has shown that more than 50 % of all the age category has experienced compassion stress greater than 60 IRI score.60 %(n=65) of adult respondents are stressed where as 38 of youth survey participants are above the normal stress scale of IRI. And 100% of children are stressed. All the five children appeared in the survey are in >60 compassion stress category.

This implies that compassion stress has a significant variation among different age group. Even if it is not specific to compassion stress, the prevailing literature findings confirm this result. a research conducted in 2010 by Cornelia Rauschenbach & Guido Hertel says there is non-linear relationship between age and stress. it has an inverted U-shaped pattern because of contextual demands that are highest for middle-age workers (Cornelia R. & Guido H. , 2010).

As to the Sex of respondents, female gender respondents take a higher proportion of the total survey respondents 85.1 % of the respondent is female while the rest 14.9 % is male. Here it can be said that gender based division of labor is manifested in the caring role. Care giving

seems to be given to females in the study area. As nursing has been reserved for female for a long, care giving also tends to be one gender role. Cross tabulation shows that 58% (n=89) of female respondents are >60 compassion stress level of IRI while males in this category accounts about 73%. This implies those females are relatively less compassionately stressed than male. This variation between both genders might have occurred due to perceived role conflict on the side of male. This is said because; it could be seen in the above analysis that there is a tendency of pushing care giving role to females in the community.

The other variable in the cluster of respondents' characteristics is educational level according to the descriptive statistics, from the total number of respondents (178) only 5.4 % of them are graduates. The rest 94.6 % (36.5 % and 58.1 %) of them are in elementary and high school level of education respectively and Paired Samples Correlations indicates that there is an inverse relation between educational level and score of compassion stress. As educational level increases score of compassion stress scale of IRI decreases. Education level determines the level of stress one experience. But, the relationship shown in Table 4.1.7 of Paired Samples Correlations is statistically weak $r(178)=-0.049$, $p>0.05$.

Related to marital status, the result showed that 62.2 % (n=111) of the care givers participated in the survey are married. According to the above table, 5.4 % of the respondents are widow. The rest 24.3% and 8.1 % are unmarried and divorced respectively. And the correlation table, table displays that as it goes from unmarried to married, divorced and widow compassion stress experienced by caregivers decreases. But, the correlation is statistically less strong $r(178)=-0.050$, $p>0.05$. This might have been caused by multitude of various exposures to stressing condition. But, there is statistical evidence to this idea.

With regard to range of family member in a household, more than 79.7 % of the survey respondents are living in medium and lower family size of a household. 44.6 % of the respondents are living with five to six member of a household. There as 35.1 % of them are (1-4) member in a family. The remaining 20.3 % of the respondents have >7 family members in the household and. Paired Samples Correlations shows there is a very weak inverse correlation between the two variables. $r(178)=-0.012$, $p>0.05$. This might be due to the fact that respondents take family members as a social capital which is a buffering factor for any form of stress. This guess is not supported by statistical evidences.

The major religious affiliation of the respondents (154 out of 178) is Christians. They are 87, 7 % of the general sample population while the rest of the respondents are Muslim and other religious followers who takes 9.6 % and 2.7 % respectively. The above data is not adequate to say Christian voluntary to provide care giving service. Because, recruited by Iddir counsels in the first place. In the second place, it might have been influenced by the demographic structure of the general population. Religious affiliation where respondent belong and score of compassion stress experienced by caregivers Cross tabulation depicts 72 % of the Christian respondents are above the normal stress level of IRI (interpersonal reactivity index). 68.7 % of Muslim respondents are stressed and beyond. And 42.8 % of other religious followers are in a stressful condition and above that. This might have occurred due to the proportion of participants in the survey.

Monthly income level of respondents were low monthly income earners (<500). About 75.7 % of them have less than 500 birr income. 21.6% of the respondents are in a medium income level (100-2000). And those 87 respondents or 64.4 % of low income earners are above the normal stress level of IRI. High income earners are in stressed level while there is no high

income earner in other scale of IRI. There is no respondent who is unstressed, much stressed or quit stressed. Whereas 33 of the respondents who are in middle income level are stressed and much stressed $r(178)=-0.064, p>0.05$.

Protective factor variables is another cluster of variables which is first hypothesized by the study and the research findings obtained support the claim that lack of protective resources puts the caregiver at risk for burden. Previous studies have emphasized the role of personal and social resources as moderators of stress and have found them to be related to greater levels of caregiving (Stoller & Pugliesi 1991, Skaff et al. 1996, Miller et al. 2001). Resources have also been noted as significant correlates of positive and negative CS of care givers.

Social approval is one of the variables clustered under protective factor variables. But, it happened to be the reverse. Paired Samples Correlation depicts that there is statistically significant positive relationship between the two variables; acceptability of the work performed by respondents & score of compassion stress experienced by caregivers. $r(178)=0.225, p<0.05$. This variable can be an answer for the research question “what are the situation based factors that get self care forgotten”.

Paired Samples Correlation shows that social approval & score of compassion stress have statistically significant and direct relationship the correlation show that the variables are positively related. $r(178)=0.225, p<0.05, CI=95\%$ this might have occurred due to an increase in burdensome commitment resulted from social approval.

This result is consistent with Haya Greenberger’s finding of the study conducted entitled as ‘Can burdened caregivers be effective facilitators of elder care-recipient health care?’ in 2001. It says social approval emerged as weakly but positively related to compassion stress. Perhaps burdened caregivers are more motivated to seek out formal support. They may also more readily

gain the attention and empathy of professionals. Yet, they may experience substantial burden. They may, for example, perceive role overload and role captivity while still expressing feelings of role competence (Haya G. ,2001).

Self efficacy is found to be one of the protective factors of CS. But, the correlation is statistically less strongr $(178) = -.042, p>0.05, CI=95\%$. Parelal to this result, Haya G, 2001 found that caregivers with high levels of mastery and self-esteem tended to have high levels of caregiving competence, which may also be considered a role-specific resource to cope up caring stress. Perhaps self efficacy is a resource protect against burden, (Haya G, 2001).

Optimism was first clustered under protective factors thinking that it is buffering resource. But, it is found to be directly correlated with score of compassion stress. However, it is statistically insignificant $r(178)=0,044, p>0.05, CI=95\%$.

This result with regard to the direction of relationship is contrary to Perkins, Elizabeth A., 2006, which have shown that optimism has beneficial effects on protecting caregivers' distress. According to Perkins, Elizabeth A. in 2006, optimism emerges as protective factors positively associated with caregiver well-being. Here we can say that as care givers become optimistic their level of increment in becoming compassionate would exceed the magnitude of decrement in their score of general stress level.

Religiosity and score of compassion stress correlation shows that there is a direct relationship. However, it is statistically insignificant $r(178)=0.080, p>0.05, CI=95\%$.based on the level of correlation, it is possible say religious orientation is not associated with caregiver compassion stress or well-being in this study. Here we can say that as care givers become religious, their level of increment in becoming compassionate would exceed the magnitude of decrement in their score of general stress level.

Number of training taken by care givers as a predicting variable showed a statistically strong relationship the score of compassion stress experienced by caregivers. Higher level of training tends to precipitate compassion stress $r(178)=0.309$, $p<0.01$. Here we can say that as care givers take more caregiving related trainings their level of increment in becoming compassionate would exceed the magnitude of decrement in their score of general stress level. Or the trainings taken are not tailored to the specific cases encountered in the practice.

Role strain (Failure of volunteer care givers to discharge ones' role), Fear of attack of respondent by care recipients, Observation of caregivers when care recipients isolate themselves from others are under the category of Risk factor variables

The above two variables' (role strain & fear of attack) correlations shows a positive correlation with score of compassion stress experienced by caregivers $r(178)=0.324$, $p<0.01$, $CI=95\%$, $r(178)=0.431$, $p<0$. The correlation implies score of compassion stress experienced by care givers increases as role strain and fear of attack of respondent by care recipients increases. The result is supported by studies like Fredriksen-Goldsen & Karen I.(2007), which says role strain is repeatedly associated with decreased psychological health among caregivers, including increased levels of caregiver compassion stress and depression. (Fredriksen.G & Karen I., 2007)

The correlation table 4.3.6 shows that there is no relation between self stigma of care recipients & score of compassion stress experienced by caregivers $r(178)=0.009$, $p>0.05$, $CI=95\%$. The absence of association between the two variables may be related to the understanding of caregivers about self stigma and the extent to which it imply.

Compassion stress was measured by a twenty item scale adapted from a measure developed by Davis (1983). This scale has three dimensions: perspective taking, empathetic concern and personal distress. To measure the compassion stress level and identify the score

experienced by each respondent, interpersonal reactivity index (IRI) is used. According to the measure, the score of compassion stress experienced by caregivers is relatively high. It is only 24.3 % of the respondent unstressed and less stressed. The rest 75.7% of the survey participants are in stressed much stressed and quit stressed category of the index (interpersonal reactivity index). The dependent variable score of compassion stress experienced by caregivers is tested by chi-square to know as to how the frequency of score of compassion stress is statistically significant, as it is shown in the table below; the chi-square test affirms that the frequency data of the above table is reliable with the test. $\chi^2(178) = 23.56, df=4, p<0.01$

In order to answer the research questions and test the above null hypothesis, the dependent variable score of compassion stress experienced by caregivers is tested by chi-square to know as to how the frequency of score of compassion stress is statistically significant, as it is shown in the table below, the chi-square test affirms that the frequency data of the above table is reliable with the test. $\chi^2(178) = 23.56, df=4, p<0.01$.

In order to test this null hypothesis, the statistical significance of correlation risk factor predictor variables are tested by paired correlations test and role strain and fear of attack by care recipients are proved to be statistically significant as $p<0.05$. Having done this, the cause and effect relationship between the two risk factors and the outcome variable is tested by regression

According to the regression test, role strain (failure of respondents to discharge ones role) seems to predict score of compassion stress, $B=2.537, t(178)=7.797, \chi^2 = .059, p<0.01$. The coefficient of determination for role strain to determine score of compassion stress varies with about 4.6 %. This implies that score of compassion stress tend to increases as failure of care givers to discharge one's own role increases. The above two tables show that the variable, fear of attack of caregivers by care recipients determines the score of compassion stress to be

experienced by them, $B=1.750$, $t(178)=4.464$, $x^2 = .0169$ $p<0.01$. The coefficient of determination for fear of attack to determine score of compassion stress varies with about 15.8%. the research hypothesis is proved to be true that there are social/personal factors. Particularly, role strain and fear of attack by care recipients are the risk factors which lead to compassion stress.

In the third Hypothesis the correlation matrix table shows that both hypothesized protective variables are not statistically significant score of compassion stress experienced by caregivers and (optimism) are positively related, $r(178)=0.139$, $p>0.05$, $CI=95\%$ and (self efficacy) and score of compassion stress are not significantly correlated, $r(178)=-0.042$, $p<0.05$, $CI=95\%$. So, the null hypothesis couldn't be rejected or the research hypothesis needs to be rejected and the null hypothesis is accepted. The result shows optimism and self efficacy do not help volunteer caregivers combat compassion stress. Even the sign of the correlation indicates that as optimism increase, the score of compassion stress tend to increases. This contradiction might have occurred because compassion stress is somewhat different form of stress which is induced by positively rated stressors like compassion, empathy, pity and the like feelings. The above literatures are telling about the general stress.

Conclusions

Volunteer caregivers to persons with HIV/AIDS report experiencing problems with compassion stress as a result of their care responsibilities. But according to the result of this study and others too, the extent to which a caregiver experience compassion stress depends up on their personal protective or precipitating characteristics.

Personal characteristics like age group of volunteer care givers determine score of compassion stress. Compassion stress has a significant variation among different age group. There is non-linear relationship between age and stress. It has an inverted U-shaped pattern because of contextual demands that are highest for middle-age workers.

Sex is also appeared to be one of the demographic factors to determine the need to engage in voluntary care giving. Female gender respondents take a higher proportion of the total survey respondents by taking 85.1 % of the population while the rest 14.9 % is male. Here it can be said that gender based division of labor is manifested in the caring role. Care giving seems to be given to females in the study area. Females are relatively less compassionately stressed than male. This variation between both genders might have occurred due to perceived role conflict on the side of male. This is said because; it could be seen in the above analysis that there is a tendency of pushing care giving role to females in the community.

The educational level volunteer care givers in the study area are somewhat low and there is an inverse relation between educational level and score of compassion stress. As educational level increases score of compassion stress scale of IRI decreases. Education level determines the level of stress one experience $r(178)=-0.049, p>0.05$.

As it goes from unmarried to married, divorced and widow compassion stress experienced by caregivers' decreases. But, the correlation is statistically less strong $r(178)=-0.050, p>0.05$. This might have been caused by multitude of various exposures to stressing condition. But, there is statistical evidence to this idea.

More than 79.7 % of the survey respondents are living in medium and lower family size of a household. There is a very weak inverse correlation between family size and score of

compassion stress. $r(178)=-0.012, p>0.05$. This might be due to the fact that respondents take family members as a social capital which is a buffering factor for any form of stress. This guess is not supported by statistical evidences.

The major religious affiliation of the respondents (154 out of 178) is Christians. But, it is not adequate to say Christian is voluntary to provide care giving service. Because, recruited by Iddir counsels in the first place. In the second place, it might have been influenced by the demographic structure of the general population. Religious affiliation and score of compassion stress Cross tabulation depicts Christian respondents are more stressed than Muslim respondents And Muslim respondents are more stressed than other religious followers. This might have occurred due to the proportion of participants in the survey.

Monthly income level of volunteer care giver was relatively low. As monthly income increases, score of compassion stress decreases (<500). $r(178)=-0.064, p>0.05$.

The research findings obtained support the claim that lack of protective resources puts the caregiver at risk for burden. Previous studies have emphasized the role of personal and social resources as moderators of stress and have found them to be related to greater levels of caregiving (Stoller & Pugliesi 1991, Skaff et al. 1996, Miller et al. 2001). Resources have also been noted as significant correlates of positive and negative CS of care givers.

There is statistically significant positive relationship between the two variables; Social approval & score of compassion stress. $r(178)=0.225, p<0.05$. This might have occurred due to an increase in burdensome commitment resulted from social approval.

Self efficacy is found to be one of the protective factors of CS. But, the correlation is statistically less stronger $(178) = -.042, p>0.05, CI=95\%$. Caregivers with high levels of mastery

and self-esteem tended to have high levels of care giving competence to cope up caring stress. Perhaps self efficacy is a resource protect against burden.

Optimism was first clustered under protective factors thinking that it is buffering resource. But, it is found to be a risk factor to score of compassion stress. However, it is statistically insignificant $r(178)=0,044$, $p>0.05$, $CI=95\%$. Here we can say that as care givers become optimistic their level of increment in empathic concern & perspective taking (compassion) would exceed the magnitude of decrement in their score of personal distress level.

Religiosity and score of compassion stress correlation shows that there is a direct relationship. However, it is statistically insignificant $r(178)=0.080$, $p>0.05$, $CI=95\%$.based on the level of correlation, it is possible say religious orientation is not associated with caregiver compassion stress or well-being in this study. Here we can say that as care givers become religious their level of increment in becoming compassionate(empathic concern & perspective taking) would exceed the magnitude of decrement in their score of personal distress level.

Number of training taken by care givers as a predicting variable showed a statistically strong relationship the score of compassion stress experienced by caregivers. Higher level of training tends to precipitate compassion stress $r(178)=0.309$, $p<0.01$. Here we can say that as care givers take more care giving related trainings their level of increment in becoming compassionate(empathic concern & perspective taking) would exceed the magnitude of decrement in their score of general stress level. Or the trainings taken are not tailored to the specific cases encountered in the practice.

Score of compassion stress increases as role strain and fear of attack of respondent increases. $r(178)=0.324$, $p<0.01$, $CI=95\%$, $r(178)=0.431$, $p<0.05$, $CI=95\%$. Whereas there is no relation between self stigma of care recipients & score of compassion stress $r(178)=0.009$,

$p > 0.05$, CI=95%. The absence of association between the two variables may be related to the understanding of caregivers about self stigma and the extent to which it imply.

The score of compassion stress experienced by volunteer caregivers in the study area is relatively high. It is only 24.3 % of the respondent unstressed and less stressed. The rest 75.7% of the survey participants are in stressed much stressed and quit stressed category of the index (interpersonal reactivity index).

There are social/personal factors that precipitate particularly, role strain and fear of attack by care recipients are the risk factors which lead to compassion stress. Score of compassion stress tend to increases as failure of care givers to discharge one's own role increases. $B=2.537$, $t(178)=7.797$, $x^2 = .059$ $p < 0.01$. Fear of attack of caregivers by care recipients determines the score of compassion stress to be experienced by them, $B=1.750$, $t(178)=4.464$, $x^2 = .0169$ $p < 0.01$.

Optimism and self efficacy do not help volunteer caregivers combat compassion stress. This contradiction might have occurred because compassion stress is somewhat different form of stress which is induced by positively rated stressors like compassion, empathy, pity and the like feelings. The above literatures are telling about the general stress.

Social work, Policy and Research Implications

Care giving for all type of marginalized segment of a society is one of the underserved tasks of social work professionals in Ethiopia. Currently, the demand for care giving services especially to PLWHA is challenging the intellectual resources of non professionals complement to social workers, Volunteer caregivers to PLWHA report experiencing problems with

compassion stress as a result of their care responsibilities since they lack personal protective characteristics while precipitating personal factors are prevailed among them.

This study could suggest some tips to be considered while directly intervening or facilitating for care giving activities as social workers. As it has been tried to indicate above, there are ascribed and learned personal protective characteristics and precipitating factors to effectively undertake or fail to carryout voluntary care giving activity.

Personal characteristics like age group of volunteer care givers determine score of compassion stress. Compassion stress has a significant variation among different age group. Sex is also appeared to be one of the demographic factors to determine the need to engage in voluntary care giving. Social structure gender based division of labor is manifested in the caring role and score of compassion stress experienced. There is an inverse relation between educational level and score of compassion stress. As educational level increases score of compassion stress scale of IRI decreases. Education level determines the level of stress one experience $r(178)=-0.049, p>0.05$. Marital status also matters compassion stress to be experienced by caregivers. as family size do since care givers may take family members as a social capital which is a buffering factor for any form of stress and there might not work overload in the family. As monthly income increases, score of compassion stress decreases (<500). $r(178)=-0.064, p>0.05$.

Care giving social workers should also recognize that there is relationship between score of compassion stress and Social approval, Self efficacy, Optimism, Religiosity, Number of training taken, role strain and fear of attack of respondent somewhat different from other type of stress as care givers owning the above qualities their level of increment in empathic concern &

perspective taking (compassion) would exceed the magnitude of decrement in their score of personal distress level and vice versa.

The score of compassion stress experienced by volunteer caregivers in the study area is relatively high. It is only 24.3 % of the respondent unstressed and less stressed. The rest 75.7% of the survey participants are in stressed much stressed and quit stressed category of the index (interpersonal reactivity index).

With regard to the policy implication, the study contributes to any HIV/AIDS policies to evaluate the negative and positive impact of compassion stress on care giving and devise various intervention strategies. The finding of this study could show some demographic, risk and protective factors which are really imperative to take in to account while developing policy strategy and implementation activities so that we can achieve reductions in the burden of care giving. According to the study finding, caregivers ascribed characteristics like age group, gender and achieved qualities such as level of education, self efficacy family size and others were extremely helpful. Perhaps those care giving characteristics are helping caregivers find resilience that empowers them to overcome their care giving difficulties.

Any policy wishing to assist HIV/AIDS care givers to cope with compassion stress can consider this researcher finding tested as effects on the social, emotional, and physical consequences of care giving at the time of recruitment, training and intervention.

As to the research implication, it can be said that the study is a breakthrough for researches to be conducted in the area of care giving and compassion stress especially in our country Ethiopia. But, the study took a very narrow part of the issues of compassion stress and volunteer care giving. The inquiry can be a foundation for related studies like informal care giving stress of demented old people, mentally ill people, and care for people with disabilities.

We don't have to underscore the necessity of recognizing contemporary social conditions that create stressors for people and decrease their ability to cope effectively with the innate behavior of care giving. One of difficulties in the modern society is the increasing number of persons caught in the "sandwich generation" "those who care for both children and elderly parents. Although this may be sequential rather than concurrent, it is nonetheless a stressor, and disproportionately so for women who are usually the primary care providers (Hunter & Sundel, 1989, p.219)

The findings regarding compassion stress of this study somewhat deviate from the general stress in some aspects. For example, the risk factors of general stress could not be a risk factor for compassion stress. The same was true for some protective factors. Therefore, there is a need for a series of studies to arrive at the realities that made the difference.

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Appendix I: Informed consent form

My name is ----- . I am a student at Addis Ababa university school of social work.

I am here to enroll and take interview from eligible study participants like you and fill in the questionnaire. I am glad to inform you that you are one of the chosen study participants to participate in this study; the purpose of this study is to assess different health related factors associated with compassion stress. The study results will be used to address issues related to care giving difficulties resulted from being compassionate. The information in this questionnaire will be kept strictly confidential, it will not be divulged to any one, your name and address will not be recorded or identified. However, it is your right to terminate your participation at any time (from the very beginning or you can answer some questions you like to do so). I will appreciate and respect what so ever your decision will be. Thus, this questionnaire will be filled only if you agree to take part in the study and I sincerely ask you to give your genuine and true responses to the questions provided you would agree to participate in the study.

So, would you like to participate in the study?

Yes/agree -----

No/disagree -----

Date - -----

Signature -----

Appendix II

Questioner

Code_____

Date (D-M-Y): _____

Segment 1: Identification

Part I Demographic information about respondents				
Put a tick mark(J) on the alternative that describes you				
No	Questions	Coding category	coding	Remark
1	chronological Age group	child (0-14)-----	1	
		youth(15-29)-----	2	
		adult (30-60)-----	3	
		old (60 & above)----	4	
2	Gender	Male -----	1	
		Female-----	2	
3	Academic status	Primary school-----	1	
		High school-----	2	
		Graduate -----	2	
4	Marital status	Unmarried-----	1	
		Married -----	2	
		Divorced-----	3	
		Widow/er-----	4	

5	Number of household member	(1-4)----- (5-7)----- Above 7-----	1 2 3	
6	Religious affiliation	Christian----- Muslim----- Other-----	1 2 3	
7	Monthly income	A) ≤ 500 ----- B) 500-1000----- C) 1000-2000----- D) ≥ 2000 -----	1 2	
<u>No</u>	Part II protective factor variables	Coding category	Coding	Remark
Self efficacy	How often do you feel confident of being successful on discharging care giving responsibilities?	Always 1 2 3 4 5 I never feel		
Social approval	How often does the community extend appreciation for your care giving services?	Always 1 2 3 4 5 Never		
Optimism	Do you believe it natural to feel that clients would face some adversity & behave differently?	I strongly disagree 1 2 3 4 5 I strongly agree		
Religiosity	How often do you undertake religious practices?	Always 1 2 3 4 5 rarely		
Part III risk factors variables				
Role strain	How often do you fail to meet your overall social expectation since you started caregiving?	Always 1 2 3 4 5 I never fail		
Self stigma	How frequent do you	Always 1 2 3 4 5 I never		

	experience cases when the care recipients prefer to be alone while visiting to serve?	experienced		
Fear of attack	How many times did you absent or interrupt services because of fear of attack since you start to give service?	I have never 1 2 3 4 \geq 5 times		
Training level	How many times did you take care giving related training?	I have never took 1 2 3 4 \geq 5 times		
	Part VI compassion stress related questioner			
1	I daydream and fantasize with some regularity about something that might happen to me	It doesn't 1 2 3 4 5 it does describe me		
2	I often have tender concerned feeling for someone less fortunate than me	It doesn't 1 2 3 4 5 it does describe me		
3	I sometimes find it difficult to see thing in other guy's point of view	It doesn't 1 2 3 4 5 it does describe me		
4	Sometimes I don't feel very sorry for other people when they are having problems.	It doesn't 1 2 3 4 5 it does describe me		
5	I really get involved with the feeling of the character in novel	It doesn't 1 2 3 4 5 it does describe me		
6	In emergency situation, I feel apprehensive and ill at ease.	It doesn't 1 2 3 4 5 it does describe me		

7	When I see someone being taken advantage of, I feel kind of protective towards them	It doesn't 1 2 3 4 5 it does describe me		
8	I sometimes feel helpless when I am in the middle of a very emotional situation.	It doesn't 1 2 3 4 5 it does describe me		
9	I sometimes try to understand my friends better by imagining how things look in their perspective.	It doesn't 1 2 3 4 5 it does describe me		
10	When I see someone get hurt, I tend to remain calm.	It doesn't 1 2 3 4 5 it does describe me		
11	Other people's misfortune doesn't usually disturb me a great deal	It doesn't 1 2 3 4 5 it does describe me		
12	Being in a tense situation scares me.	It doesn't 1 2 3 4 5 it does describe me		
13	When I see someone being treated as unfair, I sometimes don't feel very much pity for them.	It doesn't 1 2 3 4 5 it does describe me		
14	I am usually pretty effective in dealing with emergency.	It doesn't 1 2 3 4 5 it does describe me		
15	I would describe myself as pretty soft hearted person.	It doesn't 1 2 3 4 5 it does describe me		
16	I tend to lose control during emergency.	It doesn't 1 2 3 4 5 it does describe me		
17	When I am upset at someone, I usually try to put myself in the shoe of him for a while.	It doesn't 1 2 3 4 5 it does describe me		

18	When I see someone who badly needs help in an emergency, I got to pieces.	It doesn't 1 2 3 4 5 it does describe me		
19	Before criticizing someone, I try to imagine how I would feel if ii were in their place	It doesn't 1 2 3 4 5 it does describe me		
20	If I am sure I am right about something, I do not waste much time listening other's argument.	It doesn't 1 2 3 4 5 it does describe me		

የፍቃደኝነትን መጠየቂያ

ስሜ ሱለይማን ሸኩር ሲሆን በአዲስ አበባ ዩኒቨርሲቲ የሶሻል ወርክ ትምህርት ቤት የማስተር ተማሪ ነኝ። የመጣሁት በጥናቱ ተሳታፊ ለመሆን ፍቃደኛ የሆኑትንና የሚመቸዎት ከሆነ መጠይቅ ለማስጠየቅ ነው። በመጀመሪያ የጥናቱ ተሳታፊ በመሆንዎት ያለኝን ደስታ ልገልጻለሁት እወዳለሁ። የጥናቱ አላማ ከርህራሄ ወለድ ጭንቀት ጋር በተያያዙ የጤና ጉዳዮች ዙሪያ ሳይንሳዊ ግንዛቤ ማግኘት ነው። የጥናቱ ውጤት ርህራሄ ካስከተለው ጭንቀት ጋር ተያይዞ የሚመጣን እንክብካቤ የመስጠት ችግር ለመፍታት ያስችላል ተብሎ የጠበቃል።

በዚህ መጠይቅ ላይ የሰፈረ ማንኛውም መረጃ ሚስጥራዊነቱ የተጠበቀ ነው። መረጃውን በማንኛውም ማንም ሰው እንዲያገኝ አይደረግም። ስምዎና አድራሻዎ መጠይቁ ላይ አይጻፍም። በጥናቱ የመሳተፍ ውልቁን በማንኛውም ጊዜ ማፍረስ ይችላሉ። በጥናቱ ተሳትፎ ዙሪያ ያለዎትን ውሳኔ ባክብርትና ባድናቆት እቀበላለሁ። ስለዚህ የጥናቱ መጠይቅ የሚሞላው እርስዎ ሙሉ-ፍቃደኛ ሆነው ለተጠየቀው ጥያቄ ትክክለኛና እውነተኛውን መልስ ለማስፈር ደስተኛ ከሆኑ ነው።

ስለዚህ የጥናቱ ተሳታፊ መሆን ይፈልጋሉ?

- አዎ አስማማለሁ
- አይ አልስማማም
- ቀን

ፊርማ-----

መጠይቅ

ኮድ-----

ቀን -----

ክፍል አንድ

የመላሾች ስነ-ህዝባዊ ዳታ

እርስዎን ይበልጥ ከሚገልፅዎ አማራጭ ላይ የኤክስ (x) ያስቀምጡ				
ቁ	ጥያቄዎች	አማራጮች	ኮድ	ምልክት
1	የዕድሜ ክልል	a. ህፃን(0-14)----- b. ወጣት(15-29)----- c. ጎልማሳ(30-60)----- d. አረጋዊ-----		
2	ፆታ	a. ወንድ----- b. ሴት-----		
3	የትምህርት ደረጃ	a. 1ኛ ደረጃ ----- b. 2ኛ ደረጃ----- c. ምሩቅ-----		
4	የጋብቻ ሁኔታ	a. ያገባ b. ያላገባ c. ባል/ሚስቱ የሞተችበት d. የተፋታ		
4	የቤተሰብ አባላት ብዛት	a. (1-4) b. (5-7) c. ከ7 በላይ		
5	ሀይማኖት	a. ክርስትያን b. ሙስሊም c. ሌላ		
6	ወርሃዊ ገቢ	a. ከ500 ብር በታች b. ከ500-1000 ብር c. ከ1000-2000 ብር d. ከ2000 ብር በላይ		
ክፍል ሁለት				
ርህራሄ ወለድ የጭንቀት መከላከያ ተለዋዋጮች				
ሚከተሉትን ጥያቄዎች የርስዎን የስሜት ደረጃ የሚወክለውን ቁጥር በማክበብ መልሱ::				
ቁ	ጥያቄዎች	አማራጮች	ኮድ	ምልክት

Compassion Stress volunteer care givers

viii

1	እንክብካቤ የመስጠት ሀላፊነትን ስታስብ ምን ያክል ጊዜ በራስ ጠመተማመን ስሜት ተሰምቶህ ያውቃል?	ሁሌ 1:2 3 4 5 ጭራሽ ተሰምቶኝ አያውቅም		
2	ለርስዎ ለሚሰጡት የእንክብካቤ አግልግሎት ማህበረሰቡ በምን ያክል ድግግሞሽ አድናቆቱን ገልጾላጽ ያውቃል?	ሁሌ 1 2 3 4 5 በጭራሽ		
3	አንድ አገልግሎት ተቀባይ ችግር ማጋጠሙ ና በዚህም ጊዜ ለየት ያለ ባህሪ ማሳየቱ ያለና የሚያጋጥም ነው::	እጅግ በጣም አስማማለሁ 1 2 3 4 5 በፍፁም አልማማም		
4	ምን ያክል ጊዜ ሃይማኖታዊ ተግባራትን ታከናውናለህ/ሽ?	ሁሌ 1 2 3 4 5 አልፎ አልፎ		
ክፍል ሦስት ከርህራሄ ወለድ ጭንቀት ጋር የተያያዙ ጥያቄዎች				
1	በተወሰነ ድግግሞሽ ሽለ አንዳንድ ነገር ላይ ቅዠትና አዕምሮአዊ እይታ ያጋጥመኛል::	በፍፁም 1 2 3 4 5 በጣም እንጅ		
2	ከኔ የበለጠ እድለቢስ ሰው ሲያጋጥመኝ እንደሚባረቅ የሚመታኝ ስሜት አለ::	በፍፁም 1 2 3 4 5 በጣም አንጅ		
3	አንዳንድ ጊዜ በሌሎች ሰዎች በታሆኖ ማሰብ ያስቸግረኛል::	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		
4	አንዳንድ ጊዜ ሰዎች ችግር ሲያጋጥማቸው አያሳዝኑኝም::	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		
5	ባንዳንድ ልብ ወለዶች ወሰጥ ያሉትን ገፁ ባገሪያት ስሜቶች የኔ እስኪመስሉኝ ድረስ አስምጣለሁ::	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		
6	በድንገተኛ አደጋ ጊዜ ከልክ ያለፈ ብስጭትና ህመም	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		

	የሰማኛል፡፡			
7	አንድ ሰው ጥሩ ነገሩን በሌላ ሰው ሲነጠቅ ሳይለዘህ ሰው የማበር ስሜት ይሰናኛል፡፡	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		
8	ስሜትን በሚነኩ ጌዳዮች መሃል ስሆን አጋዥ አልባነት ይሰማኛል	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		
9	አንዳንድ ጓደኞችን ነገሮች ከነገሱ አይታምን ይመስላሉ ብዬ በማሰብ ለመረዳት እሞክራለሁ	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		
10	የሆነ ሰው ተጎድቶ ሳይበተረጋጋ ስሜቴ እቀጥላለሁ፡፡	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		
11	የሌሎች ሰዎች መጥፎ አጋጣሚ እኔን አይረብሽኝም፡፡	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		
12	ውጥረት በነገሰበት ሁኔታ ውስጥ መቆየት ያስፈራኛል፤፤	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		
13	አንዳንድ ጊዜ ሰው አፍትሃዊ የሆነ ነገር ሲደርስ በትሃዘኔታ አይሰማኝም፡፡	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		
14	ድንገተኛ ነገሮችን በማስተናገድ በኩል ውጤታማ ነኝ፡፡	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		
15	ራሴን የምገልፀው ልበብኩ በሚል ቃል ነው፡፡	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		
16	በድንገተኛ አጋጣሚ ወቅት ራሴን መቆጣጠር ያቅተኛል፡፡	በፍፁም 1 2 3 4 5 በጣም ይገልፀኛል		

17	የሆነ ሰው ሲያናድድኝ አንድ አፍታቆም ብዬ በሱ ፈንታ አሰባለሁ፡፡	በፍጹም 1 2 3 4 5 በጣም ይገልጸኛል		
18	ድንገተኛ ችግር ውስጥ ያለና ከፍተኛ እርዳታ የሚፈልግ ሰው ሳይ አቅሜይክዳኛል፡፡	በፍጹም 1 2 3 4 5 በጣም ይገልጸኛል		
19	ሰውን ከመኮነኔ በፊት በሱ ቦታ ሆኖ አሰባለሁ፡፡	በፍጹም 1 2 3 4 5 በጣም ይገልጸኛል		
20	በሆነ ጉዳይ ላይ እርግጠኛ ከሆንኩ ሌሎችን በማዳመጥ ጊዜዬን አላጠፋም፡፡	በፍጹም 1 2 3 4 5 በጣም ይገልጸኛል		

Appendix III

Fig 4.1

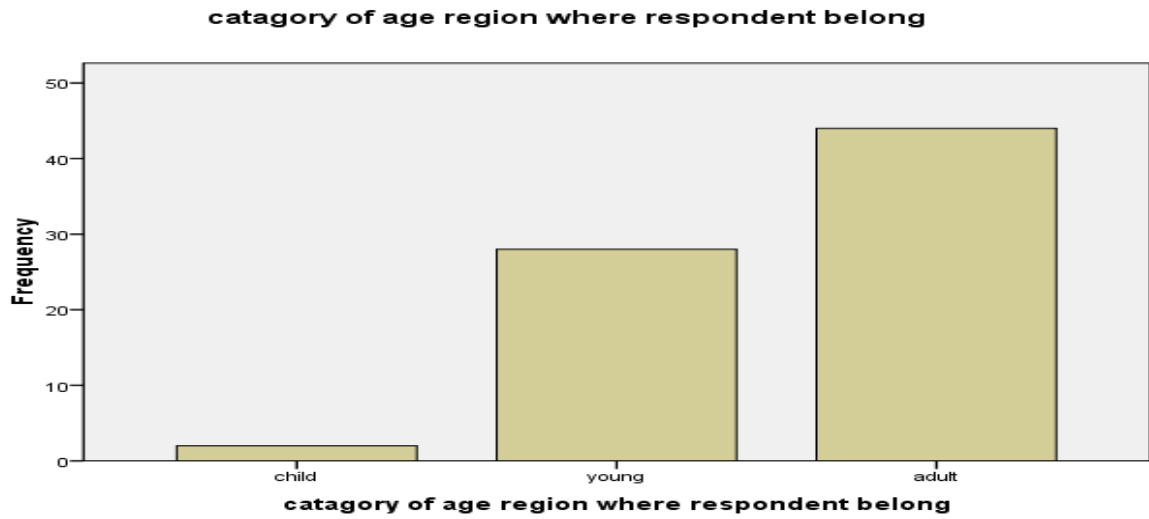


Fig 4.2

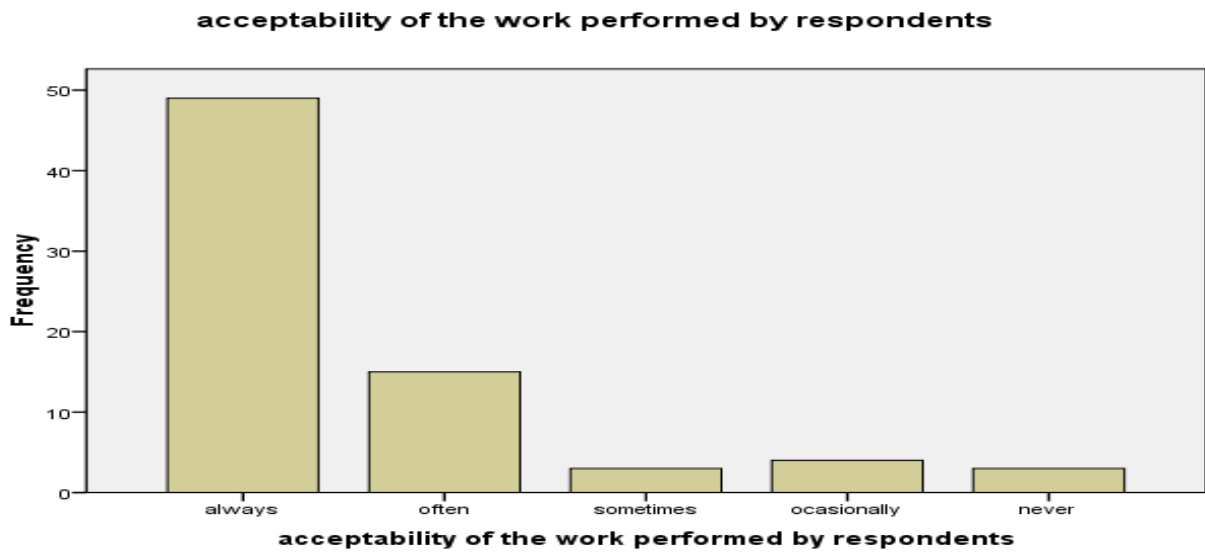


Fig 4.3

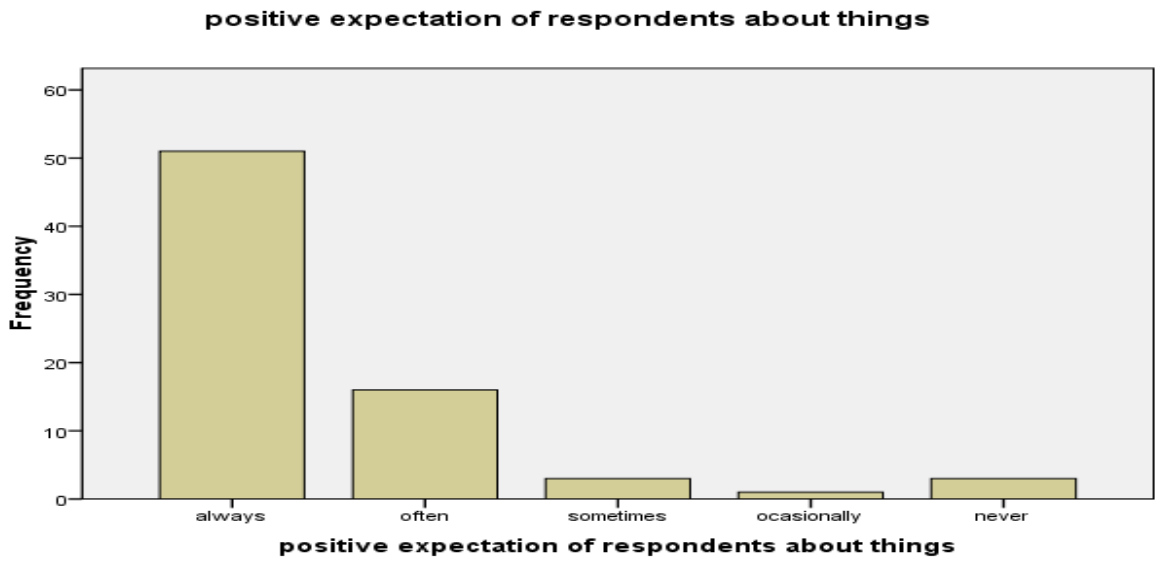


Fig 4.4

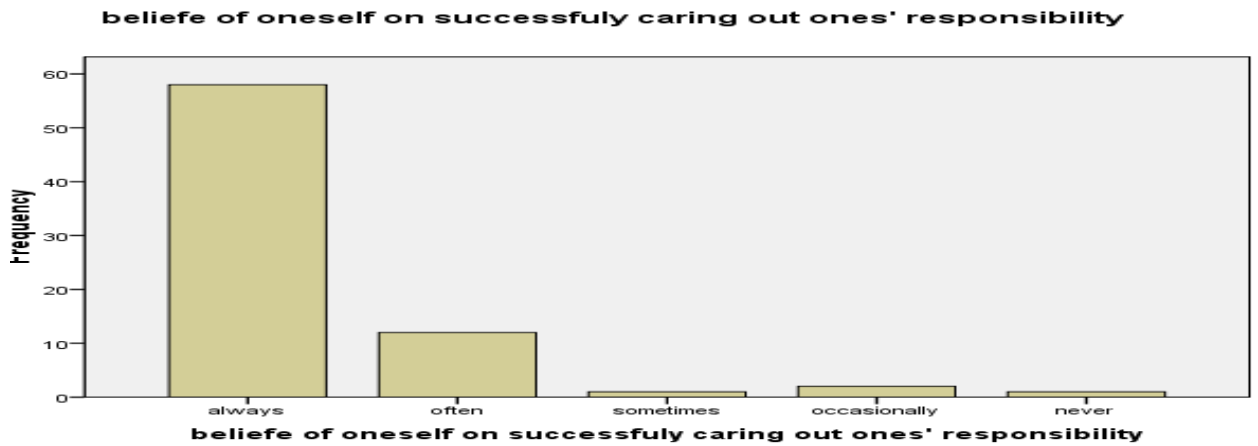


Fig 4.5

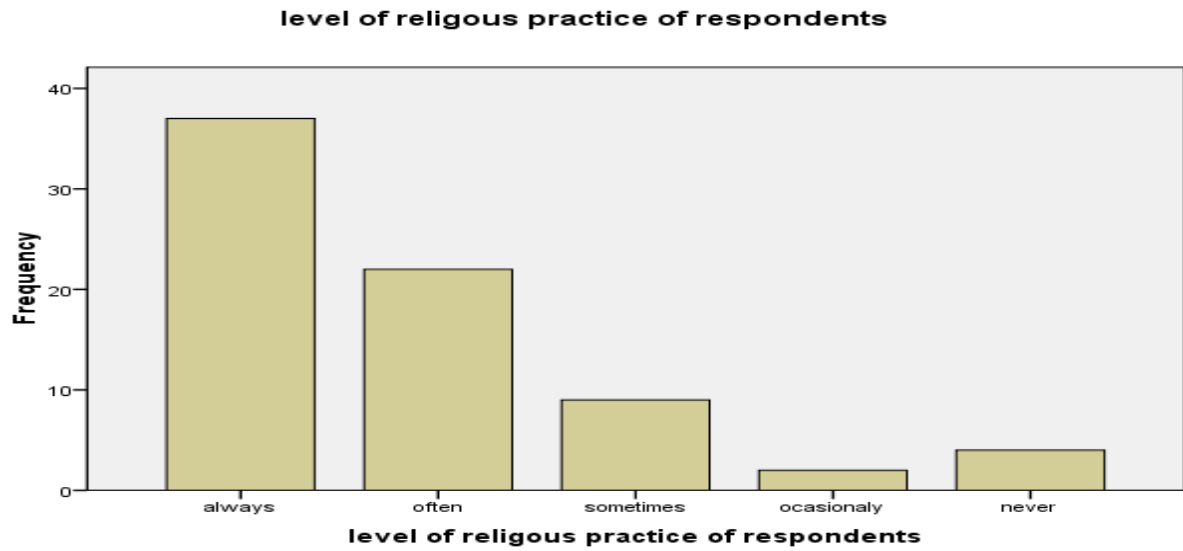


Fig 4.6

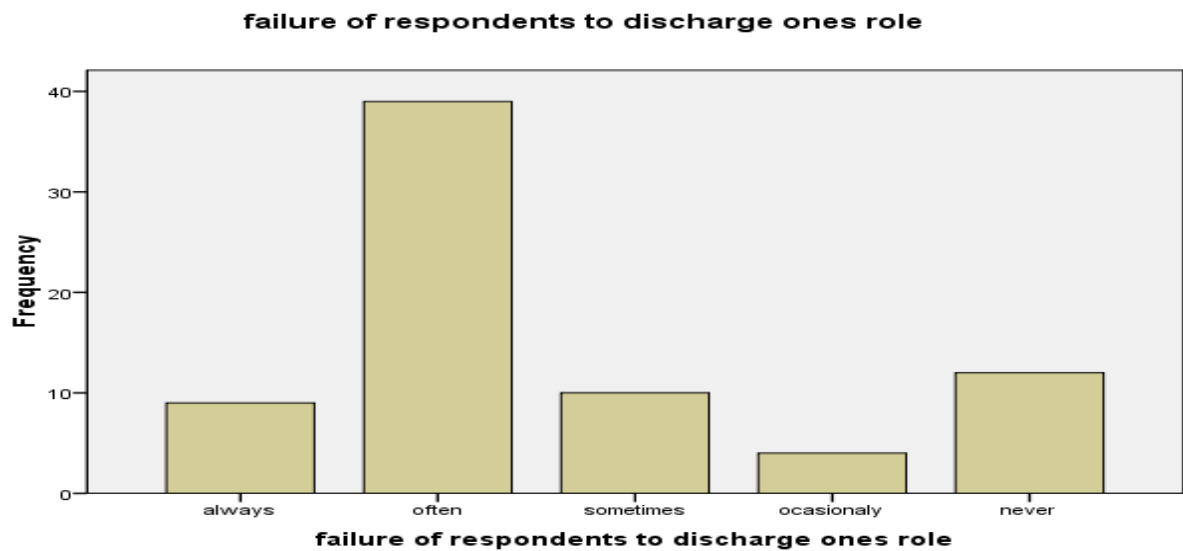


Fig 4.7

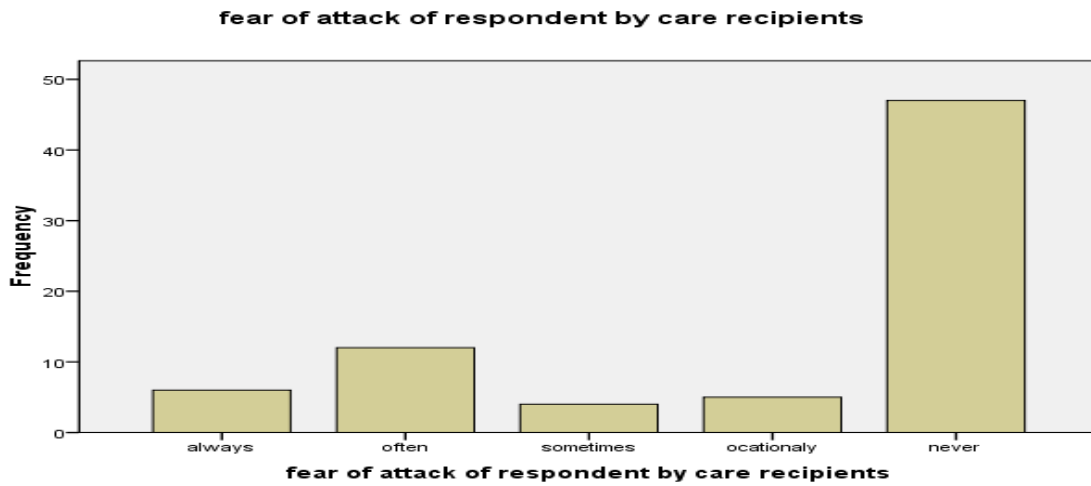


Fig 4.8

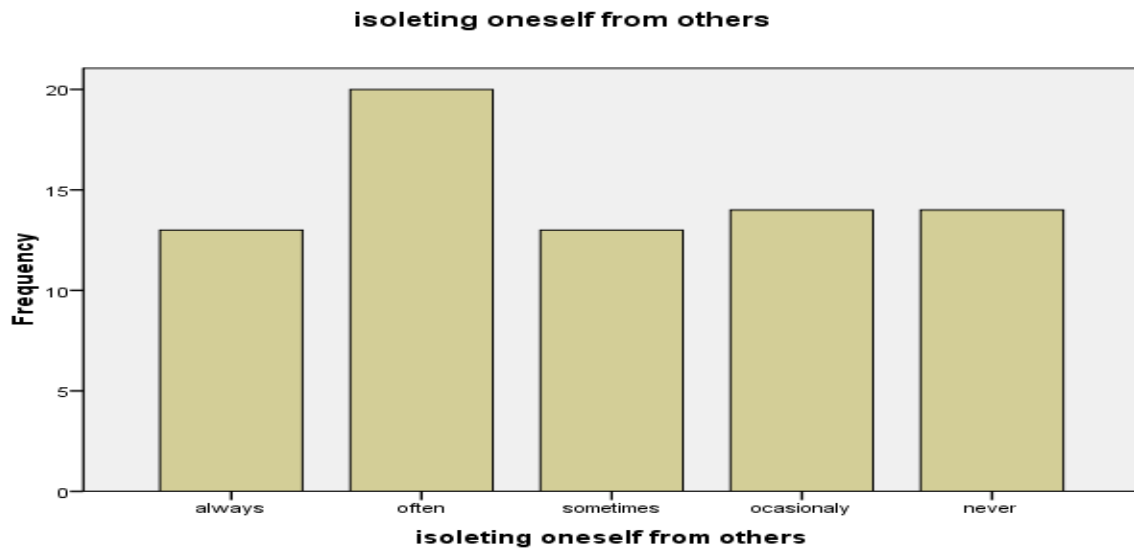


Fig 4.9

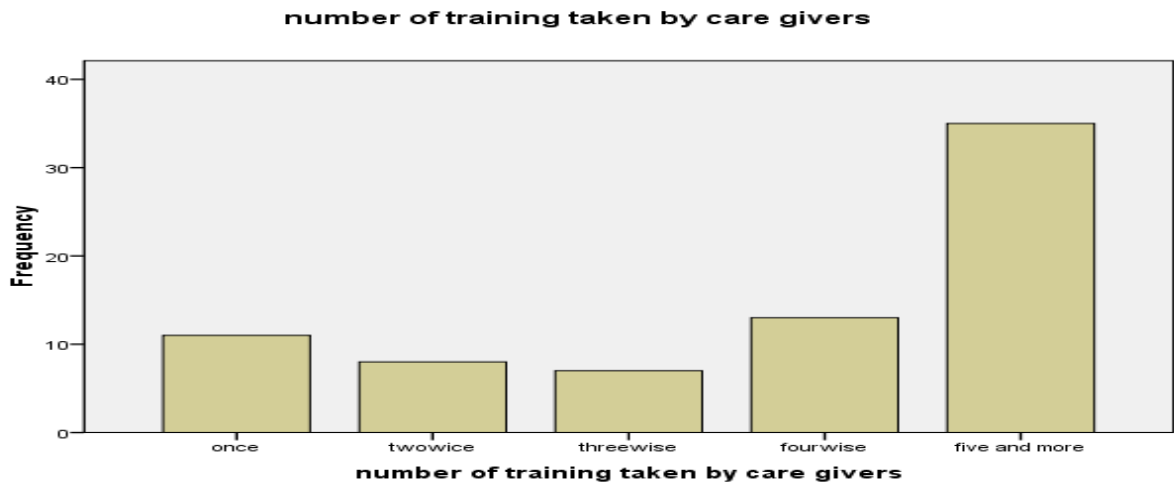
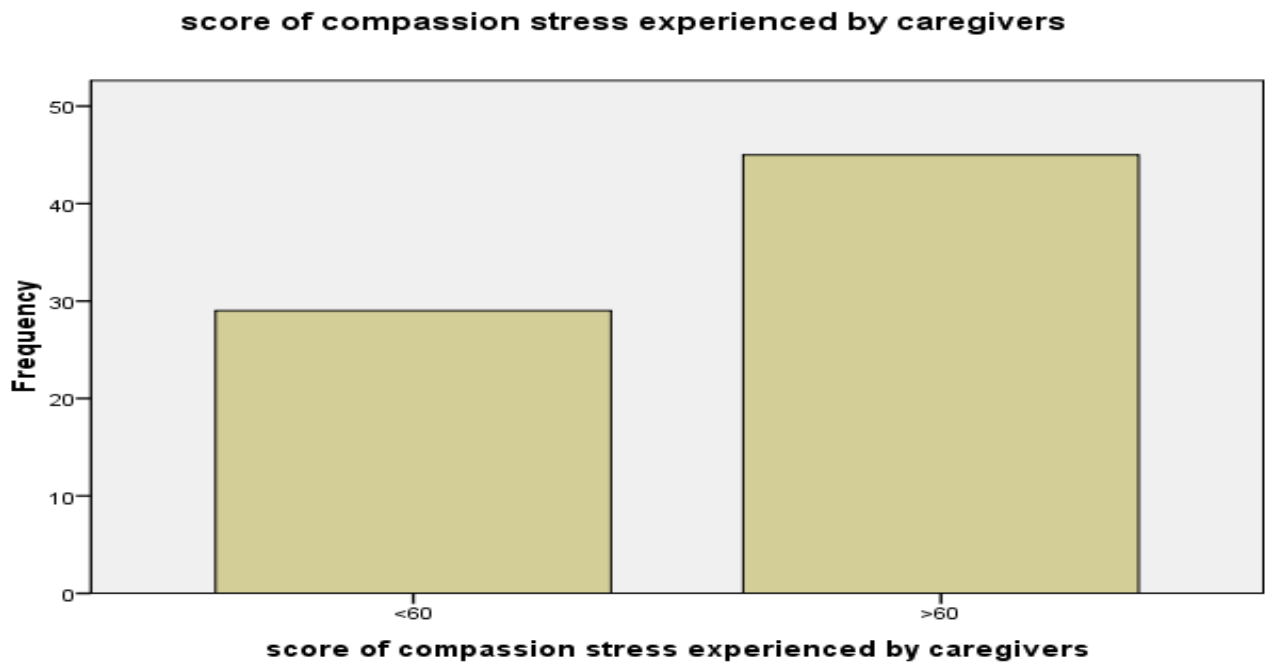


Fig 4.10



Declaration

I, Suleyman Shikur, hereby confirm that this study in the title “Compassion stress among HIV infected peoples’ volunteer caregivers in Addis Ketema (The case of NGOs’ volunteers)” is carried out by me, and any material used in this study is properly acknowledged.

Declared by: Suleyman Shikur

confirmed by

Signature_____

Advisor: Dr. Mengistu Legese

Signature:-----

Date: June 2009