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**A COMPARATIVE STUDY OF BURNOUT AND COPING  
STRATEGIES BETWEEN HIV COUNSELORS: FACE TO FACE  
AND ONLINE COUNSELING SERVICES IN ADDIS ABABA**

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## **ACRONYMS**

- AIDS – Acquired Immune Deficiency Syndrome
- COPE –Coping Orientation for Problem Experienced
- COR – Conservation of Resources
- CRDA- Christian Rehabilitation and Development Association
- DP – Depersonalization
- EE- Emotional Exhaustion
- FGD- Focus Group Discussion
- FHI- Family Health International
- HIV- Human Immune Virus
- MBI-HSS- Maslach Burnout Inventory – Human Services Survey
- MOH – Ministry Of Health
- GO- Governmental Organization
- NGO- Non Governmental Organization
- NHS- National Health Service
- OSSA- Organization of Social Services for AIDS
- PA- Personal Accomplishment
- SPSS- Statistical Packages for the Social Science
- STI'S- Sexually Transmitted Infections
- TB – Tuberculosis
- UNAIDS- United Nation Agency for International Developments
- VCT- Voluntary Counseling and Testing

## **Abstract**

*The purpose of this study was to compare burnout and coping strategies between HIV counselors in face to face and online counseling settings in Addis Ababa. The study was design quantitative and qualitative. For the quantitative data the participant were selected in a proportional stratified sampling technique included 64 face to face and 47 online HIV counselors in both counseling settings. In addition, 23 participants were selected a random purposive sampling technique to offer qualitative data from both counseling settings. For the purpose of gathering the quantitative data, the instruments namely: demographic questionnaire, Maslach Burnout Inventory and the COPE questionnaire were used to gathered quantitative data. Qualitative data was also gathered in the FGD Guide and Interview Guide.*

*Thus, this study revealed that HIV counselors in online counseling settings scored high on emotional exhaustion (30.3), depersonalization (13.53) and low in personal accomplishment (28.72) dimensions of burnout as compared to HIV counselors in face to face setting emotional exhaustion (26.21), depersonalization (11.71) and personal accomplishment (32.78) of burnout dimensions. And the difference was statistically significant in emotional exhaustion ( $t=-2.55$ ,  $p<.05$ ) and personal accomplishment. ( $t=-2.5$ ,  $p<.05$ ) dimension. But there was no a significant difference on depersonalization dimension of burnout between the two groups. In addition, a statistically significant difference was found on problem focused coping strategy ( $t=2.15$ ,  $p<.01$ ) between the two groups. No statically significant was found in emotion focused coping strategy in both groups. Statistically negative correlation was observed between some demographic variables such as age with emotional exhaustion ( $r=-.249$ ,  $p<.01$ ), age with depersonalization ( $r=-.289$ ,  $p<.01$ ) dimensions of burnout and years of experiences and personal accomplishment ( $r=-.253$ ,  $p<.01$ ) dimension of burnout. A statistically positive correlation was also observed between average number of clients served per day and emotional exhaustion ( $r=.233$   $p<.05$ ) in both groups. A statistically positive correlation was found between sex and emotional focused coping strategy at ( $r=.202$ ,  $p<.05$ ) and problem focused coping strategy at ( $r=.247$ ,  $p<.01$ ) respectively. Lastly, a significant positive correlation was also observed in the emotional exhaustion dimension of the burnout and the emotional focused coping strategy at ( $r=.263$ ,  $P.<.01$ ) in both groups. Generally, this study has shown that HIV counselors suffer from moderate to high level of burnout and online HIV counselors reported that they used frequently emotional focused coping strategy while face to face HIV counselors used problem focused coping strategy. Based on the findings, conclusions were made and recommendations were forwarded.*

# CHAPTER ONE

## INTRODUCTION

### 1.1 Background of the study

The complex and chronic nature of HIV/AIDS causes multiple challenges for both HIV counselor and healthcare professionals who treat individuals with this disease. It has been documented that many HIV counselors working with these individuals to be emotionally exhaustion and this goes over time, can lead to the experience of stress and burnout (Bellani et al., 1996). Research has suggested that burnout is a serious problem in the area of HIV counselors. Given the numerous psychosocial issues affecting the HIV-infected individual over the issues of the disease, HIV counselors have increasingly occupied important roles in the comprehensive counseling services for HIV clients. By helping HIV/AIDS individuals discover more effective ways to cope with medical and psychosocial stressors, and by addressing various social and economic needs, HIV counselors have the key positions to help HIV-infected individuals maximize their quality of life while living with this chronic and often debilitating disease (Miller, 1995).

In the past, the effect and the consequence of burnout was not considered as major problems of helping professions. However, in recent days more organizations realize that the burnout has effect on employees' health (Minirth et al., 1986). Although, the presence of work place stressors does not automatically result in the negative impact on individuals, such as stress and burnout, for instance, aspects like various coping strategies could have a moderating effect on the level of burnout that is experienced by the individuals (Dewe and Trenberth, 2004). So, it could be argued that the ability of the individual to manage their emotions could have a potential impact on the relationship between

clients, colleagues and supervisors which could reflect the quality of work and their health. It is therefore, vital for organizations and counselors to develop strategies which will be enable them to identify possible workplace stressors and an effective deal with these stressors. It is also important to identify possible factors that may moderate the effect of stress and consequently the development of burnout among helping professions on the workplace (Cooper et al., 2001.)

Stress has created the interactions with the characteristics of the employee such as the demands of the work exceed the ability of the employee to cope with them (Ross et al., 1989). Therefore, burnout is the final response to cumulative, long term negative stress and it is a reaction of progression of unsuccessful attempts to cope with variety of negative stressful events (Powell, 1993). In addition, excessive job demands, lack of proper performance recognition, unclear performance expectations, role conflict, and poor attitudes toward work, emotional distress, and frequent physical symptoms seem to be the most significant features that correlate with burnout. In helping professionals such as counselors, therapists, social workers and doctors are susceptible to burnout (Minirth et al., 1986).

Burnout is recently noted phenomena in the helping professions. Different literatures report that they occur in therapists, counselors, physicians, health workers, teachers and graduate students. Due to the medical and psychosocial complexities of HIV/AIDS, especially HIV counselors are often experienced with multiple challenges when working with clients with this disease, which may make them more vulnerable to burnout (Family Health International, 2004). Furthermore, the telephone counseling services result in particular kinds of problems for the HIV counselors that are less common in face-to-face counseling. These services have stimulated the interest of problematic callers. The most

outstanding examples here are the problematic callers. Many telephone counseling services receive calls from males who wish to talk to a female while masturbating. In addition, particular problems are raised by the chronic caller, the client who calls several times every day, the silent caller that the client, who calls but who refuses to say anything and the nuisance or prank callers these generally are stressful tasks for HIV counselors (UNAIDS, 2002).

The reasons to conducted this research was that there are little local researches has been done so far on the burnout and coping strategies among HIV counselors. However, the researchers did not study burnout and coping strategies between HIV counselors in face to face and online counseling setting. Since, I have seen working as HIV counselor in face to face and online counselor; I have observed that many HIV counselors experienced burnout. Therefore, the present study was intended to examine the levels of burnout among HIV counselors and to investigate if there was the significant difference on burnout and coping strategies between HIV counselors in face to face and online counseling settings.

## **1. 2. Statement of the Problem**

Counseling psychology is one of the most popular careers in the human services profession that involve dealing with people with varying degrees of psychosocial problems. This type of excessive involvement with clients can be extremely stressful (Maslach, & Schaufeli, 2001). Human service professionals generally enter the service with the goal of contributing to the welfare of humanity. However, it also happens that the professionals are sometimes labeled as uncaring, distant and pessimistic. This also affects the services that the professionals are striving to provide, and negatively influences the clients that so greatly needs their help. These unhelpful behaviors on the part of the professionals are caused by the

severity of the stress that they experience as a result of the intense contact with clients (Cherniss, 1980).

In different work settings, many professionals execute their daily routine work; it is inevitable to see human service professions with different emotions regarding their job. For example, there are a number of HIV counselors who are providing counseling services to the clients on face to face and online. These HIV counselors experienced different challenges in the counseling process because clients need to talk about their risk behaviors and risky environment currently feeling and future plans. As far as individual difference is concerned, HIV counselors perform their job differently. Since, I realized that such kind of circumstances will have chronic stress which can possibly cause of burnout. I also think that the consequences of this burnout will be potentially a very serious challenge for HIV counselors, their clients and counseling providing organizations at large. And again this may lead to deterioration in the quality of the service provided by the HIV counselors and negatively influences the clients who are in need for a help. It was this my observation and experiences that initiated me to develop the idea to conduct a research on comparative study of burnout and coping strategies among HIV counselors in face to face and online counseling settings.

Particularly, the study was intended to answer the following questions.

1. What is the level of burnout on HIV counselors in face to face and online counseling settings?
2. Is there a statistically significant difference in the levels of burnout in the dimension of (emotional exhaustion, depersonalization, and personal accomplishment) between HIV counselors between face to face and online counseling settings?

3. Is there a statistically significant difference in use of the emotional and problem focused coping strategies between HIV counselors in face to face and online counseling settings?
4. Is there any a statistically significant relationship between demographic variables (i.e. age, sex, average numbers of clients served per day and years of experiences) with burnout in the dimension of (emotional exhaustion, depersonalization, and personal accomplishment) between HIV counselors in face to face and online counseling settings?
5. Is there any a statistically significant relationship between demographic variables (i.e. age, sex, average numbers of clients served per day and years of experiences) with problem and emotional focused coping strategies between HIV counselors in face to face and online counseling settings?
6. Is there any a statistically significant relationship between the three dimensions of burnout (emotional exhaustion, depersonalization, and personal accomplishment) and the problem and emotional focused coping strategies?

### **1.3. Objective of the Study**

The general objective of this study was to compare burnout and coping strategies between HIV counselors who are currently employed in face to face and online counseling services in Addis Ababa.

The specific objectives of this study were the following:

- To investigate the level of burnout between HIV counselors in face to face and online counseling settings.
- To examine if there is a statistically significant difference between HIV counselors with respect of burnout dimensions in face to face and online counseling settings.

- To investigate if there is a statistically significant difference between HIV counselors in the use of emotional and problem focused coping strategies in face to face and online counseling settings.
- To examine the a statistically significant relationship between demographic variables (i.e. age, sex ,average numbers of clients served per day and years of experiences) with the dimensions of burnout (emotional exhaustion, depersonalization, and personal accomplishment) between HIV counselors in face to face and online counseling settings
- To examine a statistically significant relationship between demographic variables (i.e. age, sex, average numbers of clients served per day and years of experiences) with two categories of problem and emotional focused coping strategies.
- To determine the a statistically significant relationship between the three dimensions of burnout (emotional exhaustion, depersonalization, and personal accomplishment) and the two categories of problem and emotional focused coping strategies

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

This study will have direct significance to HIV counselors, HIV counseling organizations, clients, and other concerned bodies in many respects. Therefore, this study was considered significant for the following reasons.

- Since counselors feel more stressed with counseling a person with HIV related issues, the findings will provide with opportunity for them to take a look for the likely hazards of burnout so that they can be assisted to prevent themselves and to use their potential at a maximum possible.

- Organizations which provide in face to face and online counseling services may be benefited from the present study by making use of the findings to assist their employees to cope up with their burnout. Special privileges, incentives as well as on job trainings and work leaves as part of strategy may be taken on to these organizations to reduce the extent of HIV counselors' burnout.
- Further more, the result of the study helps to bring about pertinent data for designing viable burnout intervention, coping strategies as well as management programs for the concerning bodies which operate against the burnout of HIV counselors.

### **1.5. Delimitation of the Study**

This study was delimited to burnout and coping strategies as experienced by HIV Counselors currently employed in some face to face and all online HIV counseling settings in Addis Ababa. In addition, the scope of the study was delimited to face to face and online HIV counselors who are providing counseling services on HIV/AIDS, and related issues. HIV Counselors who are out of Addis Ababa were not being incorporated as participants in the study.

### **1.6. Limitation of the Study**

- The researcher believes that one limitation of this study is that some moderator variables such as social support, individual personality type, lifestyles, income etc., would affect the research result.
- Taking a lot of sample would have been profitable if this study had incorporated large sample size. But it was conducted owing to limited sample size time and financial constraints.

### **1.7. Operational definition of the study**

1. Burnout- is a reaction of chronic occupational stress which is characterized by a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment which occurs in HIV counselors who are providing counseling services (Maslach & Leiter, 1997).
2. Emotional Exhaustion: feeling emotionally exhausted by HIV counselors during the provision of the counseling services
3. Personal Accomplishment- HIV counselors' feeling of competence and accomplishment during the provision of counseling services.
4. Depersonalization- Refers to HIV counselors' loss of feelings and concern toward clients.
5. Coping Strategy – HIV Counselors' response to reduce and develop a strategy to learn to tolerate stressful situations encountered during stressful situation
6. Face to Face Counseling – The type of counseling service which involves provision of HIV counseling service to the client at VCT centers at the presence of both the client and the counselor in counseling room .
7. Online Counseling – The type of counseling service which involves providing HIV counseling service to the client in a telephone.
8. Problem Focused Coping Strategy- HIV counselors' action to alter the sources of the stressful situation during counseling provision.
9. Emotion Focused Coping Strategy- HIV counselors' conscious or unconscious strategy which involves altering, redirecting emotion, belief or thought so as to managing emotional distress associated with stressful situation.

## **CHAPTER TWO**

### **REVIEW OF RELATED LITERATURE**

#### **2.1 Overview**

In this section, the prior research findings related to burnout and coping strategies related HIV counselors in particular are reviewed. The review of related literature is organized in a number of sub sections as clearly indicated below. The general orientation, Meaning, definition and characteristics are presented in the first part. Theories or models of burnout and coping strategies are discussed. Next to this, empirical information of burnout and coping strategies with related to the levels, significant difference and the relation between the burnout and the coping strategies with different demographic variables like age, sex, work experience and average numbers of clients or caseload are seen. Finally, summary and the implications to the study are indicated.

#### **2.2. HIV /AIDS in Ethiopia**

The HIV pandemic created an enormous challenge to the survival of mankind worldwide. With a national adult HIV prevalence of 2.1%, Ethiopia is one of the countries most severely hit by the epidemic. Besides the dominant heterosexual transmission, vertical virus transmission from mother to child accounts for more than 90% of pediatric AIDS. According to the fifth Report of AIDS in Ethiopia, HIV/AIDS is claiming an estimated toll of as many as 115,000 lives a year and it is believed that this annual death toll could reach 200,000 unless effective prevention and treatment strategies are made available. Thirty percent of adult (15-49 years of age) deaths have been attributed to HIV/ AIDS, while the epidemic has resulted in an estimated 539,000 orphans (FMOH, 2006).

### **2.3. Face to Face Counseling**

In Ethiopia, HIV counseling service began in the late 1980s. In the early 1990s several trainings at the national level were conducted by the Ministry of Health (MOH), Christian Relief and Development Association (CRDA) and Organization of Social Services for AIDS (OSSA) for nurses and social workers from all regional hospitals and in Addis Ababa. About 3000 HIV counselors were trained. The National AIDS Council Secretariat in collaboration with International Partners' has recently produced national guidelines on VCT (FHI, 2004). Voluntary counseling and testing (VCT) for HIV infection is a process for providing individuals or couples with an HIV test. VCT consists of pretest counseling about whether to take an HIV test and what one's personal risks are for HIV infection. Clients work with the counselor during the counseling session to develop life plans for behaviors that protect themselves and others from HIV transmission and they receive referrals for needed services (FHI, 2004). Interviews and observations conducted among 25 HIV counselors in Uganda indicate that delivering VCT services to HIV clients was a stressful job. In addition to all the issues HIV counselors normally face with clients, clients have some special issues as well. Many come to the service with multiple serious problems that the counselor cannot solve. Especially, young clients tend to be uncertain and highly emotional in counseling sessions. Counselors report frustration with youth, identification with the problems that youth present, and sorrow over having to give some youth the news that they are HIV -positive (UNAIDS, 2002)

### **2.4. Online Counseling**

Online counseling expanded throughout developed countries in the 1970s to providing education and counseling on a wide range of controversial issues such as rape, drug use or suicide. By the early

1980s, when HIV/ AIDS first emerged, online counseling was already well established as a means of communication and offering support. The earliest HIV/AIDS online counseling started in American cities where the disease first appeared San Francisco and New York and targeted the gay community (UNAIDS 2002).

In Ethiopia the online service, that is, the hotline services were introduced by OSSA in 1995 since the organization has given the services in the limited extent. And Wegen AIDS Talkline (952) was established in 2004, and can be dialed toll-free from any where in Ethiopia. It responds to calls from people living in Ethiopia who seeks information and counseling on HIV/AIDS, sexually transmitted infections (STIs) and tuberculosis (TB) related issues. The Talkline offers anonymous and confidential service which allows callers to speak freely about sensitive issues without embarrassment. With the increased demand of callers (over 7,000 calls a day), Wegen Talkline has expanded its service to nationwide coverage, with 24 telephone lines, and in 10 languages. The Talkline is operational 16 hours a day and is staffed by over 90 counselors. However, the HIV Counselors are faced with very serious, difficult and emotionally trying calls every day (Wegen AIDS Talkline, 2009).

Currently in different countries call rates are expected to increase. Therefore, call for a full complement of counselors and support staff. The problem does; however, tend to have affected toll-free services more severely since prank and malicious callers do not have to pay for the calls themselves. Prank calls earn telephone charges, waste counselors' time, and frustrate and de motivate counselors. Counselors express frustration in dealing with these kinds of calls (UNAIDS, 2002).

## **2.5. Theoretical Models of Burnout**

### **i. Job Demands–Resources Model of Burnout**

According to this model, burnout may arise as a consequence of an imbalance between job demand and job resource models. Job demand refers to the physical, social, or organizational aspects of the job that requires sustained physical or mental effort. Therefore, it is associated with physiological and psychological cost (i.e., exhaustion). Job resources refer to those physical, psychological, social, or organizational aspects of the job that may do any of the following: (a) be functional in achieving work goals, (b) reduce job demands and the associated physiological and psychological cost, or (c) stimulate personal growth and development (Edward & Cooper, 1990).

### **ii. Process Model of Burnout**

Cherniss (1980) suggested a process model of burnout where aspects of the work environment and the characteristics of the individual are both viewed as sources of strain. Individuals choose to deal with these aspects in different ways, which could include negative attitudes towards the situation e.g. reducing work load, taking less responsibility for work outcomes, or becoming detached from work (Cooper et al., 2001).

### **iii. Multi-Dimensional Model of Job Burnout**

The development of the Maslach burnout model started through extensive interviews with individuals employed in human service occupations. In developing this model, the aim was to go beyond traditional research and literature on job stress, by extending the scope beyond the experience of stress that is emotional exhaustion, to include a person's response to the job or depersonalization and the response in the person self that feelings of inefficacy or personal accomplishment (Maslach & Leiter, 1997). The dimension of emotional exhaustion

represents the basic stress response, as referred to in other stress-related research, which shows positive correlations with aspects such as role overload and stress related problems. The depersonalization dimension refers to the detached, negative feelings felt towards aspects of the job and other people, as a response to the stress experienced. This dimension is not commonly found in other stress models and according to Maslach (2003) this represents the key feature of the burnout phenomenon. The way in which the third dimension, feelings of inefficacy or a "lack of personal accomplishment" relates to the other two dimensions in the model, is dependent on the situation and can either be viewed as a consequence of exhaustion or cynicism or in some cases these feelings seem to develop sequentially. Maslach (2003) further explains the construct by arguing that the way in which the three dimensions of burnout relate to the various workplace variables within the organizational setting e.g. lack of resources and information, working relationship, insufficient time, heavy work demands. Research seems to suggest that exhaustion and cynicism mostly manifests as a result of work overload and interpersonal conflict, whereas a sense of inefficacy most likely results from a lack of resources or support (Maslach, 2003). Consequently, the variation in the manifestation of these dimensions will result in different patterns of the appearance of burnout.

#### **iv. Phase Model**

Golembiewski and Munzenrider (1988) developed a model similar to Maslach's burnout model, but proposed that the second component in the Maslach model, depersonalization, should be the first phase in this model. It is argued that depersonalization constitutes the manifestation of burnout and consequently impairs performance. Golembiewski further argued that depersonalization and lack of personal accomplishment will exceed the individuals coping ability and then result in emotional

exhaustion. Emotional Exhaustion would then represent the most powerful stage in the development of burnout (Cooper et al. 2001). The phase model inherently suggests that burnout becomes more evident as the individual moves through depersonalization to reduce sense of personal accomplishment to emotional exhaustion. Therefore, the development of emotional exhaustion is strongly related to the progression of burnout. Hence, individuals in the more advanced phases will experience more severe symptoms and consequences than those in the earlier phases (Cooper et al., 2001).

#### **v. Conservation of Resources (COR) Theory**

The Conservation of Resources Theory (COR theory) suggests that individuals have access to four main categories of resources: objects e.g. house, cars, and furniture, conditions e.g. relationships, steady jobs, personal characteristics e.g. self-esteem and forms of energy money, favors. It is argued that the potential loss of these resources, the loss of resources or failure to regain resources following resources investment, threaten individuals and subsequently result in stress. The theory further proposes that burnout can develop, when resources are lost or when resources are inadequate to meet the burden the individual faces. Burnout will result where a continuous loss of resources is evident and not as a result of a single event (Cooper et al., 2001).

### **2.6. Dimensions of Burnout**

#### **i. Emotional Exhaustion**

The first component of burnout is emotional exhaustion. Emotional exhaustion is considered to be the most significant of the three components. It is characterized by a lack of energy and a feeling that one's emotional resources are used up. This may coexist with feeling of frustration and tension (Cordes & Dougherty, 1993). Maslach & Leiter,

(1997) state that emotional exhaustion refers to feelings of being emotionally overextended and drained by one's contact with other people. This emotional exhaustion can be noted in physical characteristics such as waking up just as tired as when going to bed, or lacking the required energy to take on another task or face to face encounter (Maslach & Leiter, 1997).

Several determinants of emotional exhaustion have been defined by Cordes and Dougherty (1993). The three most important ones (work overload, role conflict and interpersonal relationships) are discussed below.

The first, work overload is defined as the perception of too much work to accomplish in the time available (Powell, 1993). This is perhaps the most obvious indication of a mismatch between the person and the job. There is just too much to do in inadequate time with insufficient resources. Role conflict is the second source of emotional exhaustion. The over enthusiastic new employee at the new job may expect his/her job to be full of challenging expectations and he/she may anticipate many rewarding experiences.

These expectations can be in conflict with those individuals already within the organization. Integration these differences can lead to frustration and emotional exhaustion (Jackson & Schuler, 1986). Personal expectations can also further add to emotional exhaustion. Having unrealistic expectations of the job that one has newly undertaken and realizing that these expectations are not met, further to this frustration. Individuals, who are highly committed to their careers and view them as the centre of their lives, are also more likely to experience emotional exhaustion. The third source of emotional exhaustion is interpersonal relationships which are the root of the helping professions.

This can lead to emotional exhaustion, especially when the relationships are very intense and emotional (Maslach & Leiter, 1997).

### **ii. Depersonalization**

Depersonalization is the second component of burnout. It occurs as a direct response to the stressors of the job. It is characterized by a detachment from work and people. For those who work closely with people on a daily basis, this is demonstrated by treating people as impersonal objects (Maslach & Leiter, 1997).

### **iii. Personal Accomplishment**

The third and final component of burnout, which is described as a feeling of reduced personal accomplishment, is characterized by the individual developing a negative view of him/her and his/her ability to do their job. He/she feels inadequate and unproductive, which has a direct effect on the quality of the work produced (Cordes & Dougherty, 1993). When a professional feels inadequate and uncertain, it adds to the stress and strain him or her experiences. He or she then tends to develop a strong need for reassurance from others or becomes overly thorough in his or her work. When his or her needs continue, a sense of embarrassment and confusion sets in the helping professions, and this can impact on the relationship between client and counselor, and can lead the client to prematurely terminate the counseling relationship (Cordes & Dougherty, 1993).

According to Freudenberger, (1975) counselors' own behaviors can elicit negative outcomes such as resistance and dropping out. Thus the client will ultimately receive a lower quality of care and often discontinue with counseling as he or she becomes discontented with the level of care he or she is receiving. A good relationship between the counselor and the client is the core of the helping professions, and tends to be a major

source of gratification for the therapist. However, if a sound relationship is not built, this can cause difficulties whilst working with clients and contribute to the strain and stress experienced by the therapist, and ultimately to burnout. The difficulties include factors such as clients not being satisfied with the level of intervention received and expecting or demanding more than the professionals can deliver (Meichenbaum & Turk, 1987).

Burnout can have many negative consequences such as stress -related illness, interpersonal problems, increased use of alcohol and drugs and behavioral problems. Burned-out workers also tend to neglect important aspects of their jobs or provide a lower level of service (Freudenberger, 1975).

## **2.7. Coping Strategies**

Lazarus and Folkman (1984) have defined coping as cognitive and behavioral efforts to manage specific external and/or internal demands that are assessed as challenging or exceeding the resources of the person. Coping has been divided into either problem-focused coping, whereby the focus is upon dealing with the task at hand, or emotion-focused coping, where the person attempts to deal with the negative emotional experience (Cosway et al., 2000). It is therefore, necessary for the individual and the organization to be able to identify the sources of stress in the workplace to enable individuals to find suitable ways to deal with these stressors, before it results in destructive behaviors or actions. Furthermore, various experiences in life may produce desirable or undesirable amounts of stress. Many individuals are stimulated by a moderate amount of stress while an excessive amount of stress may create emotional, social, and physical ailments (Rupert & Morgan, 2005). Coping can be seen as something that one does to deal effectively with a stressful event. Although one stressor after another can have long term

negative effects on a person; it can also be argued that if the person can cope, or deal effectively with the series of stressors, he or she may emerge much more resilient and competent than an individual who has not had to deal with as much stress during his or her lifetime and effective coping can change a stressful event into a more manageable one (Cartwright & Cooper, 1997).

Lazarus (1986) identified two types of coping. Problem-focused coping is aimed at actively solving a problem, while emotional focused coping is aimed at reducing emotional distress. Most types of stress usually require a combination of the two types of coping, although generally, individuals tend to use problem-focused coping when they feel that they can do something constructive to deal with the stress effectively. Emotion-focused coping is utilized when the person feels that the stress is unmanageable. Protective factors are the competencies and characteristics of the individual, family or community that buffer or modify the impact of the stressors. Protective factors enable the skilled adaptation and development of individuals and families (Cooper et al., 2001).

Coping is manageable as long as the stressors do not outweigh the protective factors. Resources are defined as sources of social support for the individual. They can be seen as a social division of protective factors. Adjustment is commonly viewed as a short-term outcome of coping efforts (Lazarus & Flokman, 1984).

Active coping strategies such as problem-solving coping and seeking social support, are considered as adaptive whilst avoidance coping strategies such as denial and escaping are considered as maladaptive coping styles. The use of avoidance coping strategies is considered as a risk factor for stress. The repetitive use of active coping strategies leads to adaptation. Adaptation refers to a long-term process in which the

individual acquires an enduring feeling of being at ease with a new situation. Adaptation is the outcome of the joint process of coping efforts and the utilization of available protective factors or resources. Protective factors and coping processes could be seen as an inter-related system or a feedback loop. The more one utilizes the available, adequate protective factors to deal with the stressors, the better one can cope with difficulties. Once an appraisal is made of the stressful situation, the individual makes a valuation of the outcome of the situation and evaluates whether the consequences are going to be harmful, threatening, or whether the situation is going to pose a challenge, and what resources are available to deal with it. The intent of the outcome, along with the action itself determines the outcome. The appraisal of the situation, the coping style utilized, and the evaluation of the outcome determine what strategies the person will use, and what will become part of the individual's coping selection. Each successful coping attempt strengthens the belief of the person in respect of his/her internal locus of control. In addition, a positive self-esteem is reinforced in the person, and enables him/her to utilize more adaptive coping strategies in the future (Tamres et al., 2002). In terms of managing the experience of work stress, it is generally acknowledged that coping behaviors play an important role in mitigating the negative effects of stress. Obtaining knowledge about how different individuals are likely to cope with work stress may therefore aid organizations that wish to reduce the likelihood of negative stress-related outcomes. Accordingly, more research is required to help understand and predict the strategies and processes people use to cope with work-related stress (Cartwright & Cooper, 1997).

### **2.7.1. Dimensions of Coping**

Two broad approaches to coping are often distinguished: problem focused and emotion-focused coping. According to Tamres et al., (2002) problem-focused coping involves active and deliberate attempts to deal

with a stressor. Emotion-focused coping aims at reducing unpleasant emotions resulting from the stressor for example, accepting responsibility, seeking support from others, denial, and turning to religious. Although this dual categorization is widely used, it is by no means universally accepted (Skinner & Sherwood, 2003). Several writers have identified a third basic dimension: avoidance-focused coping (Endler & Parker, 1990). This third dimension encompasses strategies focus on and venting of emotions, behavioral and mental disengagement. This scale measures coping responses that arguably less useful (Carver et al., 1989). Based on this reason, the current study examined the differences in coping selection from a two-dimensional perspective, between problem and emotional -focused coping strategies.

## **2.8 Empirical Framework of Burnout and Coping Strategies**

### **2.8.1. Causes and Consequences of Burnout**

The worker-client relationship and client problem has a great contribution of burnout (Rupert & Morgan, 2005). They concluded that the characteristics of the employee-client relationship are the most critical antecedent to burnout. A key argument in suggestions that burnout applies only to human service providers is that it is the experience of working with people, and especially with individuals who are suffering, angry, or difficult to help, that is the core of the burnout phenomenon. Numerous studies have examined the employee-client relationship and its association with burnout. Caseload has been divided into quantitative such as frequency of contact, duration of contact, number of interactions, and percent of time spent with clients and qualitative dimensions, such as interpersonal distance e.g. phone contact versus face to face, and client characteristics such as chronic versus acute, child versus adolescent or adult. The findings quite consistently indicate, thus Client interactions that are more direct, frequent, or of

longer duration for example, or client problems that are chronic versus acute are associated with higher levels of burnout (Cordes & Dougherty, 1993).

### **2.8.2. Level of Burnout in Human Services Professions**

Burnout has been experienced by all kinds of professionals like teachers, counselors, policemen. However, the extent of burnout levels might differ from one another. The extent of burnout in professionals who perform care and support in the areas of direct involvement with clients may be higher than the other professionals (Maslach, 2003).

The study done by Bellani et al., (1996) from the sample of 474 female nurses participated as respondents in Turkey showed that nurses exhibited a moderate level of emotional exhaustion with a mean of 17.99 as compared with the range of 17-26 taken as average burnout in MBI score. And a lower level of burnout experiences in depersonalization subscale 5.72 as compared with the range of  $\leq 6$  taken as low burnout in the MBI score and high burnout experience in personal accomplishment subscale 19.83 as compared with the range of  $\leq 3$  taken as high burnout syndrome in MBI score.

Another study conducted in counseling staff in the University of Iowa the burnout levels were elevated due to the significantly low scores obtained on the personal accomplishment scale and the moderate scores obtained on the depersonalization scale. However, the stress levels of the participants were high; the levels of burnout of the participants were not significantly high as expected. When each of the three subscales was examined separately from one another, there are indications that the participants have elevated levels of burnout. This is due to the significantly low scores obtained on the personal accomplishment subscale and the high scores obtained on the emotional exhaustion and depersonalization subscales. What is interesting is that a large number

of the psychologists obtained low scores on the personal accomplishment scale, indicating that they view themselves and their ability to do their jobs in a negative way (Ross & Sastry, 1999).

### **2.8.3. Organizational Variables associated with Burnout**

In a 1998 survey of nurses specialized in AIDS care and counseling, 36% identified workplace-related stressors, which involved staff conflicts and workload. Similar findings were reported in a study of physicians caring for HIV/AIDS patients. Work overload and social relationships with colleagues, supervisors, and administrators were the main predictors of burnout (Freudenberger, 1975). In a recent study of counseling staff working in AIDS service organizations in New York City, paperwork and inadequate salaries were cited as main sources of burnout (Ross & Santry, 1999).

### **2.8.4. Predictors of HIV Counselors Burnout and coping strategies**

Several factors have been identified as increasing the risk of burnout in counselors involved in HIV/AIDS counseling. Younger counselors are more likely to experience burnout than are older counselors. This may be due to their lack of experience as well as to being over involved in their jobs. Older counselors were more likely to feel that they have personal control over their workplace stress, and they also were more likely to use effective coping strategies (Trivette, 1993). Furthermore, there did not appear to be any significant differences in burnout based on the following variables: Sex, marital status, sexual orientation and years in HIV/AIDS counseling (Lieter, 1991). However, those who are dissatisfied with their work role and workload and who do not feel mastery over their jobs are at increased risk for burnout; as a result, they may avoid clients. Counselors who were supported by their organizations or institutions were contribution and care about their well-being, listen to their

complaints, help them with their work-related problems, and treat them fairly (George & James, 1993). Less organizational support including less support from supervisors and coworkers is linked to burnout. Furthermore, HIV counselors do not always receive adequate support from supervisors and friends for choosing to work with HIV/AIDS clients, and this can contribute to burnout (Miller, 1995).

### **2.8.5. Burnout and Coping Strategies in Work Settings**

Oginska, (2006) conducted a study examining burnout among psychiatric nurses working in the Australia. The subjects were psychiatric nurses ( $N = 510$ ) employed in a Scottish National Health Service (NHS) trust, which included a range of acute hospital and community settings. Several instruments were utilized to measure, burnout and their coping strategies. The psychiatric nurses in this study had significantly lower levels of burnout as compared to the normative data. Another study about self-image and burnout among psychiatric staffs was conducted by Pines (2000) in Sweden. Data were collected from mental health workers ( $N = 754$ ) employed in a variety of mental health care settings, including psychiatric wards, small psychiatric-treatment homes, forensic wards, and community care centers. The researcher discovered that highly burned-out individuals had a significantly more negative self-image than staff who had rated themselves as experiencing low levels of burnout. A managed health care setting was assessed for burnout rates by (Snibbe et al., 1989). Primary care physicians and psychiatric clinic staffs were given the Maslach Burnout Inventory (MBI). For primary care physicians, a moderate level of emotional exhaustion and depersonalization were found while personal achievement was high. For psychiatric staff, a high level of emotional exhaustion and depersonalization were found while personal achievement was low. This entire sample had higher rates of emotional

exhaustion and depersonalization and lower rates of personal achievement than Maslach's normative sample for the MBI. Psychiatrists and social workers had significantly higher rates on the depersonalization scale than primary care physicians and psychologists. The other study was conducted by (Jenaro et al., 2007). The study was with child protection workers and in-home caregivers. This study showed that employees with less burnout tend to use adaptive, active or problem focused strategies more frequently than passive or emotional focused coping strategies.

## **2.9. The Relationship between Demographic Variables with Burnout and Coping Strategies**

### **2.9.1. Burnout and Coping strategies across Age**

Research examining age as a variable in the interaction of burnout and coping has had inconsistent findings. Coping mechanisms were found to be utilized less by younger workers than by older workers, with the exception of Social Support which appears to remain relatively stable throughout the life. However, age was not shown to be a factor that was correlated with burnout and coping in a sample consisting of 153 participants (Fogerty et al., 1999). Age was not found to be a significant variable for elementary school counselors on stress and strain measures, however results indicated that older counselors had higher coping scores than younger ones (Trivette, 1993). This indicates at least some coping strategies are better utilized by older counselors as compared to some younger counselors (Trivette, 1993). Ryan (1996) reported that counselors aged 28-37 scored significantly higher than counselors aged 47-79 on burnout.

### **2.9.2. Burnout and Coping strategies across Sex**

Results from studies have been inconsistent and thus the issue of sex continues to be of interest. Sex has not consistently been shown to be a significant variable and research has shown few differences between males and females (Decker & Borgen, 1993). Fogerty et al., (1999) also did not find sex to be significantly correlated with burnout and coping. However, a study by Marini et al., (1995) found that males scored significantly higher from females on occupational stress. These results indicate that males may experience burnout differently than females. Niles and Anderson (1993) found that males and females scores on the burnout differed substantially indicating that have sex an impact on how burnout is experienced.

The other report also indicated that female counselor reported average scores for, burnout, and coping strategies; men also reported higher stress and burnout scores and lower coping scores (Niles & Anderson, 1993).

Past theories about sex and coping have proposed that men and women cope in different ways (Endler & Parker, 1994). For example, it has long been considered that men are more likely to confront problems directly or to deny or avoid their existence, whereas women have a more emotional response to stress and prefer to seek social support from friends and family (Greenglass, 2002). Early studies provided some support for these beliefs, demonstrating that men engage in more problem-focused and avoidant coping behaviors and women favor emotion-focused strategies (Nolen-Hoeksema, 1987). Not all research has, however, produced findings consistent with these stereo typical views. Some studies have found that, although women more often seek social support and use emotion-focused coping, no sex differences exist in the use of problem-focused or avoidant coping behaviors (Carver et al., 1989).

Other studies have shown that, relative to men, women favor emotion-focused (Endler & Parker, 1994). To shed light on these issues, Tamres et al., (2002) conducted a Meta analysis of research in to sex differences in coping. Women were found to report using all coping behaviors more often than men. In no study did men report engaging in more absolute levels of coping than women. In contrast, studies investigating relative coping showed that men were more likely to use problem-focused coping relative to their use of emotion coping strategy, whereas women were more likely to seek emotional support in preference to using problem-focused or avoidant strategies (Tamres et al., 2002).

### **2.9.3. Relations between Coping Strategies and Burnout Levels**

Pearson correlations were conducted between the different coping strategies and burnout dimensions. Results have shown that personal accomplishment was positively and significantly correlated to seeing instrumental social support, planning and active coping, restraint coping, focus on efforts to solve the situation, personal growth, and positive reinterpretation, all of which are problem-focused strategies. Personal accomplishment was also negatively and significantly related to an emotion-focused strategy (Jenaro et al., 2007). Similar results have been found the study with teachers and child protection workers (Anderson, 2000).

Emotional exhaustion had significant positive correlations with emotion- and problem-focused strategies. This burnout dimension also positively correlated with several problem coping strategies like seeking instrumental social support, active coping , planning to solve the situation as well as with several emotion focused or passive strategies like seeing emotional social support, acceptance, turning to religious and restraint coping (Rohland, 1977).

This means the existence of positive relationship the use of the a variety coping strategies and the presence of emotional exhaustion, it could

possible to state that in some instances , repetitive efforts focused on coping may in fact exacerbate the psychological tiredness of the respondents. From the psychological point of view, it is important to promote alternative ways for releasing emotions strategies that relate to the promotion of health life style with the particular attention to an appropriate balance between the work and private life , learning time management, developing skill in using intentional relaxation strategies, the provision of leisure time, or other alternatives for respite, as suggested by Schaufeli and Enzman (1998), seem to be more helpful than focusing on coping skills training when facing unchangeable situations. Wallace and Brinkerhoff (1991) stated, depersonalization may be the last resource to use when coping strategies do not seem to work any longer. The data seem to indicate that once someone has suspicious or impersonal feelings toward his or her clients, no further efforts are initiated and no coping strategies are used, this also affects implications from a quality of services stand.

## **2.10. Summary and Implication**

Generally, the related literature reviewed above showed the theoretical and empirical information of burnout and coping strategies among human services professions. The review of related literature indicated that especially counselors who provide counseling services on HIV/ AIDS and related issues faced very stressful situations due to the chronic and complex nature of the clients.

In this study an attempt was made to identify the level of burnout and the use of coping strategies in a particularly setting. It also intended to examine if the existed significant difference and relationship between the demographic variables with burnout and coping strategies between HIV counselors in face to face and online counseling settings in Addis Ababa. To do so in the next chapter, the researcher designed appropriate methodology.

## **CHAPTER THREE**

### **METHODOLOGY**

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

This study involved both quantitative and qualitative data to address the research questions; more importantly, the qualitative data was used to substantiate the results obtained through empirical measures.

#### **3.2. Data Sources**

##### **3.2.1. Study Area**

The present study consisted 169 voluntary counseling and testing centers of where face to face counseling was provided and the four online counseling settings from which the study participants were selected include: Wegen AIDS Talk line, OSSA, Hiwot Ethiopia and Family Guidance Association Ethiopia (Addis Ababa Administrative City Health Bureau, 2009). The researcher preferred to select the city of Addis Ababa as area of the study because of availability where participants for the study.

##### **3.2.2. Population**

The total number of the target population of the study was 477 in both online and face to face HIV counselors. Out of the total 280 constituted the face to face and 197 HIV counselors in online counseling settings. Therefore, the target population existed in Governmental, Nongovernmental and Private counseling settings in Addis Ababa. The populations for the study incorporated those HIV counselors from the academic level of diploma to postgraduate levels (Addis Ababa Administrative City Health Bureau, 2009).

### 3.2.3 Participants

A total of 477 populations who were employed in both face to face and online counseling settings from a total target population 120 were drawn as participants of the study for quantitative data and 23 participants for qualitative data were participated. HIV counselors who were eligible for this study including those who belong to one of the following professional groups: Psychologists, nurses, sociologists, and related disciplines who were working directly with HIV/AIDS clients in face to face and online contact with HIV/AIDS and related issues because this is a practice in Ethiopian situation.

### 3. 2.4. Sample and Sampling Procedures

For the purpose of this study, 120 samples were selected by stratified sampling techniques from the total population of 477 HIV counselors from both counseling settings for the quantitative data.

Table 1 - Percentage distribution of the sample

No-	Counseling setting	Types of organization	Population				Total	
			Male		Female		#	Sample size
			#	Sample Size (25%)	#	Sample size (25%)		
1	Face to face counseling centers(VCT)	Government	64	16	49	12	113	28
		Private	23	6	24	6	47	12
		NGO	59	15	44	11	103	26
		Workplace or factory	9	2	8	2	17	4
		Sub total	155	39	125	31	280	70
2	Online counseling centers	Wegen AIDS Talk Line	42	11	48	12	90	23
		Hiwot Ethiopia	15	4	13	3	28	7
		Family Guidance Association	29	7	19	5	48	12
		OSSA	16	4	15	4	31	8
		Sub Total	102	26	95	24	197	50
3	Grand total		257	65	220	55	477	120

More specifically, as can be seen on table-1, from among the 70 participants who were selected from face to face counseling by making use of proportional selection from each organizational strata (25% of each stratum as the target population). Thus, 28 were from Governmental Organizations, 12 were from private organizations, 26 from NGO and 4 from Factory. Similarly, 50 Participants were selected from online settings by the stratified random sampling technique (25% from each stratum). Thus, 23 from Wegen AIDS Talkline, 7 from Hiwot Ethiopia, 12 from Family Guidance Association and 8 from OSSA. From the two settings, 120 sample participants (i.e. 65 males and 55 females) were taken from both counseling settings. Generally, this study consisted 120 (25 %) of 477 total population of HIV counselors enrolled in the face to face and online counseling setting in Addis Ababa. From these 4 respondents were not willing to give information on time and 5 respondents returned the questionnaires with incomplete information which can not be processed. Thus the total quantitative data processed become 111 (64 face to face and 47 online participants) with the response rate of 92.2% of the total respondents for quantitative data. For the qualitative data the respondents were selected with the random purposive sampling techniques. For In -depth interview 1 coordinator and 1 supervisor in online and 2 coordinators in face to face were participated. For the focus group discussion 9 respondents were selected in face to face and 10 respondents were selected online counseling settings.

### **3.3. Instruments**

#### **i- Questionnaire**

The quantitative data was collected using these questionnaires (i.e. the demographic questionnaire, the Maslach Burnout Inventory and the Coping Orientation to Problem Experiences (COPE) questionnaire). More

specifically, the first part the demographic questionnaire was used to gather information on the overall biography of research participants 9 items was used.

The second part the Maslach Burnout Inventory was adopted to assess the levels of burnout between the HIV counselors in terms of three dimensions: Emotional exhaustion, Depersonalization and Personal accomplishment. The Maslach Burnout Inventory- Human Services Survey (MBI-HSS) was used to get an indication of the level of burnout experienced by the helping professions in the research sample. The MBI-HSS consists of 22 statements of feelings related to work and involves three independent aspects of the burnout: *Emotional Exhaustion (EE)*, *Depersonalization (DP)*, and *Personal Accomplishment (PA)*. The authors of this instrument clearly indicated in the test manual that the scores obtained on the three subscales of the test should be considered as separate scales, and not as a single scale (i.e. by adding together the responses on all items). Consequently, three criterion scores (one for each of the separate subscales) was used in this study. It is recommended to report the personal accomplishment as direct computations of item scores rather than as diminished personal accomplishment based on reversed items. Participants used a 7-point scale with ranging from *almost never* to *almost always*. Reliability coefficients for the subscales by using Chronbach's alpha were the following .90 for emotional exhaustion, .79 for depersonalization, and .71 for personal accomplishment (Maslach & Jackson, 1996).

The third part which was the COPE Questionnaire consisting of 40 items from two major categories (i.e. problem focused and emotion focused coping strategies). Problem-focused coping strategy was measured by five subscales (active coping, planning, suppression of competing activities, restraining coping and seeking of instrumental social support). Emotion-

focused coping was also measured by five subscales (Use of seeking of emotional social support, positive interpretation and growth, acceptance, denial and turning to religions), (Carver et al., and 1989). But the three sub scales measuring responses that are arguable less useful (of focus on venting of emotions ,behavioral disengagement and mental disengagement) and one scale of alcohol- drug disengagement subscale was excluded from being part of this scale for the purpose of this study .

These coping strategies involve three independent aspects of coping, namely emotion-focused, problem-focused and ineffective coping strategies. For the purposes of this study, therefore, only emotion-focused and problem-focused coping strategies was measured, as the aim of the research was to measure the extent of effective coping utilized and not the different types of coping utilized.

The reliability coefficient for the emotional focused and problem focused coping strategies was, .72 and .85 respectively (Carver et al., 1989). Responses to each scale average across each items to form total scores .Higher scores was represents a greater preference for use of each coping strategy. These the total coping scores was be then summed to obtain an overall coping score. This overall coping score was reflect the extent to which participants approve the full range of coping strategy

## **ii. In- depth Interview Guide**

In an order to collect qualitative data from the supervisors and coordinators in both counseling settings (face to face and online), open ended structured interview guide, consisted of 11 question items for each was employed. The interview guide was mainly used to substantiate the information on major challenges of HIV counselors and their coping strategies that they employ to reduce their challenges. Furthermore, the interview guide consists of items which focused mainly on gathering information from coordinators and supervisor concerning the technical

and emotional support to the HIV counselors. In the interview 1 coordinator and 1 supervisor in online and 2 coordinators in face to face were participated.

### **iii- A Guide for Focus Group Discussion (FGD)**

Two focus group discussions were held between HIV counselors in face to face and online counseling settings consisted of 9 participants in face to face and 10 participants in online were participated in each counseling setting. For this purpose an interview guide was prepared consisted of 7 structured items as guiding questions to raise main points (themes of FGD) during discussion. The instrument was developed to increase the information obtained by the instruments for the purpose of triangulation and felt the gaps in data. The themes of focus groups discussion was mainly concerned about the challenges of HIV counselors and the coping strategies they use during providing counseling services.

### **3.4. Procedures of Data Collection**

The researcher adopted the standardized tools (MBI-HSS and COPE questionnaire) by conducting pilot study on few selected samples of 30 HIV counselors in both settings to maintain the reliability of the instrument to the present study and obtain a reliability coefficient which was obtained by using Chronbach alpha for burnout subscales emotional exhaustion  $r= 0.84$  Depersonalization  $r= 0.78$  and of personal accomplishment  $r=0.72$ . In addition to this, the coping strategies of problem focused coping strategy  $r= 0.74$  and emotional focused coping strategy  $r= 0.76$ .

First, consent was obtained from the head coordinator of the respective organizations and the participants themselves. Then the participants of the study were briefed on the purpose of the study. In addition, they were oriented as how to respond to the questionnaires which were aimed at

collecting quantitative data. In addition, as for In-depth interview and a Guide Focus Group Discussion designed to gather qualitative data. Furthermore, in the pilot study the instruments were administered. On the data obtained from the pilot study, some items were modified.

The questionnaires were distributed to HIV counselors after securing oral consent from each participant. But out of 120 participants selected to respond for quantitative data, 111 responded and the rest 4 participants were not returning back the questionnaire and 5 respondents returned the questionnaires with unfulfilled information. With respect to the process of collecting qualitative data, an In-depth interview also conducted for 2 coordinators in face to face counseling and 1 supervisor and 1 coordinator in online counseling settings. The interview was conducted in their offices and it took on average 40 minutes to conduct the each interview. Furthermore, Focus Group Discussions was conducted by 10 participants in online counseling setting from randomly purposefully selected participants from four centers. FGD was held in assembly hall of Wegen AIDS Talkline and the discussion took 1 hour and 20 minutes. The issues raised by participants were written dawn point by point. Similarly, FGD was conducted by 9 participants who were randomly purposefully selected from face to face counseling setting and the discussion was held in Zewoditu hospital assembly hall. The discussion took 1 hour and the participants' responses were written dawn by the researcher and presented according to the important theme.

### **3.5. Scoring**

The Likert type of Maslach Burnout inventory which has seven-point scales, was scored based on the rate that ranges from 0 to 6 *and* the COPE Questionnaire data gathering tool, that is four point scale, was scored based on the rate that ranges from 1 to 4 for the arguments that participants' provided from strongly agree to strongly disagree and its

rating depends on the content of the statement presented in the questions.

In categorization of MBI Scores the standard range of experienced burnout was presented as follows and it was helpful to interpret the result of research finding.

The numerical cut- off points the Maslach Burnout Inventory

Overall Sample	Low	Average	High
EE	<16	17-26	>27
DP	< 6	7-12	>13
PA	>39	38-32	<31

Source: - BMI *manual*, 1996

High level of burnout was reflected in terms of high scores emotional exhaustion and depersonalization subscales and low scores personal accomplishment subscale. Moderate level of burnout was expressed average level of the three dimensions of the burnout subscales and low level of the burnout also reflected low scores in the emotional exhaustion and depersonalization and high scores in the personal accomplishment subscale ( Maslach and Jackson, 1996).

The result of the COPE was also scored by the researcher. Raw scores based on the participants were determined for the two categories of emotional and problem focused coping strategies. The scales with higher scores indicated a reliance of the respondent of the coping strategies (Carver et al., 1989).

### **3.6. Method of Data Analysis**

First, the demographic information of the respondents was computed by descriptive statistics such as percentile and mean. Then, the mean was also employed to examine the level of burnout between HIV counselors in online and face to face counseling settings. In addition, inferential statistics was employed to analyze the obtained data by using the statistical package for the social sciences of SPSS version 16 for Windows. An alpha level of 0.05 and 0.01 were used to establish statistical analysis. More specifically, t-test was computed to see whether there was a statistically significant difference on the burnout and coping strategies between HIV counselors in face to face and online counseling settings. In addition, Person Product Moment Correlation Coefficient ( $r$ ) and Point Biserial ( $r$ ) were computed to see a statistically significant relation on burnout and coping strategies related to demographic variables between HIV counselors in both groups and also burnout dimensions with coping strategies. Besides, the data obtained through in-depth interview and guide to focus group discussions were analyzed thematically to substantiate the results obtained through the empirical data.

## CHAPTER FOUR

### 4. RESULT

In order to address the research questions the obtained data was presented and analyzed here under.

#### 4.1. Demographic Information of the Respondents

Table 2, Demographic Information

S/N	Demographical variables	Groups	counseling settings					
			Face to Face		Online		Total	
			No-	%	No-	%	No-	%
1	Sex	Female	30	46.9	22	46.8	52	46.8
		Male	34	53.1	25	53.2	59	53.2
		Total	64	100	47	100	111	100
2	Age	20-30 yrs	31	48.5	34	72.3	65	58.6
		31-40 yrs	24	37.6	13	27.7	37	33.3
		> 41 yrs	9	13.9	-	-	9	8.1
3	Educational background	Diploma	37	57.8	9	19.1	46	41.4
		Degree	26	40.6	26	55.3	52	46.8
		MA,Msc,MP H	1	1.5	12	25.5	13	11.9
4	Professional status	Nurse	45	70.3	13	27.6	58	52.3
		Psychologist	6	9.4	24	51.1	30	27.0
		Sociologist	4	4.7	6	12.8	10	9.0
		Others	9	14.1	4	8.5	13	11.7
5	Marital status	Single	28	43.7	28	59.6	56	50.5
		Married	33	51.5	19	40.4	52	46.8
		Divorced	3	4.8	-	-	3	2.7

As shown from table 2 above, the sample of this study consisted of 57.7% face to face and 42.3% online respondents. The respondents were almost equal distribution in sex with 53.2% male participants and 46.8% female participants. Furthermore, the respondents range in age from 21 to 65 years of age.

The age of the face to face respondents was ranged from 21 to 65 years of age. The majority age of face to face respondents 85.9% were between 20 to 40 years old, with the mean age of 34.5 years. Similarly all online respondents were between 21 to 40 years old with mean age of 28 years old. With respect to marital status participants, 43.8% from face to face counseling center reported that they were single, 51.6% were married and only 4.6 % were divorced. Among the online respondents 59.6% were found to be single and 40.4% respondents were married.

Regarding to educational background and professional status participants from face to face counseling settings 57.9% hold diploma, 40.6% hold first degree. Furthermore, from the online respondents, 19.1% respondents were diploma graduates, 55.3% respondents hold B.A or B.SC degree and 25.6% respondents reported that they hold M.A. degree. With respect academic background in terms of the participants' field of study, the composition from face to face counseling participants from the obtained data have shown dramatic difference. Thus, 70.3% of the respondents were found to be nurses, 9.3% of them were psychologists, 4.7% were sociologists and the rest 14% participants were from other field .Similarly, differences were also noted on the academic qualification of the participants from the online counselor participants .As indicated on the table 2 above, 27.6% were found to be nurses, 51.1% were psychologists, 12.7% were sociologists and the rest 25.6% were found to be from other field of study

#### 4.1.1. Participants Work Experience and Average number of Clients Served per a day

Table-3 Background Information of the Respondents

S/N	Variables	Groups	Type of counseling services					
			Face to face		Online		Total	
			F	%	F	%	F	%
1	Years of experiences	≤ 2 years	21	32.8	16	34.0	37	33.3
		3-5 years	25	39.1	20	42.6	45	40.6
		> 6 years	18	28.1	11	23.4	29	26.1
2	Working hours per day	1-4 hours	5	7.8	2	4.3	7	6.4
		5-8 hours	12	18.8	39	83.0	51	45.9
		9-12 hours	47	73.4	6	12.7	53	47.7
3	Average numbers of clients served	1-10 clients	33	51.6	4	8.5	47	42.3
		11-20 clients	26	40.6	5	10.6	50	45.1
		More than 21 clients	5	7.8	38	80.9	14	12.6

Data obtained through the demographic questionnaire as shown from table 3 above, participants work experience, counseling hours per day and average number of clients served per day were assessed. With regards to work experiences respondents in face to face setting 32.7% were reporting that they had ≤ 2 years work experiences, 39.1% had served for 3-5 years, 28.1 % were having an experience of > 6 years. The work experience of participants from online counseling revealed that 34% reported that they had ≤ 2 years work experiences , 42.6% respondents also had 3-5 years work experiences, 23.4% were >6 years of work experience in the counseling service.

To assessed the HIV counselors working hours per a day, respondents in face to face counseling setting the majority i.e.73.4% of respondents reported as working for 9 to 12 hours per a day. However, the majority of participants in the online counseling settings (i.e. 83 % of respondents) reported as working for 5 to 8 hours per a day. Work load is revealed by the numbers of clients they provided counseling services per day .The

obtained result in the two groups have shown differences. In this regard, among participants' from face to face counseling settings only a small percentage of (i.e. 7.9% respondents) reported as providing counseling for more than 21 clients per day. Contrary to this the largest percentage of participants in online counseling setting (80.9% of the respondents) reported that they were providing counseling services for more than 21 clients per day.

#### 4.2. Burnout between HIV Counselors in face and online counseling settings

Table 4, Summary of the Mean and Standard Deviation of Burnout Dimension

Sr.no	Sub scale	Counseling setting	Frequency	Mean	SD
1	<b>Emotional Exhaustion</b>	Face to face	64	26.21	7.68
		Online	47	30.30	10.71
2	<b>Depersonalization</b>	Face to face	64	11.71	6.46
		Online	47	13.53	5.94
3	<b>Personal accomplishment</b>	Face to face	64	32.76	8.46
		Online	47	28.72	7.95

*The norm ranges for Emotional Exhaustion include: > 27 = high, 17-26 = moderate and <16 = low. Depersonalization include: >13 = high, 7-12 = moderate and <6 = low. Lack of personal Accomplishment include: <31 = high, 32-38 = moderate, and >39 = low.*

As shown in the table 4 above, the results obtained from face to face HIV counselors' burnout from the mean score of burnout dimension of emotional exhaustion, depersonalization and personal accomplishment subscales were (26.21), (11.71) and (32.76) respectively. In light of the cut point of suggested in BMI manual (1996) the present study revealed that face to face respondents experienced moderate level of the burnout. In the case of online respondents, the results reported from the mean score of the burnout dimension of emotional exhaustion, depersonalization and the personal accomplishment subscales were (30.3), (13.53) and (28.72) respectively. This study shows that the online

participants experienced high level of burnout compared to the face to face participants. This result was substantiated by data obtained through FGD and In-depth interview. Thus, qualitative results obtained some of the challenges identified by the online respondents during the focus group discussion were the absence of non verbal cue, misreading cue, technology failure, language barriers and different cultural perspectives. The characteristics of the clients in this counseling setting was also mostly male, youth and children so that some of the clients were joking, and abusing the service .The types of clients who make this type of counseling problematic are those chronic clients who calls several times every day, and the silent clients who calls but who refuses to say anything while the respondents providing counseling services.

One female online counselor explained her stressful experiences as follows: “the online service has stimulated to call frequently for problems clients. The services mostly provide counseling service for male clients some of whom wish to talk to me while masturbating; this was very stressful for me”. All these illustrates the likelihood that online counseling was more stressful and HIV counselors were experiencing more burnout in online counseling settings than the face to face counseling settings.

**4.3. Significance Mean difference in the levels of Burnout Dimensions between HIV Counselors in face to face and online counseling settings.**

Table 5, The t-test Summary of Burnout Dimension

Sr.no	Sub scale	Counseling settings	Frequency	Mean	SD	df	t	Sig.
1	<b>Emotional Exhaustion</b>	Face to face	64	26.21	7.68	109	-2.549	.012*
		Online	47	30.30	10.7			
2	<b>Depersonalization</b>	Face to face	64	11.71	6.46	109	-1.51	.134
		Online	47	13.53	5.94			
3	<b>Personal accomplishment</b>	Face to face	64	32.76	8.46	109	2.5	.012*
		Online	47	28.72	7.95			

\*significance (p. < .05)

In order to address a research question one, whether or not there is exists a statistically significant difference in the burnout level in three dimensions in Maslash Burnout Inventory between HIV counselors in face to face and online counseling providing settings, t-test was performed. Thus, As indicated on the table 5 above, the analysis revealed that a statistically significant difference was observed in two dimensions of burnout , emotional exhaustion and personal accomplishment between online and face to face counselors with (t= - 2.44, at p<.05) and (t= 2.5 at p<.05,) respectively. Regarding emotional exhaustion, the online counselors seems to have higher mean score (30.3) than the face to face counselors (26.21). On the other hand, the face to face respondents scored higher mean value (32.76) than the online counselors (28.72) in personal accomplishment. However, there

was no statistically significant difference in the depersonalization subscale of the burnout tool between these groups with ( $t=-1.51, P >.05$ .)

This finding is substantiated by the data obtained through In -depth interview one online coordinator explained that the main stressor for the HIV counselors in the online counseling setting were some caller were abuse, prank, chronic case that touch the feeling of the counselors, and the energy taker callers like the silent, hang up, and aborted callers. In addition to this the caseload also very heavy that was between the calls there is only 10 seconds' gap.

Persistent and negative work related stressors found in the normal individuals that is characterized by emotional exhaustion and distress, this decreased motivation and the development of dysfunctional attitudes and behaviors with in the work environments. Most of the online respondents explained they perceived different work related physical, psychological and behavioral symptoms. Most of the symptoms explained by the respondents were headache, back pain, gastritis, easily tiredness to their work, aggressive, not cooperative to their clients and after they finished their work they perceived highly physical and emotional tiredness. They need completely bed rest rather than do other activities. The effect of burn out is clearly vivid from an interview response obtained from

One online female counselor she explained her feeling as follows: "I feel stressed; I have always headaches or body pain. I feel that no one appreciates our hard work, I do not sleep or eat well, I have low energy and feel unhappy or hopeless, I feel helpless because we can not meet all the needs of clients, and I also feel angry at clients because of their needs and demands. Therefore, I need special support for my well being at this time".

**4.4. Significance Mean difference in the Use of Coping Strategies between HIV Counselors in face to face and online counseling Settings**

Table 6, The t-test Summary of Emotional and Problem Focused Coping Responses

Sr.no	Type of coping	Counseling setting	N	Mean	SD	df	T	Sig.
1	Emotional Focused Coping	Face to face	64	52.25	6.91	109	-.070	.945
		Online	47	52.34	6.54			
2	Problem Focused Coping	Face to face	64	53.29	8.43	109	2.15	.034*
		Online	47	50.10	6.59			
3	COPING	Face to face	64	1.05	14.38	109	2.23	.027*
		Online	47	1.02	12.13			

\*significance (p. < .05)

As shown in the table 6 above, there was no a statistically significant difference shown in the responses of emotional focused coping strategy. The mean score from face to face respondents was (52.25). The mean score from the online respondents was (52.34). The t- test yielded the t- value of (t= -.070) at alpha level of  $p > .05$ . Hence, neither face to face nor online respondents using this coping response more than the other groups.

A statistically significant difference in the responses of the face to face and online respondents was observed in problem focused coping strategy. The face to face respondents reported a mean score of (53.29) while the online respondents reported a mean of score of (50.29). The t- test yielded the t- value of (t=2.23) at alpha level of  $p < .05$ . Therefore, the face to face respondents reported that they tend to use the coping

response of the problem focused coping strategy more than the online respondents.

Generally, a statistically significant difference in the responses of the face to face and online respondents was observed in cumulative coping strategy. The face to face respondents reported a mean score of (1.05) while the online respondents a mean of score of (1.03). The t- test yielded the t- value of (t= 2.23) at alpha level of  $p < .05$ . Hence, face to face respondent use this coping responses more than the online respondents.

This was substantiated by the results obtained through FGD. Thus, the qualitative result revealed that face to face respondents were identified different problem focused coping mechanisms such as transferring clients to the their colleagues, taking tea breaks, appoint the clients to come back for the next day, and priority setting the numbers of client to get counseling services.

#### 4.5. The Relationship between the Demographic variables and Burnout dimensions.

Table 7, Correlation Coefficient between the Burnout Dimension and Demographic Variables

Independent variable	Dependent variables					
	Emotional Exhaustion		Depressurization		Personal Accomplishment	
	Correlation Coefficient	Sig.	Correlation Coefficient	Sig.	Correlation Coefficient	Sig.
Age	-.249**	0.008	-.289**	0.002	.017	0.857
Sex	-.143	0.134	-.105	0.997	.000	0.274
Years of services experiences	-.123	0.198	-.123	0.199	-.253**	0.007
Average numbers of clients served per day.	.233*	0.014	.138	0.150	-.182	0.056

\* Significance ( $p < .05$ ) & \*\*significance ( $p < .01$ )

As shown in table 7 above, a statistically significant negative correlations at Pearson ( $r = -.249$ ) and Pearson ( $r = -.289$ ) were found between emotional exhaustion and depersonalization of burnout dimensions with age respectively at alpha level of ( $p < 0.01$ ). Furthermore, a statistically significant negative correlation was found years of services and personal accomplishment with Pearson ( $r = -.253$ ) at alpha level of ( $p < .01$ ). Moreover, a statistically significant positive correlation was observed between average numbers of clients served per day and emotional exhaustion with Pearson ( $r = .233$ ) at  $p < 0.05$ . However, there was no a statistically significant difference between the burnout dimensions and sex.

#### 4.6. The Relation between the Demographic variables and Coping strategies.

Table 8, Correlation Coefficient between the coping strategies and Demographic Variables

Variables	Coping strategies			
	Problem Focused Coping Strategy		Emotional Focused Coping Strategy	
	Correlation Coefficient	Sig.	Correlation Coefficient	Sig.
Age	.014	0.321	-.095	0.881
Sex	.202*	0.033	.247**	0.009
Years of c experiences	.039	0.683	-.135	0.157
Average numbers of clients served per a day	-.000	0.949	.008	0.935

\*significance ( $p < .05$ ) and \*\*significance ( $p < .01$ )

As shown in the table 8 above, a statistically significant positive correlations were found between sex and the coping strategies that is the problem and emotional focused coping strategies, the coefficient of correlation of Point Biserial ( $r=.202$ ) at the point of  $p. <05$  and point biserial ( $r=.247$ ) at alpha level of  $p. < .01$  respectively. However, no a statistically significant correlation was observed between the coping strategies and age, years of experiences and average numbers of clients served by the HIV counselors per day.

#### 4.7. The Relationship between Dimensions of Burnout and Coping Strategies

Table 9, Correlation Coefficient between the coping strategies and burnout Dimension

Variables	Burnout subscales					
	Emotional Exhaustion		Depersonalization		Personal Accomplishment	
	Correlation Coefficient	Sig.	Correlation Coefficient	Sig.	Correlation Coefficient	Sig.
Problem focused coping strategy	.263**	.005	-.051	0.597	.878	.015
Emotional focused coping strategy	-.018	.000	-.055	.566	.432	.000

\*\*significance ( $p. < .01$ )

As shown in table 9 above, there was a statistically significant positive correlation with Pearson ( $r=.263$ ,  $p. < 0.01$ ) between problem focused

coping strategy and emotional exhaustion dimension of the burnout. However, there was no a statistically significant correlation between the emotional focused coping strategy and the three dimension of burnout. In addition to this, no a statistically significant correlations were found between the problem focused coping strategy and the two dimensions of burnout these are depersonalization and personal accomplishment.

## CHAPTER FIVE

### DISCUSSION OF THE RESULTS

#### 5.1. Burnout between HIV Counselors in Face to face and online counseling settings

The respondents involved in this study reported that they experienced moderate to high level of burnout in face to face and online counseling settings respectively. The finding of the study revealed face to face HIV counselors experienced moderate level of burnout due to average mean score obtained from emotional exhaustion (26.21), depersonalization (11.71) and personal accomplishment (32.76) subscales. When compared the burnout level of the online respondents were higher than the face to face respondents; when each of the three subscales were examined separately from one another, there were indicated that the online respondents experienced more elevated levels of burnout than face to face respondents.

This was shown by high level in the mean score of emotional exhaustion (30.30) and depersonalization (13.53) subscales. In addition to this, the finding shown that there was low level of personal accomplishment due to low mean score of 28.72. This result supported by the study conducted by Ross & Sastry, (1999) in counseling staff in the University of Iowa when each of three subscales was examined separately from one another, there are indications that the participants have elevated levels of burnout. This is due to the significantly low scores obtained on the personal accomplishment subscale and the high scores obtained on the emotional exhaustion and depersonalization subscales. What is interesting is that a large number of the psychologists obtained low scores on the personal accomplishment scale, indicating that they view themselves and their ability to do their jobs in a negative way.

The result of this study revealed that the level of burnout in face to face and online respondents was a statistically significant difference in emotional exhaustion. The online respondents reported a mean score of (30.30) while the face to face respondents reported a mean of score of (26.21). The t-test yielded the t- value of -2.549 at alpha level of  $p < .05$ . Therefore, the online respondents identified that they tended to experienced higher burnout level in emotional exhaustion sub scale than the face to face respondents. It means that HIV counselors in the online counseling settings exhibited more feelings of tiredness and psychologically fatigue as compare to HIV counselors found in face to face counseling settings. The personal accomplishment subscale for the online respondents had a mean score (28.72) while the face to face respondents identified a mean of score of (32.76). The t- test yielded the t- value of 2.5 at alpha level of  $p < .05$ . This indicates that, the online respondents they tended to have less achievement than the face to face respondents. However, there was no a statistically significant difference in the depersonalization subscale.

This finding is some extent similar to a research conducted in a managed health care setting which assessed for burnout level by (Snibbe, et al., 1989). In this research primary care physicians and psychiatric clinic staffs were given the Maslach Burnout Inventory (MBI). For primary care physicians, a moderate level of emotional exhaustion and depersonalization were found while personal achievement was high. For psychiatric staff, a high level of emotional exhaustion and depersonalization were found while personal achievement was high. The entire sample had higher rates of emotional exhaustion and depersonalization and lower rates of personal achievement than Maslach's normative sample for the MBI. Psychiatrists and social workers had significantly higher level on the depersonalization scale than the primary care physicians and psychologists.

The data obtained from the focus group discussion of this study also indicated that online respondents tended to face more burnout than the face to face respondents. Most online respondents explained that they were perceived different work related physical, psychological and behavioral symptoms. Most of the symptoms explained by the respondents were headache, back pain, gastritis, easily tiredness to their work, being aggressive, not being cooperative to their clients and after they finished their work they perceived high physical and emotional tiredness.

## **5.2. Coping strategies between Face to face and Online HIV Counselors**

In this study, a statistically significance difference was reported in the regarding problem focused coping strategy between HIV counselors in face to face and online settings. The face to face respondents reported a mean score of (53.29) while the online respondents had a mean score of (50.29). The t- test yielded the t- value of 2.153 at alpha level of  $p < .05$ . This indicated that, the face to face respondents that they tended to use the coping response of the problem focused coping strategy more than the online respondents. This study was supported by previous studies with child protection workers and in-home caregivers by Jenaro, et al., (2007). This study showed that employees with less burnout tended to use adaptive, active or problem focused coping strategies more frequently than passive or emotional focused coping strategies. In this study, problem focused strategies were the most potential responses for face to face respondents than online respondents. This indicates that burnout level of face to face respondents were less than that of online respondents.

Similarly, the result obtained from the focus group discussion showed that the online and face to face respondents used different coping

strategies to minimize their stressful events. For example, online respondents mostly used coping strategies such as express the unpleasant emotions to the other persons, trying to denial the case, taking bed rest, taking some alcohols, listening to music, being busy with other activities etc. Moreover, most of face to face respondents mostly used coping strategies such as transferring clients to the their colleagues; taking tea breaks, appointing the clients to come back the next day, asking permission and going to rest , priority setting of the number of clients who would get counseling services etc.

### **5.3. Burnout and Coping Strategies related to Demographic Variables**

The third purpose of this study was to see the relationship between demographic variables (i.e. age, sex, average numbers of clients served per a day and years of experiences) and burnout subscales as well as coping strategies between HIV counselors in face to face and online counseling settings.

The findings of this study showed that a statistically significant negative correlations were found between age with emotional exhaustion and depersonalization at Pearson ( $r = -.249$ ) and ( $r = -.289$ ) at the  $p < .01$  level of significance respectively. However, a statistically significant positive correlation was found on the average number of clients' served per day or caseload and emotional exhaustion at Pearson ( $r = .233$ ) at the  $p < .05$  level of significance. This study was supported by the study conducted by Ryan (1996) who reported that counselors aged 28-37 scored significantly higher than counselors aged 47-79 on burnout. This indicated that as age increases, the emotional exhaustion and depersonalization levels (burnout) decrease. No a statistically significant correlation was identified between sex of the respondents and the burnout subscales. This finding was supported by Fogerty, et al., (1999)

in their research they did not find sex to be significantly correlated with burnout subscales and coping strategies. However, this study did not supported a study conducted by Marini, et al., (1995) found that males scored significantly higher than females on occupational stress. These results indicate that males may experience burnout differently from females.

The number of clients served per day was found a statistically significant positively correlated with the emotional exhaustion at Pearson ( $r = .233$ ) at the  $p < .05$  level of significance. This indicates that the number of clients on caseload increases, the level of emotional exhaustion reported by HIV counselors also increases. This study is supported by (Cordes & Dougherty, 1993). In this study caseload was divided into quantitative (frequency of contact, duration of contact, number of interactions, and percent of time spent with clients) and qualitative dimensions, such as interpersonal distance (e.g. phone contact versus face to face), and client characteristics (chronic versus acute, child versus adolescent or adult). The findings quite consistently indicate, that client interactions that are more direct, frequent, or of longer duration or client problems that are chronic versus acute are associated with higher levels of burnout.

The years of experience was determined by taking the HIV counselors' years of experience in the organization. As the result this indicates that a statistically significant negative correlation was revealed; this implies that there is a relationship between years of experience and personal accomplishment at Pearson ( $r = -.253$ ) at the  $p < .01$  level of significance. This indicates that as the number of years of experiences of the HIV counselors' increases, the respondents performance achievement deceases. The findings in this study did not support the previous research findings regarding years of experiences and the burnout dimensions.

A statistically significant positive correlation were found in the correlations of sex with problem focused and emotional focused coping strategies at Point Biserial ( $r = .222$ ) and ( $r = .267$ ) at the  $p < .05$  and  $p < .01$  level of significance respectively. The problem focused coping strategy has mean score of (53.79 & 50.32) for female and male HIV counselors respectively. Furthermore, the emotional focused coping strategy mean score of (54.19 & 50.61) for female and male HIV counselors respectively. This indicated that female HIV counselors tended to use the coping response of problem and emotional focused coping strategies more frequently than the male HIV counselors. This finding is inline with the findings of Niles & Anderson, (1993) who indicated that female counselors reported average scores for burnout and coping strategies; men also reported higher stress and burnout scores and lower coping scores.

However, early studies provided some contradicted idea demonstrating that men engage in more problem-focused and women favor emotion-focused strategies (Nolen-Hoeksema, 1987). As showed in this study female respondents engaged more in problem and emotional focused coping strategies than male respondents. Not all research has, however, produced findings consistent with these stereo typical views. Some studies have found that, although women more often seek social support and use emotion-focused coping, no sex differences exist in the use of problem-focused coping strategy (Carver, et al., 1989). Other studies have shown that, relative to men, women favor emotion-focused (Endler & Parker, 1994). To provide evidence to this study, Tamres et al. (2002) conducted a Meta analysis of research in to sex differences in coping strategies. Women were found to report using all coping behaviors more often than men. No study did men report engaging in more absolute levels of coping than women. In contrast to this study, (Tamres, et al., 2002) showed that men were more likely to use problem-focused coping

relative to their use of emotion coping strategy, whereas women were more likely to seek emotional support in preference to using problem-focused coping strategy.

Lastly, a statistically significant positive correlation was found in the problem focused coping strategy with the emotional exhaustion at Pearson ( $r = .263$ ) at the  $p < .01$  level of significance. However, there was no a statistically significant correlation with emotional focused coping strategy and the three dimension of burnout. This study supported by a study conducted by Schaufeli and Enzman (1998) This means the existence of positive relationship with the use of a variety coping strategies and the presence of emotional exhaustion, it could possible to state that in some instances , repeatitative efforts focused on coping may in fact exacerbate the psychological tiredness of the respondents.

## CHAPTER SIX

### SUMMARY, CONCLUSION AND RECOMMENDATIONS

#### 6.1. SUMMARY

The aim of this study was to compare burnout and coping strategies between HIV counselors in face to face and online counseling settings.

The objectives of this study was include to determine the level of the burnout in both settings, to see a statistically significant difference of burnout and coping strategies between HIV counselors in face to face and online counseling settings, to determine the relationship between the major demographic variables of HIV counselors with that of burnout as well as coping strategies, and to identify the relationship between the dimensions of burnout and the coping strategies.

The population for this study for the quantitative data consisted of 477 currently working face to face and online HIV counselors .The sample consisted of 64 face to face and 47 online HIV counselors. In addition to this, the qualitative data for the in- depth interview 2 coordinators in face to face and 1 coordinator and 1 supervisor were participated. In the focus group discussion 10 participants in online and 9 participants in face to face counseling settings were participated.

The questionnaires those were the demographic questionnaire, Maslach burnout inventory, and the COPE questionnaire were used to collect the quantitative data. On the other hand, the interview guide and the FGD guide were used to gather the qualitative data.

The quantitative and qualitative design was employed to conduct this study. For this purpose two types sampling techniques were used. Thus, the stratified sampling was used to select the respondents for the

quantitative study. Where as, random purposive sampling techniques was used to select respondents for the qualitative study. After securing consent from the organizations and the study participants, the data was collected and analyzed.

The quantitative data was analyzed using descriptive and inferential statistics using the statistical package for the social sciences of SPSS version 16 for Windows. The inferential statistics were generated. An alpha level of 0.05 and 0.01 were used to establish statistical analysis. Where as, the qualitative data was used to substitutive the empirical data and was stated in a way of narrative descriptive of the phenomena.

In this study, in both groups, in face to face and online HIV counselors were experienced moderate to high level of burnout level respectively. HIV counselors who were working in face to face counseling setting experienced moderate level of burnout due to the average mean score of the three burnout subscales. However, the online counseling settings, the finding indicate that the HIV counselors manifested high level of burnout level due to the high mean score of emotional exhaustion and depersonalization subscales and the low mean score of the personal accomplishment.

Moreover, a statistically significant difference was reported in the face to face and online respondents in the emotional exhaustion and the personal accomplishment but there was no significant difference in the depersonalization.

A statistically significant difference was reported in the use of coping strategies in the face to face and the online HIV counselors in problem focused coping strategies. In this regard, the face to face HIV counselors were found using problem focused coping strategies more than the online HIV counselors.

A statistically significant negative correlation was reported between the demographic variables of age with the emotional exhaustion and depersonalization dimensions of burnout. Furthermore, a statistically significant positive correlation was found between average numbers of clients served per day or caseload and the emotional exhaustion dimension of burnout. In addition to this, on the coping strategies aspects a statistically significant positive correlation was found between sex and the emotional and problem focused coping strategies.

Finally, a statistically significant positive correlation was reported between problem focused coping strategy and the emotional exhaustion dimension of burnout. Although, no a statistically significant correlation was found between emotional focused coping strategy and the three dimension of burnout.

## **6.2. CONCLUSIONS**

Based on the summary of the major findings of the study the researcher has drawn the following conclusions.

1. This study shows that the face to face and online HIV counselors experienced a moderate and high level of burnout respectively. The results indicate that a statistically significant difference was found in the face to face and the online HIV counselors in the emotional exhaustion and the personal accomplishment dimensions of burnout. However, there was no a statistically significant difference in the depersonalization dimensions of burnout.
2. A statistically significant difference was reported between the face to face and online HIV counselors with respect to problem focused coping strategy. In this regards, face to face HIV counselors used it most frequently when they face a stressful events while they were providing counseling services for their clients.

3. This study shows that a statistically significant negative correlation was found between the demographic variable of age and the burnout dimensions of emotional exhaustion and depersonalization. And also there was a statistically significant negative correlation between years of experiences and personal accomplishment. Where as, there was a statistically significant negative correlation was found in average number of clients served per day and the emotional exhaustion dimension of the burnout.
4. There was also a statistically significant positive correlation was found between the demographic variables of sex and the problem and emotional focused coping strategies in both groups of HIV counselors.
5. Finally, in this study a statistically significant positive correlation was reported between the problem focused coping strategy and the emotional exhaustion dimensions of burnout.

### **6.3. RECOMMENDATIONS**

Based on the findings of the study, the following recommendations are forwarded to remedy the problems.

1. The researcher kindly suggest the need to create favorable working condition to HIV counselors in terms of provision of annual work leave, maintaining optimal work load, optimal working time, and the like to enable the HIV counselors so that they can perform their tasks with minimal risk of developing a burnout. Thus, GOs and NGOs organizations dealing with HIV counseling shall consider these factors for the well being of the HIV counselors.
2. Supervisors and coordinators of HIV counseling shall be responsible to undertake various programs to equip the HIV

counselors with skills and competences by using different basic trainings and coping strategies skill training including coaching and self awareness.

3. The need to establish peer support will have advantage in face to face and online counseling settings for mutual sharing of experiences and coping strategies. Thus, there has to be a coordinated effort by the HIV counselors and the responsible employers.
4. The researcher kindly suggests that identification of HIV counselors at risk of burnout shall be made as early as possible. Thus, HIV counselors identified as having burnout and who are in stressful situations shall be referred to further supportive counseling services. Life skill training, burnout management and periodic professional training shall be rendered in their mid career conditions by the concerned organizations.
5. Proper orientation to the potential clients shall be made at each levels of community about the benefits of both types of counseling. In addition, proper orientation on how to make online counseling shall be given through mass media such as ETV, radio, news papers and magazines.
6. Moderator factors such as social support, personality type of the HIV counselors, and cultural context of Ethiopia as moderator variables of burnout were not considered in this study. Thus, further research that addresses these variables shall be incorporated.

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# APPENDICES

## Appendix -1

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF PSYCHOLOGY (COUNSELING PSYCHOLOGY)

### *GENERAL DIRECTION*

The main purpose of this questionnaire is to gather the information about the comparative study of burnout and coping strategies among HIV counselors in face to face and online counseling services in Addis Ababa.

I would like to inform you that all your responses keep in confidentiality. Your truthful and honest responses have a great contribution for the success of this study. Please don't write your name in this questionnaire.

Thank you in advance for taking your precious time to response this questionnaire!

The Researcher

### **PART ONE**

Personal Information

Please circle the appropriate response

1. Sex    A) Male                      B) Female
2. Age \_\_\_\_\_
3. Marital status    A) Single    B) married    C) divorced    D) Windowed  
E) Others \_\_\_\_\_
4. Type of organization currently you employed
  - 4.1 VCT center    A) Private    B) Government    C) Non Government organization

4.2) Online (Telephone) counseling center

A) Private B) Government C) Non Government organization

5. Educational level

A) Certificate B) Diploma C) Degree D) MA/Msc Degree E) Others \_\_\_\_\_

6. What is your profession?

A) Nurse B) Psychologist C) Sociologist D) Health officer E)

Others \_\_\_\_\_

7. for how many years you have been provide counseling services?

\_\_\_\_\_

8. How many clients on average do you provide counseling services per a day?

\_\_\_\_\_

9. For how many hours per a day do you provide counseling services?

\_\_\_\_\_

## PART TWO

The following 22 statements are related to the work situation. Please read through these carefully and then decide to what extent this applies to your working environment. If you have previously experienced the feelings, accordingly encircle a number (0-6) in the column that best describes how strong this feeling was, so that these are never, very mild, mild, very noticeable, moderate, strong and very strong. Please indicate this mark (✓) the alternative most applicable to you and on how your experiences in the following statement.

0= Never    1= Very mild    2= Mild    3= Very noticeable

4= Moderate    5= Strong    6= Very strong

Sr.no	Statements	Please circle how you experiences the following feelings						
		0	1	2	3	4	5	6
1	I feel emotionally tired from my work	0	1	2	3	4	5	6
2	I feel used up at the end of the work day	0	1	2	3	4	5	6
3	I feel fatigued when I get up in the morning and have to face another day on the job	0	1	2	3	4	5	6
4	Working with clients all day is really a strain for me	0	1	2	3	4	5	6
5	I feel burnout from my work	0	1	2	3	4	5	6
6	I feel I am working too hard on my work	0	1	2	3	4	5	6
7	Working with clients directly puts too much stress on me	0	1	2	3	4	5	6
8	I feel like I am at the end of my rope	0	1	2	3	4	5	6
9	I can easily understand how my clients feel about things.	0	1	2	3	4	5	6
10	I feel treat some clients as if they were impersonal objects	0	1	2	3	4	5	6
11	I have become more hot or inflame toward clients since I provided the counseling services	0	1	2	3	4	5	6
12	I worry that this job is hardening me emotionally	0	1	2	3	4	5	6
13	I do not really care what happen to some clients	0	1	2	3	4	5	6
14	I am frustrated to my job							
15	I feel clients blame me for some of their problems	0	1	2	3	4	5	6
16	I deal effectively with the problems of my clients	0	1	2	3	4	5	6
17	I feel I am positively influencing other people's lives through my work	0	1	2	3	4	5	6
18	I feel very energetic	0	1	2	3	4	5	6
19	I can easily create a relaxed atmosphere with my clients	0	1	2	3	4	5	6
20	I feel joyful after working closely with my clients	0	1	2	3	4	5	6
21	I have accomplished many meaningful things in this job In my work ,	0	1	2	3	4	5	6
22	I deal with emotional problems very calmly	0	1	2	3	4	5	6

### PART THREE

I am interested in how people respond when they confront difficult or stressful events in their work environments. There are lots of ways to try to deal with these stressful events at work places. This questionnaire asks you to indicate what you generally do and feel when you experience on performing your counseling duties. Obviously different events bring some what different responses, but think what you usually do when you are under a lot of stressful events when you provide counseling services. There is no right or wrong answers, and responses must indicate what you do rather than what “most people” do. Please indicate this mark (√) the alternative most applicable to your experiences on the scale next to each statement.

1 = I usually don't do this at all

2 = I usually do this a little bit

3 = I usually do this a medium amount

4 = I usually do this a lot

Sr.no	Statements	Reponses of stressful events			
		1	2	3	4
1	I ask people who have had similar experiences what they did	1	2	3	4
2	I refuse to believe that it has happened	1	2	3	4
3	I try to grow as a person as a result of the experience.	1	2	3	4
4	I force myself to wait for the right time to do something.	1	2	3	4
5	I put aside other activities in order to concentrate on this	1	2	3	4
6	I take additional action to get rid of the problem	1	2	3	4
7	I get used to the idea that it happened.	1	2	3	4

8	I talk to someone about how I feel	1	2	3	4
9	I think about how I might best handle the problem.	1	2	3	4
10	I put my trust in God	1	2	3	4
11	I try to get emotional support from friends or relatives.	1	2	3	4
12	I say to myself: "This isn't real"	1	2	3	4
13	I try to see it in a different light, to make it seem more positive.	1	2	3	4
14	I make sure not to make matters worse by acting too soon.	1	2	3	4
15	I try hard to prevent other things from interfering with my efforts at dealing with this.	1	2	3	4
16	I make a plan of action	1	2	3	4
17	I learn to live with it.	1	2	3	4
18	I try to get advice from someone about what to do.	1	2	3	4
19	I do what has to be done, one step at a time.	1	2	3	4
20	I pray more than usual	1	2	3	4
21	I get sympathy and understanding from someone	1	2	3	4
22	I pretend that it hasn't really happened	1	2	3	4
23	I look for something good in what has happened.	1	2	3	4
24	I restrain myself from doing anything too quickly.	1	2	3	4
25	I take direct action to get around the problem	1	2	3	4

26	I accept that this has happened and that it can't be changed.	1	2	3	4
27	I talk to someone who could do something concrete about the problem.	1	2	3	4
28	I try to come up with a strategy about what to do	1	2	3	4
29	I try to find comfort in my religion.	1	2	3	4
30	I focus on dealing with the problem	1	2	3	4
31	I talk to someone to find out more about the situation.	1	2	3	4
32	I act as though it hasn't even happened.	1	2	3	4
33	I learn something from the experience.	1	2	3	4
34	I hold off doing anything about it until the situation permits	1	2	3	4
35	I concentrate my efforts on doing something about it.	1	2	3	4
36	I keep myself from getting distracted by other thoughts or activities.	1	2	3	4
37	I think hard about what steps to take.	1	2	3	4
38	I accept the reality of the fact that it happened	1	2	3	4
39	I discuss my feelings with someone	1	2	3	4
40	I seek God's help.	1	2	3	4

APPENDIX - 2

IN-DEPTH INTERVIEW GUIDE LINE FOR SUPERVISORS

1. Sex A) Male B) Female
2. Age \_\_\_\_\_
3. Marital status A) Single B) married C) divorced D) Windowed  
E) Others \_\_\_\_\_
4. What is your educational background?  
A) Nurse B) Psychologist C) Sociologist D) Others \_\_\_\_\_
5. Type of your organization
  - 5.1 VCT center A) Private B) Government C) Non Government organization
  - 5.2 Online (Telephone) counseling center  
A) Private B) Government C) Non Government organization
6. How many years as you work as supervisor?  
\_\_\_\_\_
7. Would you please explain the main objectives of your support to the counselors?  
\_\_\_\_\_
8. Would you please mention the support you providing for the counselors?  
\_\_\_\_\_
  - 8.1 Do you think the support is adequate for the counselors? A) Yes B) No
  - 8.2 If your response was no, what are the reasons?  
\_\_\_\_\_
9. Is there any limitations not provide adequate support for the counselors?  
\_\_\_\_\_
10. What are the major stressful events face during counseling of counselors you have got during your supervision?  
\_\_\_\_\_
11. What do you suggest to minimize counselors burnout in your counseling centers?  
\_\_\_\_\_

## APPENDIX - 3

### IN-DEPTH INTERVIEW GUIDE LINE FOR COORDINATORS

#### Background Information

1. Sex A) Male B) Female
2. Age \_\_\_\_\_
3. Marital status A) Single B) married C) divorced D) Widowed  
E) Others \_\_\_\_\_
4. What is your educational background?  
A) Nurse B) Psychologist C) Sociologist D) Others \_\_\_\_\_
5. Type of your organization
  - 5.1 VCT center A) Private B) Government C) Non Government organization
  - 5.2 Online (Telephone) counseling center  
A) Private B) Government C) Non Government organization
6. How many years as you work as supervisor?  
\_\_\_\_\_
7. Would you explain the main objectives of your support to the counselors?  
\_\_\_\_\_
8. What are the major contributes for the counselors' burnout?  
\_\_\_\_\_
9. Is there any burnout management program for the counselors? For how long and it is effective?  
\_\_\_\_\_
10. How do you evaluate the counseling services provided by the counselors?  
\_\_\_\_\_
11. What do you suggest to minimize counselors burnout in your counseling centers?  
\_\_\_\_\_

APPENDIX - 4

A GUIDE FOR FOCUS GROUP DISCUSSION (FGD) FOR COUNSELORS

Background Information

Sr.no	Sex	Age	Educational background	Years of experiences

1. Do you think your counseling duties are meaningful and important?  
\_\_\_\_\_
2. What are the major challenges you faced while dealing with clients?  
\_\_\_\_\_
3. Do you have any physical, behavioral or emotional perceived symptoms in relation to your counseling duties?  
\_\_\_\_\_
4. How do you cope with these challenges?  
\_\_\_\_\_
5. Which coping strategies are effective to you and why?  
\_\_\_\_\_
6. What kind of support do you need in your counseling duties?  
\_\_\_\_\_

APPENDIX - 5

Table . Summary of the Mean of the Burnout Dimensions and Sex

Variables	Sex	F	Mean
Emotional exhaustion	Male	59	29.35
	Female	52	26.69
Depersonalization	Male	59	13.10
	Female	52	11.79
Personal Accomplishment	Male	59	31.05
	Female	52	31.06

APPENDIX - 6


Table - Summary of the Mean of the Coping Strategies and Sex

	Sex	N	Mean
Problem focused coping strategy	Male	59	50.32
	Female	52	53.79
Emotional focused coping strategy	Male	59	50.61
	Female	52	54.19

## Declaration

I, the under signed, declare that this Thesis is my original work and has not been presented for a Degree in any other University and that all sources of materials duly acknowledged.

Name: Desalegn Getachew

Signature -----

This thesis has been submitted for examination with my approval as a University advisor.



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Dr. Sentayehu Taddesse (PhD)