

**Depression, Anxiety and Stress among Counseling Service  
Providers in Addis Ababa**



**Addis Ababa University**

**College of Education and Behavioral Studies**

**School of Psychology**

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**November 2020**

**Addis Ababa, Ethiopia**

**Depression, Anxiety and Stress among Counseling Service Providers  
in Addis Ababa**

**Addis Ababa University**

**College of Education and Behavioral Studies**

**School of Psychology**

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**November 2020**  
**Addis Ababa, Ethiopia**

## **DECLARATION**

I, hereby declare that the research entitled **Depression, Anxiety and Stress among Counseling Service Providers in Addis Ababa** is my original work and is my own effort and study. It is done by me independently except for the guidance and suggestion of my research advisor. It is presented, in partial fulfillment of the requirements for the degree of MA in Psychology.

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## **Acronyms and Abbreviations**

ANOVA: Analysis of Variance

BA: Bachelors of Art

DASS: Depression, Anxiety and Stress Scale

MA: Masters of Art

SPSS: Statistical Package for Social Science

TEFL: Teaching English as a Foreign Language

WHO: World Health Organization

## Abstract

*The purpose of this study was to examine the prevalence, gender and age differences, educational qualification difference and association between years of work experience on depression, anxiety and stress among counseling service providers in Addis Ababa city. Quantitative approach specifically cross-sectional survey design was employed to achieve the objectives of this study. One hundred thirteen (males= 56, 49.6% and females=57, 50.4%) counseling service providers participated in the study. From a total of 26 counseling organizations 20 of them selected by using simple random sampling method. All Available counseling service providers who work in these organizations were taken. Depression, Anxiety and Stress Scale (DASS-21) was utilized in the current study. The collected data were analyzed using descriptive statistics including frequency and percentage and inferential statistics such as Independent sample t-test, one-way analysis of variance and Pearson product moment correlation. The result showed that 54%, 74.3% and 43.4% of the respondents were at mild, moderate, severe and extremely severe level of depression, anxiety and stress respectively. The study also found that there were no statistically significant gender differences on levels of depression, anxiety and stress. The present study also suggested that there was no statistically significant difference between BA degrees and MA holders and above on level of anxiety and stress. However, respondents having BA degree had high level of depression than MA holders and above. On the other hand, this study found that no statistically significant mean difference on level of depression and stress among respondents from different age groups. Finally, with regard to the relationship between years of work experience and depression, anxiety and stress; the finding of this study noted that years of work experience has statistically weak positive association with anxiety and stress whereas depression has negative weak association with years of work experience. According to the results of this study we can conclude that majority of the respondents could be at risk of depression and anxiety. We can also conclude that the non-significant differences found between DASS scores of counseling service providers in gender might be due to experiencing similar activities and working under similar circumstances. It is also possible to say BA degree holders experience more depressive symptoms than MA holders. Up on the present study, it can be also concluding that displaying this symptom is related to different personal and social factors either directly or indirectly. Unlike depression, stress and anxiety scores were positively correlated to years of work experience. Up on the findings of the present study the researcher recommend that stakeholders should develop strategies in place to identify and support all counseling service providers suffering from depression and anxiety and attention should be given for counseling service providers having BA degree through providing additional courses and trainings.*

**Key words:** Depression, Anxiety and Stress

# CHAPTER ONE

## INTRODUCTION

This chapter deals with background of the study, statement of the problem, objectives of the study, delimitation of the study, limitation of the study and operational definition of variables.

### 1.1. Background of the study

World Health Organization (2013) defined “Health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatrists Association,2013) defined a mental health problem as being a clinically significant disturbance to an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in mental functioning, and is usually associated with significant distress and impairment in social and occupational functioning”.

In recent years, about 450 million people suffer from a mental or behavioral disorder. Common mental disorders refer to two main diagnostic categories: depressive disorders and anxiety disorders. These disorders are highly prevalent in the general population (WHO, 2017).

According to American Psychiatrist Association (2013) depression involves either depressed mood or loss of interest or pleasure in daily activities, as well as at least four of the following: significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive guilt, and recurrent thoughts of death or suicide. These symptoms must have occurred over at least a two-week period of time in which they have been deemed to have caused clinically significant impairment in important areas of functioning. Today, the total number of people living with depression in the world is 322 million (WHO, 2017).

Robert cited in Kebede et al (2019) has seen anxiety as a vague feeling of apprehension, worry, uneasiness, or dread, the source of which is often non-specific or unknown to the individual. However, its emotion prepares the individual to the environmental changes or helps to create a response to those changes (Mebratu, Abebaw & Getinet, 2016). The total estimated number of people living with anxiety disorders in the world is 264 million (WHO, 2017).

Stress is also a worldwide issue and high levels of stress may lead to or exacerbate unhealthy behaviors, such as smoking, over/under eating, excessive alcohol consumption, and substance abuse (Sinah & Yau, 2013).

Mental health problems are more common among mental health professionals because work in this area places high emotional demands and stresses on practitioners, and to start off with, those with lived experience maybe more likely to be attracted to work in this field. According Denis&Melanie (2017) those in the helping professions often work with clients in emotional pain, taking in that pain, but not always taking care of themselves.

Although promoting self-care is now part of most counselor training programs, few practitioners have well-developed, flexible, and adaptive plans for self-care that they consistently implement. However, as opposed to the extensive research conducted with the general public, little is known about the mental health of providers of mental health services. The culture within health and mental health professions may leave their members viewing mental health problems as a weakness, and feeling that they should be mentally resilient and able to cope on their own. Correspondingly, they may experience shame and embarrassment and fear of being judged negatively by the public, their family, friends, employers, and coworkers when they do developmental health problems (Corrigan, 2004; Garcia&Crocker,2008; Garelick,2012; Kessler et al.,2001; Sireyetal.,2001).

## 1.2. Statement of the Problem

Although mental health problems experienced by the general population have been studied extensively, few studies have looked specifically at such difficulties experienced by counseling service providers. Psychologists are people, and as people, their level of mental health functioning fluctuates continuously in accordance with the many demands of their lives. In addition to psychologists having comparable mental health problems to the general public, their professional demands contribute to their impairment due to the unique risk factors they face (Good et al, cited in Kimberly, 2016).

Guidance counselors stay busy. Regardless of the age group they serve, counselors are often required to minister to large populations, assess problems, develop treatments, do referrals, do classroom guidance, handle some staff development, work with individuals and groups, act as mediators in a crisis, and the like (Kathryn 1990). Similarly, Denis and Melanie (2017) stated that undoubtedly, counselors hear heavy stories and walk with clients through dark journeys, and they unavoidably carry some of those experiences with them after the session ends.

Because counselors absorb and hold emotional pain presented by clients and feel the needs of clients so acutely, lack of self-care combined with harmful coping practices can increase risk of burnout, compassion fatigue, and vicarious trauma. Counseling is a stress-filled profession (Denis & Melanie, 2017).

Different studies have been undertaken to identify the problems faced by counseling service providers for example, Kimberly (2016) conducted a research and find out there is a portion of psychologists who identified with having a diagnosable psychiatric disorder (81%) within the continuum spectrum of severity, and approximately 70% believed they also presented with personality-disordered traits over the course of their lifetime. Furthermore, substance abuse, depression, anxiety and eating disorders were some of the psychiatric concerns. Other prominent

psychiatric concerns reported among psychologists were depressive-type disorders that included symptoms such as isolation and loneliness, mood dysregulation, relationship dissatisfaction, somatic illness, and hopelessness/helplessness.

Another researcher Kevin (2016) conducted in-depth qualitative interviews with ten mental health professionals and found that each of whom, at the time of the interviews, had at least six years of experience working therapeutically within a community population, had each experienced symptom consistent with depression at least once in their adult lives and were able to speak about their recovery and how this influenced their work with clients.

Many studies regarding to the psychological problems of different professions and population have been conducted in the Western world and in our country. In our country, Ethiopia. there are some studies conducted on the issue. Most of those research works focus on different professions and population. For instance, a cross-sectional study conducted by Yeshaw & Mossie (2016) on the prevalence of Depression, anxiety and stress among Jimma University Staffs were found to be 22%, 19.2% and 28.2% respectively. Another study conducted by Sileshi & Mulugeta (2018) which aims to examine the magnitude/extent of DAS (Depression, Anxiety and Stress) among Addis Ababa University students and its relationship with academic achievement, found that 18.5% of the students scored high on depression, (28.6%) had experienced some form of anxiety and (22.4%) of the students were under stressful conditions.

Psychological problems like depression, anxiety and stress have a huge effect on society and individual, which can lead to the suicidal tendency, relationship problems, medical dropouts, and impaired work ability. To the researcher's knowledge there is no such study that assessed the levels of depression, anxiety and stress in the Ethiopian counseling service providers. Therefore, this calls for the need to study in the area. Hence, this study assessed the level of depression, anxiety and stress among counseling service providers in Addis Ababa.

### **1.3. Objectives of the Study**

#### **1.3.1. General Objective**

The general objective of this study was to examine the prevalence of depression, anxiety and stress of counseling service providers in Addis Ababa City.

#### **1.3.2. Specific Objectives**

The specific objectives of this study were:

- ❖ To assess the prevalence of depression, anxiety and stress among counseling service providers
- ❖ To examine gender and age differences in depression, anxiety and stress among counseling service providers
- ❖ To find out educational qualification difference in depression, anxiety and stress among counseling service providers
- ❖ To examine the association between years of work experience in depression, anxiety and stress among counseling service providers

### **1.4. Significance of the Study**

The finding of this study can be significant for the mental health professionals, it will provide necessary information about the level of depression, anxiety and stress among counseling service providers. The finding of this study may also help to raise awareness about psychological problems (depression, anxiety and stress) that counseling service providers face. Specifically, the finding of this study uses for mental health care centers and psychologist to understand the psychological problem of counseling service providers. The study may also serve as a literature for future researchers who want to conduct a research in this area and other related issues.

### **1.5. Delimitation of the study**

In terms of variables, the study was delimited to depression, anxiety and stress among counseling service providers in Addis Ababa. In terms of gender, both groups (male and female) who work at different counseling centers in Addis Ababa were included. Counselors with different educational background and with different years of experience were also included. In terms of age participants from different age groups were included. With regard to study setting, the research was delimited to study only in Addis Ababa city due to time and financial constraints.

### **1.6. Limitations of the study**

The data were collected based on self-reporting questionnaire. As data were collected by questionnaire in Addis Ababa, the researcher could not apply a detailed interview and conducting a diagnosis which helps to gain deeper understanding about the depression, anxiety and stress due to the pandemic of COVID-19. Additionally, it lacks local literatures concerning depression, anxiety and stress of counseling service providers.

### **1.7. Operational Definition of Variables**

**Counselor:** refers to a professional trained in core area of psychology with knowledge, skills and professional attitudes of helping people deal with challenges in their lives by creating a relationship with them.

**Depression:** According to this study the existence and prevalence of depression, anxiety and stress is determined by depression, anxiety and stress scale(DASS) and the scale ranges from 0-4 Normal, 5-6 Mild depression, 7-10 Moderate depression, 11-13 Severe depression and 13+ Extremely severe depression.

**Anxiety:** According to DASS the scale for anxiety ranges from 0- 3 Normal, 4-5 Mild anxiety, 6-7 Moderate anxiety, 8-9, Severe anxiety, 9+ Extremely sever anxiety.

**Stress:** According to DASS the scale for stress ranges from 0-7 Normal, 8-9 Mild, 10-12 Moderate, 13-16 Severe, 16+ Extremely severe.

## **CHAPTER TWO**

### **REVIEW OF RELATED LITERATURE**

#### **2.1 Overview of Psychological problems**

American Psychiatrists Association (2013) classifies different types of psychological problem: Neurodevelopmental disorders, Schizophrenia Spectrum and Other Psychotic disorders, Bipolar and Related disorders, Depressive disorders, Anxiety disorders, Obsessive-Compulsive and Related disorders, Trauma- and Stressor related disorders, Dissociative Disorders, Somatic Symptom and Related Disorders, Feeding and Eating Disorders, Elimination disorders, Sleep-Wake disorders, Sexual dysfunctions, Gender dysphoria, Disruptive, impulse-Control and Conduct disorders, Substance-related and Addictive disorders, Neurocognitive disorders, Personality disorders, Paraphilic disorders, Other Mental disorders, Medication-Induced movement disorders and other adverse effects of medication, other conditions that may be a focus of clinical attention.

Psychological problems are diverse and cause not only personal suffering but also loss of workdays and heavy burden to health care systems. Depression, anxiety, and stress are some of the major psychological problems that cause disability globally, and no one is free from these problems (Yeshaw & Mossie, 2017).

#### **2.2. Overview of Depression, Anxiety and stress**

According to the Center for Disease Control and Prevention (CDC, 2010), one out of every 10 adult Americans currently report depression. Depression is a mood disorder that is characterized by dysphoria, sadness, anxiety, withdrawal, hopelessness, despair, loss of sleep or excessive need for sleep, and possible exaggerated guilt feelings or thoughts (Kahn,2001). If the above characterizations affect psychological, physical, or interpersonal function for at least two weeks, a depression diagnosis may be given. Physical signs and symptoms of depression

include headache, changes in appetite, loss of energy, and gastrointestinal disturbances. Intellectual symptoms may include slowed thinking, indecisiveness, poor concentration, and impaired memory (Kahn, 2001).

No single cause is identified for depression. Predictors of depression include age, race, gender, education level, and marital status. Further, it may be associated with many factors including past family history and psychosocial stressors. These psychosocial stressors can range from death of a spouse to employment loss to possibly urban living. Expectedly, changes in one's own environment can play a role in the development of depression. These environmental change may include sudden changes in one's external environment, or any major loss (Kahn,2001).

Depression involves a feeling of low mood that lasts for a long time and affects everyday life. People with depression experience feelings of hopelessness, despairing, guilty, worthlessness, unmotivated and exhausted. It can also affect self-esteem, sleep, appetite, sex drive and, sometimes, physical health. The total number of people suffering from depression in the world reaches 322 million (WHO, 2017).

Another common mental health problem is anxiety. Anxiety disorders are a group of disorders that have as their central feature the inability to regulate fear or worry. Although anxiety in itself is likely to feature in the clinical presentation of most patients, somatic complaints such as chest pain, palpitations, respiratory difficulty, headaches, and the like are also common, and these symptoms may be more common in developing countries. A number of different types of anxiety disorder exist, some of which are now briefly described (Hyman, Chisholm, Kessler, Patel, & Whiteford, 2006)

Studies show that the total estimated number of people living with anxiety disorders in the world is 264 million (WHO 2017). In a survey conducted by the National Institute of Mental Health, the prevalence of anxiety disorder was found to be 8.3%. Specifically, in the United

States, generalized anxiety disorders affect 6.8 million adults (Kahn ,2001). This number may be underestimated as anxiety disorders often present with physical symptoms and the psychological components often go unrecognized. Anxiety can be caused by a combination of physical and environmental Factors; Anxiety also can be marked by feelings of uneasiness, tension and apprehension (Kahn,2001). Physical signs and symptoms can include increased heart rate, blood pressure, and respiratory rate, sweating, difficulty swallowing, dizziness, and chest pain. Because anxiety may be so debilitating, some individuals may turn to smoking, and alcohol and/or drug abuse Kahn (2001).

The main symptom of **panic disorder** is an unexpected panic attack, which is a discrete period of intense fear accompanied by physiologic symptoms such as a racing heart, shortness of breath, sweating, or dizziness. People with panic disorder may have an intense fear of losing control or of dying. Panic disorder is diagnosed when panic attacks are recurrent and give rise to anticipatory anxiety about additional attacks. People with panic disorder may progressively restrict their lives to avoid situations in which panic attacks occur or situations from which it might be difficult to escape should a panic attack occur. They commonly avoid crowds, traveling, bridges, and elevators, and ultimately some individuals may stop leaving home altogether. Pervasive phobic avoidance is described as agoraphobia. (Hyman, Chisholm, Kessler, Patel, & Whiteford, 2006)

**Generalized anxiety disorder** is characterized by chronic unrealistic and excessive worry. These symptoms are accompanied by specific anxiety-related symptoms such as sympathetic nervous system arousal, excessive vigilance, and motor tension. Posttraumatic stress disorder follows serious trauma. It is accompanied by emotional numbness, punctuated by intrusive reliving of the traumatic episode, generally initiated by environmental cues that act as reminders of the trauma; by disturbed sleep; and by hyper arousal, such as exaggerated startle responses. (Hyman, Chisholm, Kessler, Patel, & Whiteford,2006)

**social anxiety disorder (social phobia)** is characterized by a persistent fear of social situations or performance situations that expose a person to potential scrutiny by others. The affected person has intense fear that he or she will act in a way that will be humiliating. Separating social anxiety disorder from extremes of normal temperament, such as shyness, is difficult. Nonetheless, social anxiety disorder can be quite disabling. Simple phobias are extreme fear in the presence of discrete stimuli or cues, such as fear of heights. (Hyman, Chisholm, Kessler, Patel, & Whiteford, 2006)

Concerning stress, stress is an uncomfortable emotional experience accompanied by predictable biochemical, physiological and behavioral changes that can lead to health consequences, which can also affect the immune, cardiovascular, neuroendocrine, and central nervous systems (APA, 2017).

Stress is a widespread phenomenon that endures all human lifespan. All people have experienced it throughout their history and throughout human history. In psychological sciences, stress is defined as a feeling of mental press and tension. Low levels of stress might be desired, useful, and even healthy. Normal stress helps to improve the biological, psychological, and social health and facilitates performance. Furthermore, positive stress is considered as an important factor to motivation, adaptation, and reaction to surrounding environment. However, high levels of stress could result in biological, psychological, and social problems and even serious harms to people (Mohammad, Azad & Hakim, 2015).

According to Mohammed et al (2015), stress can be externally caused with environmental source, or caused by internal perceptions of the individual. The internal perception can produce anxiety, and/or other negative emotions and feelings such as press, pain, sadness, etc., and result in serious psychological disorders such as post-traumatic stress disorder (PTSD).

Although there was no sufficient nationwide survey conducted in Ethiopia to determine the prevalence of depression, a survey done by WHO in collaboration with Jimma University indicated that the prevalence of depression in Ethiopia was 9.1%. On the other hand, the prevalence of depression in Ethiopia was reported to be 5% according to the Ethiopian Federal Ministry of Health report of 2012(Bitew,2014). The prevalence of depression, anxiety, and stress among jimma university staffs was found to be 22.9%, 19.2% and 28.2% respectively (Yigezie and Andualem, 2016).

Another study conducted among Addis Ababa university students revealed that the prevalence of depression anxiety and stress was 18.5%,28.6% and 22.4% respectively (Sileshi & Mulugeta,2018). A cross sectional study conducted among Ethiopian adults showed that the prevalence of depression was 17.5%. (Getasew, Haregwoin, Zebiba, Amsalu, Wubalem and Tesfa,2016). Another study conducted in Ethiopia which is focused on depression among women in rural Ethiopia as related to socioeconomic factors revealed that 12-month prevalence of depressive episodes among women in rural Ethiopia was 4.4% (Deyessa, Berhane, Alem, Hogberg & Kullgren ,2008).

### **2.3. Nature of psychological problems**

There is no single cause for depression. However, there are factors associated with depression. These include age, race, gender, education level, and marital status. It may also be related to many factors including past family history and psychosocial stressor. Not surprisingly, changes in one's own environment can play a role in the development of depression. This environmental change may include sudden changes in one's external environment, or any major loss. (kahn,2001)

Depression is associated with a combination of genetic, psychological, environmental, and biological factors. Risk factors for depression include pregnancy, childbirth, (peri) menopause,

hormonal factors and menstruation, (low tolerance to) stress, impulsive behavior, alcohol or Substance abuse, and family history of depression, alcohol abuse or suicide. Other factors such as poverty, severe or chronic medical conditions, insomnia, being a female, intimate partner violence, (childhood) sexual abuse and tobacco use are also associated with depression.

Anxiety can be caused by a combination of physical and environmental factors. Anxiety can be marked by feelings of uneasiness, tension and apprehension. Physical signs and symptoms can include increased heart rate, blood pressure, and respiratory rate, sweating, difficulty swallowing, dizziness, and chest pain. Because of its debilitating nature, some individuals with anxiety may experience smoking, and alcohol and/or drug abuse (Kahn, 2001).

## **2.4. Counselors and psychological problems**

A good number of studies indicate that therapists and other mental health professionals experience depression at a higher rate than the general population (Kevin, 2016). Of course, depression is not the only element that is problematic to therapists. In a somewhat related manner , Deutsch (1985) found 82% of respondents had experienced relationship difficulties over the course of their lives. Pope and Tabachnick (1994) found between 35-42% of respondents experienced episodes of irritability, emotional exhaustion, concern over the size of their caseload, poor sleep, and doubts about their effectiveness as a therapist, interpersonal issues, fatigue, anxiety, and isolation. In a survey of distressed psychologists, Thoreson, Miller and Krauskopf (1989) found that 10% experienced distress in the areas of marital/relationship difficulties, physical illness, alcohol use loneliness as well as depression. Norcross, Strausser Kirtland and Missar (1988) reported that, while undergoing therapy, 13% of psychotherapists listed depression as a presenting problem during their treatment.

Counselors and clinicians working in the area of addiction are called upon to show empathy, understanding and giving, yet they must control their own emotions and

responses in dealing with clients. During their professional relationships with clients, clinicians are highly likely to suffer from emotional, mental and physical exhaustion. In the absence of boundaries and little care given to oneself, addiction counselors can be more exposed to fatigue and burnout. Stress can bring about a number of problems including burnout, low morale, health problems, turnover, low productivity and much more without proper management. Early identification of these stressors and appropriate intervention strategies can help address these challenges and reduce stress thereby promoting personal health and wellness (Denis &Melanie, 2017).

According to Denis &Melanie (2017) addiction counselors deal with a very challenging patient population. These clients have complex problems including medical issues, as well as legal, family, housing and employment problems. Workers, whose intention is to help, can get overly involved with (often very needy) patients. In addition, the job requires a huge amount of empathy, yet counselors must face client relapse and ambiguous success every day.

Other stressors arise because of an organization is unable to implement measures to support staff in their long hours of work, coupled with a lack of clear career paths. These make counselors to become completely drained (burned-out) and dissatisfied with their job. Eventually, they may seek other employment opportunities and unfortunately, end up leaving the remaining employees to carry even larger caseloads, which piles on more work-related stress! The wellbeing of an organization, the professional team, and the addiction treatment and recovery field depends on how well the issues of stress, burnout, relapse, and job turn-over can be addressed (Denis &Melanie, 2017).

According Tay (2018) of the 678 clinical psychologists who completed the survey, 62.7% (n =425) had experienced a mental health problem(s) at some point in their lives. Almost half (n =195) of these 425 psychologists had experienced more than one mental health problem, with12.2% having experienced three or more types of mental health problems

## **2.5. Depression, anxiety and stress among counseling service providers**

A study by Gilroy et al (cited in Kevin, 2016) found out that depression, especially dysthymia, to be the most frequently acknowledged diagnosis at 36% of the 242 counseling psychologists surveyed. According to Kimberly (2016), there is a portion of psychologists who identified with having a diagnosable psychiatric disorder (81%) within the continuum spectrum of severity, and approximately 70% believed they also presented with personality-disordered traits over the course of their lifetime. The prevalence of depression ranges from 11% to 62% and anxiety stretches from 36% to 51%.

The most common psychiatric concerns prevalent among psychologists were depressive-type disorders that included symptoms such as isolation and loneliness (9%), mood dysregulation, relationship dissatisfaction (11%), somatic illness (10%), and hopelessness/helplessness (Kimberly, 2016).

According to Tay (2016), In the UK, research conducted by Cushway and Tyler (1994) revealed that 75% of clinical psychologists were moderately to severely stressed and 29.4% had experienced a mental health problem. Arvay and Uhlemann (1996) found in a survey of trauma counselors that therapists were at risk for developing stress symptoms similar to those experienced by trauma survivors. Using the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979), the authors found that 14% of the respondents (n = 161) reported frequently experiencing high stress levels similar to clients with post-traumatic Stress disorder.

## **2.6. Gender difference in depression, anxiety and stress**

Some studies have tried to examine depression in relation to female mental health professionals. The results seem to correlate with the findings of mental health therapists in general. Gilroy et al (cited in Kimberly, 2016) using 425 psychologists revealed that female

mental health professionals are at a greater risk for depression and revealed that approximately 62% of the participants identified themselves as depressed. Women reported more frequent states and higher levels of depression (60%) than men (40%). Similarly, Gilroy et al (cited in Kevin, 2016) found 76% of 220 woman psychotherapist reported some form of depressive disorders. Approximately 49% of these indicated they were aware of being given a DSM-IV diagnosis.

Matud (2004) indicated that compared to men, women have more daily stress, experience more chronic problems, conflicts and daily demands and frustrations. Although women and men did not differ in the number of life events and changes experienced within the past two years, these events seemed to impact women since they rated them as less desirable and controllable than men did and they were more associated with health problems.

## **2.7. The role of work of experience in depression, anxiety and stress**

Although in some studies participants were asked about how long they had worked in direct care (Robins, 2009), or for how long they had worked in that particular role (e.g., Rossi et al., 2012). Of these 10 studies, only some reported that experience was related to compassion fatigue. Compassion fatigue increased with years spent working in the field of trauma counseling (Birck,2001), with a strong correlation reported, although this particular study had a very small sample size (N=25). Many years of experience as a mental health practitioner in a children's hospital were also more likely to report high compassion fatigue (Robins et al., 2009). However, one study found that as years spent in the mental health field increased, compassion fatigue decreased (Thompson et al., 2014), although the strength of the correlation here was small.

## **2.8. Educational Qualification**

Varying levels of education, training and cultural beliefs across countries may influence the attitudes of mental health professionals towards mental health problems and impinge on the comparability of findings across countries (Tay et al,2018). Clayton, Marten, Davis and

Wochnik (1980) Cited research by Kevin (2016) found that 39% of woman physicians and 30% of women PhDs had met criteria for major depression during their lifetime with an additional 12% meeting criteria for either questionable or very brief depression among physicians (11% for the female PhD's).

## **2.9. Theories of psychological problems**

### **2.9.1. Theory of depression**

#### **Beck's Cognitive Theory of Depression**

Beck's most central assumption is that depression is principally a cognitive disorder characterized by three negative, self-relevant beliefs. These include a negative view of the self (when depressed, people believe they are defective, deficient, and worthless), a negative view of the world (when depressed, people are dissatisfied with their current life situation and believe the world is making unreasonable demands upon them), and a negative view of the future (when depressed, people are pessimistic about their ability to attain desired outcomes). Beck refers to these beliefs (which encompass feelings of hopelessness and worthlessness) as the negative cognitive triad and assumes that they are the central feature of all types of depression. This means that other aspects of depression, such as somatic disturbances (e.g., trouble sleeping), motivational disturbances (e.g., passivity and withdrawal), and affective disturbances (e.g., intense sadness), arise in response to these beliefs (Beck et al., 1979).

Beck also believes that automatic, reflexive quality are word used to describe these thoughts. They seem to appear "out of blue," without provocation or conscious awareness. As depression gets worse, they become increasingly repetitive and intrusive. In extreme cases, they may virtually dominate thinking, making it difficult for the depressed person to treat depression, which involves monitoring these thoughts, noting when they occur, and under what circumstances. By doing so, Beck argues, one can gain control over these

thoughts and eliminate them.

Counselors hear heavy stories and walk with clients through dark journeys, and they unavoidably carry some of those experiences with them after the session ends due to these and other issues counselors develop depressive symptoms (Denis & Melanie, 2017).

## **2.9.2. Theory of anxiety**

### **Existential Theory**

According to existentialists, anxiety is of two types: normal anxiety and neurotic anxiety. Normal anxiety is directly proportional to the situation. It is within our awareness (not requiring repression or other defensive processes) and can be used creatively. In contrast, neurotic anxiety is disproportionate to the situation; it is usually repressed, denied, or otherwise avoided, and is not used for creative or constructive purposes. Instead, it is destructive.

The goal of existential treatment is not to do away with anxiety, but to reduce neurotic anxiety. In doing so clients are helped to live with and cope effectively and creatively with the normal anxiety that accompanies existence.

The existential therapist helps clients face and embrace “ultimate concerns” of existence (Van Deurzen-Smith, 1997). These ultimate concerns of existence produce anxiety that must be dealt with either directly or indirectly via defense mechanisms (although for existentialists, defense mechanisms are not an elusive, automatic unconscious process, but a style or pattern of avoiding anxiety that can and should be brought to awareness). Existentialists argue that the ultimate concerns identified to be relevant to psychotherapy are death, freedom, isolation, and meaninglessness (Irving Yalom, 1980). These four ultimate concerns capture the nature of reality for existentialists. Everyone who lives is confronted with real demands and truths inherent in human existence. In turn, we are all free to choose our response to those demands and anxiety-producing truths (Sommers, 2012).

psychologists treating particular disorders, such as depression, anxiety, and suicide increase their ability to see similar symptoms within themselves, as well as with ongoing reminders in treatment; this can be one explanation to the mirroring of disorders between psychologists and the general public or the patients they are treating (Nachshoni et al., 2008).

### **2.9.3. Theory of Stress**

#### **I. Psychological Stress: The Lazarus Theory**

Any psychological stress theory focuses on two central concepts: appraisal, i.e., individuals' evaluation of the significance of what is happening for their well-being, and coping, i.e., individuals' efforts in thought and action to manage specific demands (Lazarus, 1993).

Stress is perceived as a relational concept, i.e., stress is not defined as a specific kind of external stimulation nor a specific pattern of physiological, behavioral, or subjective reactions. Instead, stress is viewed as a relationship ('transaction') between individuals and their environment. Psychological stress refers to a relationship with the environment that the person appraises as significant for his or her wellbeing and in which the demands tax or exceed available coping resources' (Lazarus and Folkman 1986,). This definition points to two processes as central mediators within the person–environment transaction: cognitive appraisal and coping. (Khrono, 2001).

The concept of appraisal, introduced into emotion research by Arnold (1960) and elaborated with respect to stress processes by Lazarus is the most important factor for understanding stress-relevant transactions. This concept is based on the idea that emotional processes, including stress, are dependent on actual expectancies that persons manifest with regard to the significance and outcome of a specific encounter. This concept is necessary to explain individual differences in quality, intensity, and duration of an elicited emotion in environments that are objectively equal for different individuals. It is generally understood that the resulting state is generated,

maintained, and eventually altered by a specific pattern of appraisals. These appraisals, in turn, are determined by a number of personal and situational factors. The most important factors on the personal side are motivational dispositions, goals, values, and generalized expectancies. Relevant situational parameters are predictability, controllability, and imminence of a potentially stressful events (Khrono,2001).

In his monograph on emotion and adaptation, Lazarus (1991) developed a comprehensive emotion theory that also includes a stress theory (Lazarus, 1993). Primary and secondary appraisal are considered to be the two basic forms of appraisal. These forms rely on different sources of information. Primary appraisal concerns whether something of relevance to the individual's wellbeing occurs, whereas secondary appraisal is related to coping options (Khrono, 2001).

Within primary appraisal, three components are distinguished: goal relevance describes the extent to which an encounter refers to issues about which the person cares. Goal congruence defines the extent to which an episode proceeds in accordance with personal goals. Type of ego-involvement designates aspects of personal commitment such as self-esteem, moral values, ego-ideal, or ego-identity. Likewise, three secondary appraisal components are distinguished: blame or credit results from an individual's appraisal of who is responsible for a certain event. By coping potential, Lazarus means a person's evaluation of the prospects for generating certain behavioral or cognitive operations that will positively influence a personally relevant encounter. Future expectations refer to the appraisal of the further course of an encounter with respect to goal congruence or incongruence (Khrono, 2001).

Specific patterns of primary and secondary appraisal can cause different kinds of stress. Three types are distinguished: harm, threat, and challenge (Lazarus and Folkman 1984). Harm refers to the (psychological) damage or loss that has already happened. Threat is the anticipation of harm that may be imminent. Challenge results from demands that a person feels confident

about mastering. These different kinds of psychological stress are embedded in specific types of emotional reactions, thus illustrating the close conjunction of the fields of stress and emotions (Khrone, 2001).

Having a general disposition of care and concern for clients is an essential characteristic of counselors. An essential practice that counselors must learn is to turn that care and concern toward themselves, or in other words have a practice of self-care. If counselors do not learn to care for themselves, they may experience stress in their personal and professional lives, leading to burnout (Nelson et al.,2017)

## **II. Coping Theories**

The Lazarus model represents a specific type of coping theory. These theories may be classified according to two independent parameters: (a) trait-oriented versus state oriented, and (b) micro analytic versus macro analytic approaches (Krohne 1996). Trait oriented and state-oriented research strategies have different objectives: The trait-oriented (or dispositional) strategy aims at early identification of individuals whose coping resources and tendencies are inadequate for the demands of a specific stressful encounter. An early identification of these persons will offer the opportunity for establishing a selection (or placement) procedure or a successful primary prevention program. Research that is state oriented, i.e., which centers around actual coping, has a more general objective (Khrone,2001). This research investigates the relationships between coping strategies employed by an individual and outcome variable such as self-reported or objectively registered coping efficiency, emotional reactions accompanying and following certain coping efforts, or variables of adaptational outcome (e.g., health status or test performance). This research strategy intends to lay the foundation for a general modificatory program to improve coping efficacy. Micro analytic approaches focus on a large number of specific coping strategies, whereas macro analytic analysis operates at a higher level of abstraction, thus concentrating on more fundamental constructs (Khrone, 2001).

## **2.10. Summary of the literature review**

Psychological problems are diverse and cause not only personal suffering but also loss of workdays and heavy burden to health care systems. The major mental health problems that cause disability globally now are, Depression, anxiety, and stress, and no one is immune to these problems.

Depression is a feeling of low mood that lasts for a long time and affects everyday life. It can make a person feel hopeless, despairing, guilty, worthless, unmotivated and exhausted. It can affect self-esteem, sleep, appetite, sex drive and, sometimes, physical health.

Anxiety disorders are a group of disorders that have as their central feature the inability to regulate fear or worry. Although anxiety in itself is likely to feature in the clinical presentation of most patients, somatic complaints such as chest pain, palpitations, respiratory difficulty, headaches, and the like are also common, and these symptoms may be more common in developing countries.

Stress is an uncomfortable emotional experience accompanied by predictable biochemical, physiological and behavioral changes that can lead to health consequences, which can also affect the immune, cardiovascular, neuroendocrine, and central nervous systems.

Psychologists are people, and as people, their level of mental health functioning fluctuates continuously in accordance with the many demands of their lives. In addition to psychologists having comparable mental health problems to the general public, their professional demands contribute to their impairment due to the unique risk factors they face

## **CHAPTER THREE**

### **METHODS**

This chapter deals with the description of research design, study setting, population and participants, samples and sampling technique, data collection instruments, pilot study, procedures of data collection, methods of data analysis, and ethical considerations.

#### **3.1. Research Design**

This study aimed to assess the prevalence of depression, anxiety and stress among counseling service providers in Addis Ababa. Therefore, the study employed a quantitative method particularly a cross-sectional survey design. This design was preferred because the researcher used to collect information from respondents at a single time through questionnaire.

#### **3.2. Study Setting**

The study was conducted in Addis Ababa which is a capital city of Ethiopia. The exact number of counseling service centers in Addis Ababa is not identified. However, according to the information that the researcher gets from Ethiopian Psychological association and Addis Ababa labour and Social affairs bureau it is believed that more than 26 centers are providing counseling service in Addis Ababa. Hence, all of those centers has been included as a population of this study. From this 26 centers 20 of them selected by using simple random sampling. From these selected centers 6 of them are located at bole sub city, 2 at kirkos sub city, 3 of them are located at Lideta Sub city, another 2 at Yeka sub city, and the remaining 7 of them located at Nifas silk lafto , Gulele, Kolfe keranio ,Addis ketema and akaki kality sub city.

#### **3.3. Population, Sample and sampling technique**

The population of this study was counseling service providers who work in counseling centers including hospitals and prison center in Addis Ababa city. Obviously it is difficult to find a list of all the details of the number of counseling service providers in Addis Ababa. With the help

of Ethiopian Psychological association and Addis Ababa labour and social affairs bureau the researcher try to list out 26 counseling centers. Subsequent to identifying the population as a study area target participants were included to the sample. From a total of 26 counseling organizations 20 of them selected by using simple random sampling method which is a probability sampling technique. Although it was challenging to obtain respondents for this study, 113 counseling service providers who works at different organization in Addis Ababa were selected. All Available counseling service providers who work in these organizations were included. Participants were drawn from different organizations including Abrhot Psychological Services, Posterity Psychological Therapy & training center, Bezna Counseling & Training Service, Alta Counseling & Training, Impact Ethiopia psychological services & public health consulting ,New Life Rehab center, Yehiwot Tesfa counseling and social service center, Aha Psychological Service, Erq Mead Psychological service, Fikat psychological service, Lebeza psychiatry Clinic, Sitota Center for Mental Health Care, Armed Force General Hospital, St. Paul's Hospital, Eka Kotebe General Hospital, Amanuel Mental Specialize Hospital, Integrated Family Service Organization, A Hope Ethiopia, Tesfa Addis Parents childhood cancer organization and Kality Correctional Center. As the population was so small, 75% of them were taken as a sample of the study.

### **3.4. Data collection instruments**

In order to collect data from respondents, self-reporting scales that included socio-demographic questionnaire and DASS-21.

#### **I. Socio-demographic characteristics questionnaire**

The questionnaire contained 6 items and respondents were asked to indicate their age, sex, marital status, educational qualification, work setting years of work experience. Indeed, age, sex and educational qualification and years of work experience were utilized to address the stated objectives.

## **II. DASS-21**

The Depression, Anxiety and Stress Scales were applied in order to reveal the psychological status of the individuals. DASS-21 is a very well-known scale that measures the negative emotional states of depression, anxiety and stress. The scale consists of three self-report subscales that comprise seven items each with related content. The depression subscale assesses dysphoria, hopelessness, devaluation of life, self-depreciation, and lack of interest/involvement, anhedonia, and inertia. The anxiety subscale measures autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress subscale measures relaxation difficulty, nervous arousal, agitation, irritability and impatience. Participants are requested to use a 4-point severity/frequency scale to rate the extent to which they had experienced each negative state over the past week (Lovibond & Lovibond, 1995a).

The DASS-21 symptom is based on 4-point severity scale ranging from 0 to 3 measures and scores are categorized into normal, mild, moderate, severe and extremely severe (Lovibond & Lovibond, 1995b) for each subscale, as per the DASS manual. The minimum score is zero and the maximum score is 21. The final score of DASS-21 can be categorized based on cutoff points.

Items 1, 6, 8, 11, 12, 14, & 18 are components of the stress subscale; items 2, 4, 7, 9, 15, 19, & 20 stand for anxiety whereas the depression subscale consists of 3, 5, 10, 13, 16, 17, & 21.

Internal consistency for each of the subscales of the 21-item version scales was typically high. Specifically, Cronbach's alpha for depression was 0.96 to 0.97, 0.84 to 0.92 for anxiety, and 0.90 to 0.95 for stress.

### **3.5 Pilot Study**

Pilot study was conducted to ensure the quality of items of the questionnaire. For checking the reliability of items, Cronbach's Alpha was used. The English version of the instruments was translated to Amharic language by the researcher, one MA student of counseling

psychology, and MA students of TEFL department in Addis Ababa University. Additionally, its content validity was checked by 2 counseling psychology professionals in order to measure the content and clarity of items.

Then, pilot test was done for checking the clarity of items, language problem, reliability and feasibility of the measures as well as for identifying the proper ways of administering the measures to be used in the main study. Therefore, in order to minimize sampling errors for the main study a total of 28 respondents completed the survey. The participants fill the data using online questionnaire. The Cronbach's coefficient values ( $\alpha$ ) for depression, anxiety and stress was .82, .71 and .71 respectively.

### **3.6. Procedure of data collection**

In the beginning, the researcher collected letter of support from School of Psychology and forwarded it to Addis Ababa labour and social affairs bureau and Ethiopian Psychological association so as to identify the number of study population. I explained to the office that I am a graduate student in Addis Ababa University and I articulated my interest to conduct research on counseling service providers. They become willing to cooperate and they provided me the lists of 26 counseling centers in Addis Ababa and general suggestions on how I can access them. From a total of 26 accessible counseling organizations 20 of them selected by using simple random sampling method. Following the selection of the institutions, all available counselors who are providing counseling service in these centers were included.

Due to the confirmation of COVID-19 Pandemic it was difficult to collect all data by meeting participants in person because of this reason the researcher prepares online questionnaire and administers it using Telegram.

The data collection procedure was held under the supervision of the researcher and other two employed data collectors in order to help in gathering necessary information for the current study. The assistant data collectors have background in psychology and were trained by the

researcher on how they collect the data. Participants were informed about the purpose of the study and the questionnaire was filled-in and completed by meeting in person and using online survey.

### **3.7 Methods of data analysis**

In order to address the stated objectives both descriptive and inferential statistics were used to analyze the data. So, the data were entered and cleaned through SPSS version 24, and the alpha value (p) of .05 was also determined for all significance tests. After the data were collected from the participants the researcher employed the following data analysis methods: Frequency and percentage were analyzed to assess the status of depression, anxiety and stress of counseling providers, Independent sample t-test was also computed to examine whether there is gender and educational qualification difference in depression, anxiety and stress among counseling service providers. Furthermore, One-way ANOVA was utilized to examine whether there is years of work experience difference in depression, anxiety and stress among counseling services providers. Finally, Pearson product moment correlation was computed to assess the relationship between years of work experience and depression, anxiety and stress.

### **3.8. Ethical Considerations**

The current study was emphasized on depression, anxiety and stress among counseling service providers in different counseling Centers of Addis Ababa. Respondents have shown their willingness to participate in this study. Additionally, respondents were informed about the nature and purpose of the study and also the researcher has informed the participants that the findings of the present study will be confidential and used only for educational purpose.

## CHAPTER FOUR

### Results

In this section, the results of the present study are discussed in line with the research questions presented in the introduction section of this study. Thus, in order to address the research questions both descriptive and inferential statistics were employed.

#### 4.1 Background information of the respondents

Table 1: *Background characteristics of the respondents (N=113)*

Demographic Variables	Categories	Frequency (N)	Percentage (%)
Gender	Male	56	49.6%
	Female	57	50.4%
Age in year's	≤30	55	48.7%
	31-40	41	36.3%
	≥40	17	15%
Marital status	Unmarried	62	54.9%
	Married	44	35.9%
	Divorced	6	5.3%
	Widowed	1	0.9%
Educational status	Bachelor's degree	83	73.5%
	Master's degree and above	30	26.5%
Work setting	Private counseling centers	63	55.8%
	Hospitals	21	18.6%
	Prison centers	2	1.7%
	NGO's &Rehabs	27	23.8%
Work experience	≤ 5 years	58	51.3%
	6-10 years	33	29.2%
	≥ 11 years	22	19.5%

The above Table 1 reveals that a total of 113 research participants were participated in the current study. Among these, 56(49.6 %) of the respondents were males while 57 (50.4 %) were female counseling service providers so; similar amount of respondents were participated in the study. Along with age majority 55(48.7 %) of the respondents were below the age of 30 followed by 41(36.3%) whose age ranges from 31-40 years and the remaining 17(15.0%) were above the age of 41. As can be seen from Table 1 above, majority 62(54.9 %) of the respondent's marital status is unmarried and marital status of the rest participants are married 44 (35.9%), divorced 6 (5.3%) and widowed 1 (0.9%). As can be observed from the above Table 1 58 (51.3%) of the participants had below five years' work experience concerning counseling and related issues and 33 (29.2%) and 22 (19.5%) of the participants had 6 up to 10 and above 11 years work experience respectively. Regarding to educational background of the respondent's majority of the counseling service providers 83 (73.5%) had bachelor's degree and the remaining 30 (26.5%) respondents were MA holders and above. The above Table 1 also reported that majority of the respondents 63 (55.8%) were working at private counseling centers followed by hospitals 21 (18.6%), prison centers 2(1.7%) and NGOs and Rehabs 27 (23.8%),

#### **4.2 Prevalence of depression, anxiety and stress among counseling service providers**

The following tables (Table 4, 5 and 6) depict the prevalence of depression, anxiety and stress among counseling service providers. Here, scores from each aspect were calculated separately, and up on the manual of DASS the categorizations are classified under five groups which are normal, mild, moderate, severe and extremely severe.

#### 4.2.1 Depression scale results of the respondents

**Table 2: Depression scores of the respondents**

Scores	Magnitude	Frequency	Percentage
0-4	Normal	52	46 %
5-6	Mild	38	33.6%
7-10	Moderate	19	16.8%
11-13	Severe	3	2.7%
13 and above	extremely severe	1	0.9%
Total		113	100%

Out of 113 respondents in Addis Ababa who participated in the current study, the overall prevalence of depression was 54% according to DASS-21 cut of scores. Among those respondents 33.6 %, 16.8% and 2.7% had mild, moderate and severe depressive symptoms respectively. The remaining 0.9% had severe depressive symptom.

#### 4.2.2 Anxiety scale results of the respondents

**Table 3: Anxiety scores of the respondents**

Scores	Magnitude	Frequency	Percentage
0-3	Normal	29	25.7%
4-5	Mild	48	42.5 %
6-7	Moderate	24	21.2 %
8-9	Severe	12	10.6
9 and above	extremely severe	-	-
Total		113	100 %

As the above Table 3 shown 25.7 % of the respondents were free from it while the rest had anxiety symptoms with different magnitude. Among those, 42.5% and 16.2% had mild and moderate anxiety symptoms, respectively. The remaining 10.6 % had severe anxiety symptom.

#### 4.2.3 Stress scale results of the respondents

**Table 4: Stress scores of the respondents**

Scores	Magnitude	Frequency	Percentage
0-7	Normal	64	56.6%
8-9	Mild	32	28.4 %
10-12	Moderate	17	15 %
13-16	Severe	-	-
16 and above	extremely severe	-	-
Total		113	100%

As the above Table 4 shown majority of the respondents 56.6 % do not have any relevant stress scores based on DASS-21 scoring manual. Those who were with mild and moderate level of stress consist of 28.3 % and 15 % correspondingly. Nevertheless, no severe and extremely severe level of stress (0%) was noted.

#### 4.3 Depression, anxiety and stress difference across gender among counseling service providers

In this section, an independent sample t-test was computed to examine mean difference in depression, anxiety and stress across gender. Therefore, the following Table 5 has shown the mean, standard deviation, degree of freedom, t-value and p values of the study variables with respect to gender.

**Table 5:** Independent Sample t-test Comparison for the level of depression, anxiety and stress across gender

<b>Variables</b>	<b>Sex</b>	<b>M</b>	<b>SD</b>	<b>df</b>	<b>t</b>	<b>Sig. (2-tailed)</b>
Depression	Male	1.88	.935	111	1.046	.298
	Female	1.70	.823			
Anxiety	Male	2.21	.929	111	.519	.605
	Female	2.12	.946			
Stress	Male	1.63	.776	111	.580	.563
	Female	1.54	.709			

Significant at,  $p < 0.05$

As can be seen in the above Table 5, the Independent sample t-test was computed to examine whether there was gender difference in depression, anxiety and stress scores. The result showed that there was no statistically significant mean difference between male ( $M=1.88$ ,  $SD= .935$ ) and female research participants ( $M= 1.70$ ,  $SD= .823$ ),  $t(111) = 1.046$ ,  $p=.298$  on their depression score. Additionally, Independent sample t- test analysis for anxiety indicated that the difference between males ( $M=2.21$ ,  $SD=.929$ ) and females ( $M= 2.12$ ,  $SD=.946$ ),  $t(111) = .519$ ,  $p= .605$  anxiety score is not a statistically significant. The study result also reported that no statistically significant mean difference was obtained between male ( $M= 1.63$ ,  $SD= .776$ ) and females ( $M= 1.54$ ,  $SD= .709$ ),  $t(111)$ ,  $p= .563$  on their stress score.

Table 6: *Independent Sample t-test Comparison for the level of depression, anxiety and stress across educational status*

Variables	Educational		M	SD	Df	T	Sig. (2-tailed)
	Status						
Depression	BA degree		1.90	.905			
	MA holders & Above		1.47	.730	111	2.376	.019
Anxiety	BA degree		2.27	.964			
	MA holders & Above		1.90	.803	111	1.854	.066
Stress	BA degree		1.60	.732			
	MA holders & Above		1.53	.776	111	.436	.664

Significant at,  $p < 0.05$

Note. BA= Bachelors of Art

MA= Masters of Art

The above Table 6 reveals independent *t*-test analysis that was computed to test any difference of depression, anxiety and stress scores between the respondents having BA degree and MA degree and above. The findings of the study showed that, there was statistically significant mean difference between respondents with BA degree ( $M=1.90$ ,  $SD=1.47$ ) and MA degree and above ( $M=1.47$ ,  $SD=.730$ ),  $t(111) = 2.376$ ,  $p = .019$  on their depression score. According to the finding of the present study, respondents with BA degree had more depressed symptoms than their respective MA holders. However, there was no statistically significant mean difference between counselors having BA degree ( $M= 2.27$ ,  $SD=.964$ ) and MA holders and above ( $M=1.90$ ,  $SD=.803$ ),  $t(111) = 1.854$ ,  $p=.066$  on their anxiety scores. Besides, the Independent sample *t*-test result for stress scores revealed that there was no statistically

significant mean difference between respondents having BA degree ( $M=1.60$ ,  $SD=.964$ ) and MA degree and above ( $M=1.53$ ,  $SD=.776$ ),  $t(111) = .436$ ,  $p = .664$  on their stress score.

#### 4.5 Depression, anxiety and stress difference across Age

In this section, one-way ANOVA was computed to test the difference in depression, anxiety and stress across age of the respondents. Therefore, the following table 7 displays the ANOVA analysis.

Table 7: One-Way ANOVA Result of depression, anxiety and stress scores across Age

Variable	Age		Sum of Squares	df	Mean Square	F	Sig. (2-tailed)
DP	≤30	Between Groups	1.672	2	.836		
	31-40	Within Groups	85.231	110	.775	1.079	.344
	≥41	Total	86.903	112			
AX	≤30	Between Groups	5.310	2	2.655		
	31-40	Within Groups	92.495	110	.841	3.157	.046
	≥41	Total	97.805	112			
ST	≤30	Between Groups	1.844	2	.992		
	31-40	Within Groups	59.608	110	.542	1.701	.187
	≥41	Total	61.451	112			

Significant at,  $<0.05$

Note. DP=

Depression

AX= Anxiety

ST= Stress

One Way ANOVA was employed to compare mean scores of the three age groups in depression, anxiety and stress scores. As indicated in Table 7 above, no statistically significant difference was found in depression scores across the three age groups,  $F(2,110) = 1.079, p = .344$ . In the above Table 7 the result of ANOVA test also revealed that there was no statistically significant difference among the three groups on their stress score,  $F(2,110) = 1.701, p = .187$ . The above findings tell us that the respondents found at different age groups did not varied on their symptoms of depression and stress without being considered their age variation. However, through an examination of One-way ANOVA analysis statistically significant difference was found on their anxiety score across all age groups,  $F(2,110) = 3.157, p = .046$ . Therefore, Post-hoc analysis was required to show a multiple comparison for identifying the exact mean difference among the three groups on anxiety score. Thus, a Tukey post hoc analysis finding can be observed in Table 8 below.

Table 8: *Tukey's Post Hoc Analysis of level of anxiety for Participants at Different Age Groups*

(I)AGE	(J) AGE	<u>Mean Difference</u>		Sig.	<u>95% Confidence Interval</u>	
		(I-J)	Std. Error		Lower Bound	Upper Bound
≤30	31-40	-.475*	.189	.036	-.92	-.03
	≥41	-.213	.254	.681	-.82	.39
31-40	≤30	.475*	.189	.036	.03	.92
	≥41	.263	.265	.583	-.37	.89
≥41	≤30	.213	.254	.681	-.39	.82
	31-40	-2.63	.265	.583	-.89	.37

\* The mean difference is significant at the 0.05 level (2-tailed).

The above Table 8 depicts, respondents aged 31 to 40 and below 30 years were significantly differed at  $p = .036$ . Respondents age ranged from 31 to 40 had higher anxiety symptoms ( $M = 2.44, SD = .896$ ) than respondents whose age below 30 ( $M = 1.96, SD = .896$ ).

The post hoc analysis also revealed that, respondents above the age of 41 ( $M= 2.18$ ,  $SD= 1.185$ ) were not statistically significant different from the age groups of 31 to 40 and below 30 with respect to anxiety

#### **4.6 Depression, anxiety and stress difference across work experience**

In order to analyze work experiences difference among the counseling service providers in depression, anxiety, and stress; One-Way ANOVA was utilized. The finding is presented as follows.

Table 9: *Pearson Product-Moment Correlations between work experience and depression, anxiety and stress*

<b>Variables</b>	<b>Depression</b>	<b>Anxiety</b>	<b>Stress</b>
Years of work experience	-.034	.139	.155

The Table 9 above displays the correlation matrix of counseling service providers work experience and depression, anxiety and stress. The matrix indicated insignificant of positive and negative association among the study variables. The finding of bivariate correlation between years of work experience and depression reported that there was a negative association,  $r(113) = -.034$ ,  $p=.718$  but it was not statistically significant. However, anxiety is found to be statistically weak positive association with years of work experience  $r(113) = .139$ ,  $p= .092$ . Besides, stress has statistically negative relationship with years of work experience,  $r(113) = .155$ ,  $p= .102$ .

## **CHAPTER FIVE**

### **DISCUSSION**

The main purpose of this study was to examine the prevalence of depression, anxiety and stress among counseling service providers in Addis Ababa. Therefore, discussions of the findings are presented along with the research questions stated in the first chapter of this study. Moreover, the findings of the present study are discussed in light of the previous studies.

#### **5.1 Prevalence of depression, anxiety and stress**

A total of 113 counseling service providers who work in different organizations and centers participated in the study from Addis Ababa city. Majority of the respondents were below the age of 30. In this study, the prevalence of depression among the counseling service providers was 54%. This study is consistent with the previous findings that were conducted by different researchers. For example, Gilroy et al (cited in Kimberly, 2016) conducted a study among 425 psychologists found out that they are at risk for depression and revealed that approximately 62% of the participants identified themselves as depressed. The current study finding is also partially similar with previous study undertaken by Pope and Tabachnick (1994). The finding of the analysis shows that between 35-42% of respondents experienced episodes of irritability, emotional exhaustion, concern over the size of their caseload, poor sleep, and doubts about their effectiveness as a therapist, interpersonal issues, fatigue, anxiety, and isolation.

However, the current study finding is incongruent with the findings conducted by Thoreson, Miller and Krauskopf (1989) revealed that 10% of the psychologists experienced depression. The present study result also found to be disagreed with a study investigated by Norcross, Strausser Kirtland and Missar (1988) reported that, while undergoing therapy, 13% of psychotherapists

listed depression as a presenting problem during their treatment. Besides, the current study finding is not further supported by Kimberly (2016) who suggested that 9 % of the psychologists were depressive-type disorders that included symptoms such as isolation and loneliness.

In this study, the prevalence of anxiety among the counseling service providers was 74.3. This finding is relatively consistent with previous study that was conducted by Gilroy et al (cited in Kevin, 2016) among the counseling psychologists and reported that the prevalence of anxiety was stretching from 36% to 51%.

The result of this study concerning prevalence of stress among the research participants indicated that, marginally majority of the counseling service providers 56.6% have normal level of stress. On the other hand, 43.4% of the respondents have mild and moderate level of stress.

The current study finding is inconsistent with a research conducted by Cushway and Tyler (1994) who revealed that 75% of clinical psychologists were moderately to severely stress. Similarly, the finding of this study also incongruent with that of Thoreson, Miller and Krauskopf (1989) who found that 10% of the psychologists experienced distress in the areas of marital difficulties, physical illness, alcohol use and loneliness.

## **5.2 Depression, anxiety and stress scores difference across gender**

The findings of the present study displayed that, there is no statistically significant difference between male and female on their depression, anxiety and stress scores. The obtained result of gender difference in this study is not corresponding with other previous studies. For example, research investigated by Gilroy et al (cited in Kimberly, 2016) suggested that women respondents had high depressive symptom than their respective. We can possibly infer from this analysis that being male or female did not bring a significant difference to display symptoms in depression, anxiety and stress.

### **5.3 Depression, anxiety and stress scores difference across educational status**

With respect to the difference of educational status and their levels of depression, anxiety and stress an independent sample t-test was computed. According to this study, there was no statistically significant difference between BA degree and MA and above participants in anxiety and stress. This result indicated that none of these had exhibit high symptoms of anxiety and stress. In other words, counseling service providers with different educational background did not vary on their status of anxiety and stress.

However, in the current study result statistically significant difference was found on depression for respondents having different educational background. This result claimed that BA degree's counseling service providers had display high level of depression than MA holders and above.

### **5.4 Depression, anxiety and stress scores difference across age**

To examine depression, anxiety and stress with regard to age of the respondents, one-way ANOVA was computed. As we have seen in the results section of this study there was no statistically significant mean difference on depression and stress scores across the three age groups. On the other hand, there was a significant mean difference on anxiety scores among counseling service providers from different groups. Following this a post-hoc test was found out that the proportion of respondents age ranged from 31 to 40 had higher anxiety symptoms ( $M=2.44$ ,  $SD=.896$ ) than respondents whose age below 30 ( $M=1.96$ ,  $SD=8.96$ ). This report suggested that, as age increases, exhibiting symptoms of anxiety increases.

### **5.5 Years of work experience and depression, anxiety and stress**

To correlate years of work experience and depression, anxiety and stress, a bivariate correlation analysis was utilized. The finding of the current study reported that years of work

experience was positively correlated with anxiety and stress. However, there was a negative association between years of work experience and depression. The present study finding entails that as years of work experience increases, symptoms of anxiety and stress also increases while the level of depression diminishes.

A study undertaken by Birck (2001) is partially agreed with the present study finding of the association between years of work experience and anxiety and stress who revealed that year of work experience and compassion fatigue had strong positive association. Further, compassion fatigue increased with years spent working in the field of trauma counseling because compassion fatigue is one of the main aspects of anxiety and stress.

Besides, Robins et al. (2009) have also hold congruent result with present finding who posited that respondents who had worked for longer as a mental health practitioner in a children's hospital were also more likely to report high compassion fatigue. However, the current study finding is not supported by Thompson et al. (2014) who suggested that as years spent in the mental health field increased, compassion fatigue decreased.

## CHAPTER SIX

### SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter is devoted to present summary, conclusions and recommendations forwarded based on the study findings.

#### 6.1 Summary

The main purpose of the study was to examine depression, anxiety and stress among counseling service providers in Addis Ababa city. The study was also aimed to assess the prevalence of depression, anxiety and stress and to investigate the significant difference of depression, anxiety and stress with gender and the other socio demographic variables. 113 respondents (males= 56 and females= 57) were participated in the current. To collect data, the short form of DASS contained 21-items was utilized. Before the main data was collected, pilot test was undertaken for 28 counseling service providers in Addis Ababa.

Then after the main data were gathered from 113 respondents, SPSS version 24 was utilized to analyze the data. The collected data was analyzed using both descriptive and inferential statistical analysis. Descriptive statistics were used to examine the prevalence of the study variables and inferential statistics were utilized to check the statistical significance of the tests. Therefore, only percentage and frequency was computed to assess the prevalence of depression, anxiety and stress. To analyze gender difference and educational status on depression, anxiety and stress independent sample t-test was employed. To examine age difference on depression, anxiety and stress, one-way ANOVA was used. Finally, Pearson product moment correlation was utilized to see the relationship between years of work experience and depression, anxiety and stress.

The result shows that 49.6 % and 50.4% of respondents were male and female counseling service providers respectively. Regarding prevalence of depression; 46 % of the respondents were at normal, 33.6 % at mild, 16.8 % moderate, at severe 2.7 % and 0.9 % extremely severe level of depression. On the other hand, this study suggested that 74.3 % of the research participants were at mild, moderate and severe level of anxiety. The study also revealed that majority of counseling service providers (56.6 %) was at normal level of stress.

As to this study, there were no statistically significant gender differences on levels of depression, anxiety and stress. The present study also confirmed that there was no statistically significant difference between BA degrees and MA holders and above on level of anxiety and stress. However, there was statistically significant difference between respondents with BA degree and MA and above on level of depression. Therefore, respondents having BA degree had high level of depression than MA holders and above.

Concerning age difference, there was statistically significant mean difference on anxiety for the age groups. This argued that age ranged from 31 to 40 had higher anxiety symptoms ( $M=2.44$ ,  $SD=.896$ ) than respondents whose age below 30 ( $M=1.96$ ,  $SD=.896$ ). However, the study result found that no statistically significant mean difference on level of depression and stress among respondents from different age groups.

With regard to the relationship between years of work experience and depression, anxiety and stress; the finding of the study noted that years of work experience has statistically weak positive association with anxiety and stress whereas depression has negative weak association with years of work experience.

## **6.2 Conclusion**

Based on the results given above, the following conclusions are drawn.

According to DASS, majority of counseling service providers score showed a mild, moderate, severe and extremely severe rate of depression and anxiety. Hence, majority of the

respondents could be at risk of depression and anxiety. According to the results of this study, there were non-significant differences found between DASS scores of counseling service providers in gender. The possible reason for this might be due to experiencing similar activities and working under similar circumstances.

There was statistically significant difference between BA degrees and MA holders and above examined in this study on depression. It is possible to say that counseling service providers with BA degree experience more depressive symptoms than MA holders. Up on the present study, it can be concluding that displaying this symptom is related to different personal and social factors either directly or indirectly. Unlike depression, stress and anxiety scores were positively correlated to years of work experience.

### **6.3 Recommendations**

Up on the findings of the present study, the following recommendations are forwarded:

- The prevalence of depression and anxiety among counseling service providers has major implications. So, stakeholders should develop strategies in place to identify and support all counseling service providers suffering from depression anxiety.
- In terms of depressive symptoms, various concerning bodies in Addis Ababa should give attention for counseling service providers having BA degree through providing additional courses and trainings.
- counseling organization should play their role by giving much emphasis for those who provides psychological service by creating a consistent plan to engage in self-care.
- The focus of the study was considering the counseling service providers so; further study should be undertaken by including other health care professionals in different geographical settings and by including other variables that were not included in the current study such as religion, family income, etc.

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## Appendices

### Appendix A: Instruments

#### Appendix A-1: Instrument English Version

Addis Ababa University

College of Education and Behavioral Studies

School of Psychology

Dear participants, the purpose of this questionnaire is to gather data for the study on "Depression, Anxiety and Stress among Counseling Service Providers in Addis Ababa city". I would like to ask your kind collaboration to take part in the study. The information you provide is very useful for successful completion of this research. The data is required only for an academic research and will be confidential from any third party,

#### **PART ONE: Socio-demographic data**

DIRECTION: For the following questions, please respond either by a word/phrase of your

opinion or by making "✓" on the option of your choice and write your correct response in blank space.

1. Age: \_\_\_\_\_

2. Sex: Male  Female

3. Years of work experience: \_\_\_\_\_

4. Marital status: Single  Married  Divorced  Widowed

5. Educational qualification: BA  MA and above

6 work setting: Hospital  school  private counseling center  NGO's  Prison center

#### **PART TWO: Depression, anxiety and stress scale**

DIRECTION: Please read each statement and by circling on the option of your choice which indicates how much the statement applied to you over the past week. There is no right or wrong answers. The rating scale is as follows:

0 Did not apply to me at all - NEVER

1 Applied to me to some degree, or some of the time - SOMETIMES

2 Applied to me to a considerable degree, or a good part of time - OFTEN

3 Applied to me very much, or most of the time - ALMOST ALWAYS

No.	Items	1	2	3	4
1	I found it hard to wind down				
2	I was aware of dryness of my mouth				
3	I couldn't seem to experience any positive feeling at All				
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)				
5	I found it difficult to work up the initiative to do Things				
6	I tended to over-react to situations				
7	I experienced trembling (eg, in the hands)				
8	I felt that I was using a lot of nervous energy				
9	I was worried about situations in which I might panic and make a fool of myself				
10	I felt that I had nothing to look forward to				
11	I found myself getting agitated				
12	I found it difficult to relax				
13	I felt down-hearted and blue				
14	I was intolerant of anything that kept me from getting on with what I was doing				
15	I felt I was close to panic				
16	I was unable to become enthusiastic about anything				
17	I felt I wasn't worth much as a person				
18	I felt that I was rather touchy				
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)				
20	I felt scared without any good reason				
21	I felt that life was meaningless				

**Appendix A-2: Instrument Amharic Version**

**በአዲስ አበባ ዩኒቨርሲቲ**

**የትምህርትና ባህሪ ጥናት ኮሌጅ**

**የሳይኮሎጂ ትምህርት ቤት**

ውድ የጥናቱ ተሳታፊዎች የዚህ ቃለ-መጠይቅ ዋና ዓላማ አዲስ አበባ በሚገኙ የ ካውንስሊንግ አገልግሎት የሚሰጡ ያላቸውን የ ድባቱ፣ ከባድ ጭንቀት እና ጭንቀት ደረጃ ምርምር ለማካሄድ ነው ።ይህ እርስዎ የሚሞሉት መጠይቅ ከጥናቱ አላማ ወጭ ለሌላ ለማናቸውም ጉዳይ የማይወል ስለመሆኑ ላረገግጥልዎ እወዳለው። ለጥናቱ ግብ እርስዎ በመጠይቁ ላይ የሚሰጡት ምላሽ ወሳኝ በመሆኑ በሁሉም ክፍሎች ላይ ላሉት ጥያቄዎች እውነተኛ እና ግልጽ የሆነ ምላሽ እንዲሰጡ በትህትና አጠይቃለሁ ።

**ክፍል አንድ ፡ አጠቃላይ መረጃ**

**መመሪያ:** ለሚከተሉት ጥያቄዎች እያንዳንዱን ጥያቄ በጥሞና በማንበብ ወይም በመዳመጥ፡ በተቀመጠው ሳጥን ውስጥ፡ የ"✓" ምልክት በማድረግ ወይም የተጠየቀውን መረጃ በመጻፍ መልስ ይስጡ። ባዶ ቦታ ላይ መሙላት በሚያስፈልግ፡ ተገቢ መልስ ይስጡ።

1.ዕድሜ:-----

2. ጾታ: ወንድ  ሴት

3.የ ስራ ዐመት ልምድ:-----

4. የ ትዳር ሁኔታ: ያላገባ/ች  ያገባ/ች  የተፋታ/ች  በሞት የተለየባቸው

5. የ ትምህርት ደረጃ: የ መጀመርያ ዲግሪ  ሁለተኛ ዲግሪ እና ከዚያ በላይ

6. የምትሰሩበት/ሪበት ቦታ: የ ካውንስሊንግ ማእከል  ሆስፒታል  ትምህርት ቤት  መንግስታዊ ያልሆነ ድርጅት  ማረምያ ቤት

**ክፍል ሁለት: የ ድባቱ፣ ከባድ ጭንቀት እና ጭንቀት መለኪያ**

ከዚህ በታች የተዘረዘሩትን እያንዳንዱን ጥያቄዎች ካነበቡ በኋላ መልስ ነው በማህት የሚመርጡትን ከተዘረዘሩት አራት አማራጮች ውስጥ በአሁኑኑ አንድ ሳምንት ውስጥ እርሶን በይበልጥ ይገልጻል በማህት የሚመርጡትን በማክበብ መልስ ይስጡ። የ መለኪያ ደረጃ እንደሚከተሉት ተዘርዘርዋል:

- 0 ፈጽሞ የእኔን ሁኔታ አይገልጽም (አልቀበለውም)
- 1 አንዳንድ ጊዜ (አልፎ አልፎ)
- 2 ብዙ ጊዜ (በተደጋጋሚ)
- 3 እጅግ በጣም ብዙ ጊዜ (ሁል ጊዜ)

ቁጥር	ዕረፍተ-ነገሮች	1	2	3	4
1	መጨነቅ በማቆም ዘና ለማለት ይከብደኝ ነበር				
2	አፌ ሲደርቅ ይታወቀኝ ነበር				
3	ምንም እይነት ጥሩ ስሜት እየተሰማኝ አልነበረም				
4	ለመተንፈስ አቸገር ነበር (ለምሳሌ-ከልክ ያለፈ ቶሎ ቶሎ መተንፈስ፣ ያለምንም አካላዊ እንቅስቃሴ ትንፋሽ ማጣት)				
5	ማንኛውንም ነገር ለማካናወን ተነሳሽነትን አጣለሁ				
6	አንዳንድ ነገሮችን ከተገቢው በላይ አጋንንናለሁ				
7	መንቀጥቀጥ አጋጥሞኛል(ለምሳሌ-እጅ ላይ)				
8	ብዙ የነርቨስ (ስሜታዊ) ጉልበት እንደተጠቀምኩ ይሰማኛል				
9	አንዳንድ አጋጣሚዎች ላይ ተጨንቄ እራሴን እንዳላዋርድ አስጋ ነበር				
10	ምንም ወደፊት የሚያጓጓ ነገር እንደሌላሁኝ ይሰማኛል				
11	የመንፈስ መረበሽ ውስጥ እራሴን አገኘዋለሁ				
12	የመዝናናት መንፈስ ውስጥ መግባት ይከብደኛል				
13	የሀዘን ስሜት ይሰማኝ ነበር				
14	ከማንኛውም አያደረኩት ከነበረው ነገር የሚያስቆመኝን ነገር መታገስ አልቻልኩም				
15	ልረበሽ ትንሽ የቀረኝ እንደሆነ ይሰማኛል				
16	ለማንኛውንም ነገር በጥሩ ስሜት ማየት አቅቶኝ ነበር				
17	እንደ ሰው ምንም የማልረባ መስሎ ይሰማኝ ነበር				
18	ትንሽ የሚበቃው እንደሆንኩ ይሰማኛል				
19	የአካል እንቅስቃሴ በሌላው የልቤን ድርጊት አስተውል ነበር(ምሳሌ-የልብ ምት መጠን መጨመር፣ የልብ ምት መዘለል)				
20	ያለምንም ምክንያት ፍርሃት ይሰማኛል				
21	ህይወት ትርጉም እንደሌላሁ ይሰማኛል				

