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PERCEIVED SOURCES OF WORK - RELATED STRESS AND COPING STRATEGIES AMONG VCT COUNSELORS IN ADDIS ABABA.

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List of Abbreviations

AAHAPCO	**Addis Ababa HIV/AIDS Prevention and Control Office**
HAPCO	**HIV/AIDS Prevention and Control Office**
UNAIDS	**Joint united Nations Programs on HIV/ AIDS**
VCT	**Voluntary Counseling and Testing**

ABSTRACT

Stress and burnout are clearly problems for counselors and evidence so far have also indicated this fact. However, very little has been done to assess the sources of work related stress and coping strategies among VCT counselors in Addis Ababa.

Accordingly, the major objective of this study was to identify major sources of work related stress and coping strategies used among VCT counselors. The study also attempted to asses VCT counselors in relation to their selection, training, and support and supervision they received. The study covered 30 different VCT sites, selected based on daily client flow. From these centers all the 58 full time working VCT counselors were included in the study. The Data obtained through structured questionnaire. Descriptive statistics like mean, frequency, and standard deviation was used for demographic and professional background characteristics and for identification of work related stressor and coping strategies. Univarite Analysis of Variance was also used to work on how demographic variables explain: overall stress, overall coping, categories of stress and categories of coping.

The most stressing factor in this study is category of ,' Job Conditions' particularly, time pressure, increased caseloads, poor job promotion, and unsuitable counseling room have lead VCT counselors to experience work related stress. Besides, the category of ' Organizational structures and processes,' particularly, inconsistent and inadequate information from supervisors, staffs interfere during counseling of clients and others take decisions concerning ones duties, are found to be the second stress contributing factor among VCT counselors.

The most frequently used coping strategies among VCT counselors were positive ones, including planful problem solving, positive reappraisal and seeking social support, respectively.

To overcome work related stress regional government, institutions or NGOs should regularly conduct stress management programs for VCT counselors.

CHAPTER I

Introduction

1.1. Background of the Problem

The topic of stress and burnout among mental health professionals has been the subject of much research for many years. Researchers have found that the perception of high stress levels in professionals lead to professional burnout and result in low morale, poor job satisfaction and substandard care (Warren; cited in Huey, 2007). Stress has become a serious health issue, not just in terms of an individual's mental and physical wellbeing, but also for employers and governments. Lou and Shiau (1997) stress causes half of all absenteeism, 40% of turnover, and that 5% of the total workforce accounts for the reduced productivity due to preventable stress.

Documentation of stress at work indicates that stressors can come from multiple sources. Some stressors are identified as routine work stress, or those intrinsic to the job, some are related to the employee's role within the organization (role identity stress), some to interpersonal stress, some to career development, and still others to work environment stress or of the climate and organization of the work place (Steber, 1998).

In the helping profession, such as counseling, close interactions with clients, time pressures, diminishing resources, increased workloads, and diminishing rewards from their work outcomes can lead to severe reactions to stress and burnout (Bellani and Furlani, 1996). The high perceived stress and burnout report symptoms such as emotional exhaustion reduced personal accomplishments, loss of positive attitude toward clients, lowered self- esteem, and the intention to quit (Bellani and Furani, 1996).

There is also growing evidence to indicate that mental health professionals by the nature of their work have particular vulnerability to stress, with prolonged stress having the potential to cause detrimental effects that can impact service delivery and quality of care. Aside from the detrimental effects of stress within the work place, those effects can spillover into the professional's personal life, thus affecting his or her social or family functioning (Gray- Toft & Anderson, 1981).

Mental health professionals are represented by a number of disciplines, including psychiatry, psychology, counseling, mental health social work, and occupational therapy (Leiter & Harvie, 1996). Overriding common factor leading to stress and burnout in mental health professionals are their constant dealing with the emotional pain of others, their ongoing challenges of setting appropriate boundaries in their professional interactions, as well as their non reciprocated constant attentiveness to clients' problems and needs (Rabin et al., 1999).

Job stress produces negative effects for both the organization and the employee. For the organization, the results are disorganization, disruption in normal operations, lowered productivity, and lower margins of profit. For employee, the effects are threefold: increased in physical health problems, psychological distress, and behavioral change (Rice, 1992). Within the mental profession, the effects of job stress are experienced at yet another level, the individuals, couples, and families who seek the services of qualified mental health counselors. High incidence of job stress and burnout results in a loss positive attitude towards the client, a depersonalization, and diminishing resources to adequately address the needs of those seeking professionals assistance.

Researchers have documented that those involved in mental health profession such as counseling are experiencing high level of stress and burnout (Raquepaw & Miller, 1989 cited in Huey, 2007). Therefore, this study try to determine the major sources of work related stress and coping mechanism as perceived by VCT- Counselors in Addis Ababa.

1.2. Statement of the Problem

The effect of stress and burnout can have a number of deleterious effects on ones physical, psychological, social and occupational functioning. It has been found to relate to low worker morale, impaired work performance, reduced productively, absenteeism, adverse interpersonal relations with clients, negative attitude towards work, lower job satisfaction, high job turnover, lower quality of life, and poorer health and psychological well-being (Rabin, et al., 1999). Further the consequences of on going occupational stress and burnout among health professional include reduced quality of care and high reports of mortality (Gray-Toft & Anderson, 1981).Collectively these findings suggest that occupational stress and burnout, if left unchecked, can negatively impact professional well-being and may lead to professional impairment.

Tuner (1997 cited in Huey. 2007) assessed the relationships between the role stress experienced by mental health case managers and their respective levels of burnout and job performance factors (e.g. absenteeism, turnover intentions, job satisfaction, and affective commitment to the organization). Case managers who perceived increased levels of role stress were found to experience increased burnout and turnover expectations, while those who perceived decreased role stress reported increased job satisfaction and affective commitment to the organization.

Burnout has been identified as significant problem among health professionals who are working in chronic and critical care (Gueritault-Chalvin, Kalichman, Demi, Peterson 2000), such as HIV, oncology, surgery, and intensive care (Miller, 1995), even more so, it is a significant problem facing mental health professionals because of the very nature of their work in dealing with emotionally troubled persons often over extended periods of time (Moore & Cooper, 1996).

Shinn, Rosario, Morch and Chestnut's (1984) survey of mental health practitioners found that the job stressor most frequently identified across various institutions was poor job design, involving conditions such as excessive workload and role conflict. The lack of positive reinforcement or recognition for good work was reported by 44% of the mental health professionals in this survey as a source of job dissatisfaction and stress. Collectively, these studies suggest that the experience of occupational stress and burnout in mental health professionals appear to be most evident in work situations that inhibit mental health professionals' capacity to realize their value through their work.

According to the situation assessment of VCT practice in Ethiopia conducted in June 2006, there were about 102 institutions were involved in the service. It was found that most of the institutions do not follow standardized guidelines. Furthermore due to the absence of effective monitoring and evaluation mechanisms, the quality of the service suffers. The following are among the few barriers identified as affecting VCT in Ethiopia.

- Burnout of counselors
- Lack of training manuals for counselors
- Lack of supportive supervision and monitoring and evaluation

Counseling perhaps more than any other area of service provision, its service quality determine the outcome, however, high perceived stress level and lack of effective coping skill could present a barrier to this goal. Therefore, those involved in service provision or counseling must asses this problem, in order to ensure they give good counseling and identify effective strategies to deal with it. The study attempted to address the following questions.

1. What are the major sources of work related stress as perceived by VCT-Counselors in Addis Ababa?
2. What major strategies do these counselors use to overcome their stress?
3. Is there significant difference among demographic variables of age, gender, religion or marital status and perceived work stress and coping?

1.3. General Objective.

To identify the major sources of work related stress and coping strategies as perceived by VCT-Counselors.

1.3.1 Specific Objectives

* **To** identify the major sources of work related stress among VCT- Counselors.

* **To** find out the major coping strategies used by VCT- Counselors.

* **To** assess how the demographic variables (age, sex, religion, and marital status) explain overall stress, overall coping, categories of stress and categories of coping.

1.4. Operational Definition

1. **Perceived work related stress**: The harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources or needs of the worker.
2. **Coping mechanism**: an individual's adaptive response to perceived stress as measured by the ways of coping questionnaire.

1.5. Significance of the Study

According to Gulick and Urwick (1967; cited in Walton, 2002) there are seven functions inherent in the administrative role. These functions are planning, organizing, staffing, directing, coordinating, reporting and budgeting.

The identification of high job stress and burnout in mental health professionals or counselors can have implication for each of these functions. These implications can affect administrators or service providers at varying levels.

Planning: is "workings out in broad outline the things that need to be done and the method for doing them to accomplish the purpose set for enterprise" (Gulick& Urwick, 1967, p.13 cited in Walton. 2002). Counselors' high job stress and burnout can lead to reduced quality of care and mortality (Gray-Toft & Anderson, 1981). Administrators need to develop a plan to manage or overcome volunteers or staffs stress, thereby, enhancing the quality of counseling service.

Organizing: is "the establishment of the formal structure of authority through which work subdivision are arranged, defined and coordinated for defined objective" (Gulick& Urwick, 1996, p.13; cited in Walton, 2002). Administrators need to organize their resource to address the problem of high perceived job stress. This includes reorganization of strong organizational policies to include stress management.

Staffing: is defined as "the whole personnel function of bringing in and training the staff and maintaining favorable condition of work" (Gulick & Urwick, 1996, p.13; cited in Walton, 2002). This includes providing adequate training and ongoing support and supervision to ensure good counseling service.

Gulick and Urwick (1969; cited in Walton, 2002) define directing as "the continues task of making decision and embodying them in specified general orders and instructions and serving as the leader of the enterprise" (p. 13). Administrator need to communicate to departments or organizational hierarchies the importance of staffs stress levels and the methods to cope with them.

Coordinating: is "the all important duty of inter-relating the various parts of the work" (Gulick & Urwick, 1996, p.13; cited in Walton, 2002). This includes creating opportunities for socializing and networking with other counselors.

The sixth administrative function identified by Gulick and Urwick (1969) is reporting. The definition of reporting is " keeping those to whom the executives is responsible informed as to what is going on, which thus includes keeping himself and his subordinates informed through records, research and inspection "[p.13] (cited in Walton, 2002).

Lastly, Gulick and Urwick (1969; cited in Walton, 2002) identified budgeting as seventh administrative function. The definition of budgeting is "all that goes (P.13). This includes adequate logistical and financial support and professional motivation such as praise when you have done good work.

The result of this study will help VCT-Counselors and their agencies in providing possible methods of reducing work related stress. Also believed to help professionals and their agencies to become more aware about work related stress and subsequent risks associated with it.

1.6. Limitations

1. The result of this study can not be generalized to entire VCT counselors because of the limited sample seize of the population.
2. For identifying major VCT sites this study is based on the 2007 – 2008 research report so the writer also believed there might be a little bit change

CHAPTER II

REVIEW OF RELATED LITERATURE

Even though some stress is necessary for motivation and personal growth, in some cases stress can overwhelm an individual and affects their ability to function effectively. Stress and burnout are clearly problems for counselors and the evidence culled so far indicates that these factors not only affect the level of performance and the success of their interventions with their patients, but also their job satisfaction and ultimately their own health (Carson & Fagin, 1996).

The review of literature for this study will help to define the sources of occupational stress inherent to jobs of mental health counselors as well as possible ways of coping mechanism for these stressors.

2.1.1. Stress

Stress arises from any interaction between an individuals and the environment when the individual perceives the situation as threatening, challenging or possibly damaging. Essentially, the individual perceives that a situation may tax or exceed the individual's resources (Lazarus, 1977; cited in Walton, 2002). Similarly, the author by coating the definition of stress used by Hans Selye, says that, stress is "the non specific response of the body to any demand," (P.15).

Hans Selye (1952; cited in Walton, 2002) conducted the initial research on stress. Seyle's work was based on the premise that any activity or emotion can cause stress, which will require some type of change or adaptation from individual. The definition of stress used by Seyle (1976; cited in Walton, 2oo2) is "the non –specific response of the body to any demand," (P.15). Seyle's theory support that some stress is necessary to maintain life, but if the non-specific response places increased demand for adaptation, the effects on the individual may be damaging or excessive. After conducting extensive animal and human research, Seyle (1973; cited in Walton, 2002) identified a predictable pattern of response to stress that he termed the general adaptation syndrome (GAS). He identified three stages to this syndrome.

The first stage is the alarm stage that is the immediate stress response. The individual perceives a stressor that causes the body to begin a physiological response. This response is automatic and unconscious. It is at this point that the individual initiates the flight or fight response to the stimuli.

The second stage is the stage of resistance. This is the stage where adaptation and coping occurs. After a large amount of the individual's available energy, the body enters the last stage. This third and final stage is termed exhaustion.

2.1.2. Sources of Stress

We encounter many different types of stressors. Some are biological (toxins, heat, cold), some psychological (threat to self-esteem, depression), other sociological (unemployment, death of loved one, birth of a child), and still others philosophical (use of time, purpose in life). In any case, regardless of the stressor, the body's reaction will be the same (Greenberg, 1990).

Stressors most common to our lives involve the adaptation to change or the experience of daily hassles. Thomas Holmes and Richard Rahe (1967) found that the more significant changes a person had in his or her life, the greater the chance that he or she would contract some physical or psychological illness. Since they conceptualized stress as adapting to change, Holmes and Rahe viewed more change as equivalent to more stress and consequently, more illness and disease.

Richard Lazarus (1984), in his studies, found that daily hassles a person experience are more harmful to his or her health than are the significant life changes that concerned Holmes and Rahe. Lazarus believes these daily events are so damaging to health because of how frequently they occur, as compared to the major life events that Holmes and Rahe researched, which were usually encountered only rarely.

2.1. 3. Occupational Stress

One definition of occupational stress suggests that job stress results from job features that pose a threat to the individual. Threat may be due to either excessive job demands or insufficient supplies to meet employee's needs. When the job requires too much work in too short a time, job overload exists. Supply deficits concern things employees expect from their jobs: adequate salary, job satisfaction, and promotion or growth on the job (Rice, 1992).

Attempts to identify the sources of occupational stress have discovered many culprits. Cary Cooper has developed concise yet complete lists of six sources of work stress (Cooper, 1983):

(1) Job Condition – Quantitative & qualitative work overload, people decisions, physical danger, techno- stress.

(2) Role Stress- Role ambiguity, sex bias and sex-role stereotypes

(3) Interpersonal Factors- Poor work and social support systems, lack of management concern for the worker, political rivalry, jealousy, or anger

(4) Career Development- Under promotion, over promotion, job security, frustrated ambitions.

(5) Organizational Structure- Rigid and impersonal structure, political battles, inadequate supervision or training, non participative decision making

(6) Home-work Interface-Spillover, lack of support from spouse, marital conflict, dual career stress

Using a self report questionnaire amongst a sample of 267 teachers, drawn from primary schools in the north and eastern regions of England, Chaplain (1995) established a picture of stress and job satisfaction. Teachers scored the frequency and intensity of 18 items on a stress scale. A principal components analysis was carried out and three factors of occupational stress were identified; professional concerns, pupil behavior and attitude, and professional tasks. The strongest correlations were found between professional concerns and occupational stress.

When specific facets of job satisfaction were examined, teachers were most satisfied with their professional performance and least satisfied with teaching resources. Stress and job satisfaction were found to be negatively correlated. High reports of occupational stress were related to low levels of job satisfaction (Chaplin, 1995).

2.1.4. Occupational Stress in Mental Health Counselors

A study was conducted by Donat and Neal (1991) to systematically identify common situational sources of occupational stress experienced by psychiatric aides, mental health workers, and licensed practical nurses in state hospital setting. Thirty-nine situations were identified that were associated with high levels of anxiety, depression, and confusion. Participants were 100 direct care staff members from the day and evening shift at a public residential psychiatric facility in the Commonwealth of Virginia.

Eight factors, accounting for 71% of the total variance were revealed. These factors were labeled as follows: staff conflict over duties/ treatment decisions; inconsistent/unfair work conditions; lack of respect from coworkers/ the system; inadequate care by other staff members, lack administrative support for duties; and working with uncooperative/incapable residents.

The results of the study indicate that the damaging impact of stress and burnout can be compounded in institutional settings such as state hospitals. In such settings, staff members with relatively low levels of education and compensation, such as psychiatric attendants, are more numerous and have the majority of interpersonal interactions with residents. The combination of an exceptionally impaired resident population, lack of adequate professional guidance, and low pay can add to stress and burnout experienced in such settings (Donate & Neal, 1991).

insecurity is prevalent (Carson & Fagin, 1996). There is evidence that dissatisfaction is beginning to spread amongst mental health workers and that many of the previously dedicated and committed professionals are opting to leave the service, plan for an early retirement at the peak of their capacity, or more worryingly, develop strategies of survival which distance them from patient care and see the job "only as a job" (Carson & Fagin, 1996).

2.1. 5. Transactional Model of Work Stress

This theory is the currently prominent and the diversely acknowledged one. Is labeled as the Cognitive Transactional Theory. It is because it is processed in one's mind. It is also transactional because it exchange between the individual person under stress and the environment that is inducing.

Lazarus and Folkman's transactional model of stress has been used to conceptualize the relationship between occupational stress and health, resulting in the development of a transactional model of work stress (Cox, 1985; Cox et al., 1993). In this framework, the concept of stress is specific to the complex perceptual and cognitive processes that underlie peoples' interactions with their work environment (Cox et al., 1993). Work stress is defined as the psychological state that represents an imbalance or mismatch between people's perceptions of the demands placed on them in their work environment and their ability to cope with those demands (Cox, 1985; Cox et al., 1993). Similar to the traditional transactional model of stress, the work stress model asserts that a person's experience of occupational stress and distress is dependent upon his or her cognitive appraisal processes and coping efforts. Failed at coping can lead a person to experience

changes in general well-being such as negative emotions, unpleasantness, general discomfort, and feeling of tension and being worn out(Cox et al ., 1993).

Given the nature of their work, it has been suggested that mental health professionals who work with HIV/ AIDS individuals are vulnerable to stress and burnout (Slagle, 1996; Joseph, 1998). If occupational stress is not managed effectively, over time, it can have serious repercussions for organizations by undermining service delivery and quality of care, and the well being of both the professionals and the individuals they serve.

2.1.6. Stress and the Social Context

i. Stress and Socioeconomic Status (SES) - Kessler (1979) as quoted in Williams and House (1991) described the impact of lower socio-economic status on stress as follows: "... comparable stressful events have stronger negative effects on people of lower socio-economic status than on people of higher status.

ii. Sex difference in stress- Billings and Moos (1984) citing both their own study (1981) and Pearlin and Schooler (1978) states "... there is some evidence that in comparison with men, women are more exposed to environmental stressors, have fewer supportive social resources, and use less efficacious coping patterns" (p.880). It is apparent worldwide that women, compared to men, experience more stress by being labeled as inferior. In instance, they are given lower opportunity for education, religious and political involvement, etc. These in turn increase stress.

iii. Age difference in stress: - stressful life event vary with age level. Younger and older people do not experience similar problems. Life events like job change,

financial matters, unemployment, love affairs distress younger people. Older people are stressed more by retirement, bad health conditions, death of loved ones, etc. studies of Tuner, Wheaton, and Lloyd (1995) substantiate the idea that younger people have more life events, hence more stressed, than older people.

iv. Stress related to marital status: it is widely believed that married persons have more outlets (so lesser tension) than unmarried ones. They are also at an advantage for having closer companion who share both stressful life events and daily hassles. The work of catharsis as helping people on their psychological health is seen here. On the other hand, divorced, widowed, and separated people do not have intimate persons to turn to in times of distress. This in turn adds up in appraising stressful events as threats. Hence, such people may experience more stress and its negative consequences like illness.

2.1.7.Some Related Issues with Stress

What determines' stress? Basically, there are individual differences in dealing with stress. How stress is appraised varies from one person to another. Some may appraise a certain stressful situation as threat while others may appraise the same event as challenge. Their coping strategies would obviously correspond to their difference in appraisal. Coon (1983) says

> "...the intensity of the body's stress response often depends on what we think and tell to ourselves about stressors" (p.324).

Engle and Snegrove (1984) lists variables that influence level of stress.

1. People's expectations

Expectations help us make predictions. Since predictable events will not be exclusively new when they occur, level of stress obviously decrease. For example, an electrical shock experiment used rats as subjects. One group was given shock randomly and the other group was shocked on scheduled basis. The group that was shocked on random basis developed more ulcer than the other group to whom the shock was administered on schedule. Uncertainty and suspense make stressfulness difficult to deal with in contrast to predictability.

2. Amount of responsibility

This is experienced more in working areas. Common example of responsible individuals who could be more stressed are, air traffic controller and health Professionals. These people are said to handle the lives of a lots of people at any given time.

3. Amount of information

Information is known to be the backbone of activities in life: from a simple household level to the international level and from the primitive to the scientific arena of life. It can, therefore, be reduced that lack of information increases the stressfulness of a situation. On the other hand, ample amount of reliable information decreases stress.

2.2. Coping

It is unrealistic to think that you can eliminate stress from either your personal life or professional life. Yet you don't have to be the victim of stress, for you can recognize how you are being affected by it and can make decisions about how to think, feel, and behave in stressful situations. You can become aware of your destructive reactions and learn constructive way of coping with it. In short, you can learn to manage and control stress rather than being controlled by it (Corey & Corey, 1993).

Lazarus (1977) defines coping as a reaction to stressors. This reaction is the individual's attempt to master condition of harm, threat or challenge (Goosen & Bush, 1979). Coping mechanism are "those direct, active tendencies aimed at eliminating a stressful event," (Lazarus, 1977, p. 8). The process of coping may consist of a rather large array of overt and covert behaviors. The process of coping is a very complex response that occurs when an individual attempt to remove stress or what is perceived as a threat from one's environment. The actual reaction one has to an environmental event is as important as the event itself (Garland & Bush, 1982). Therefore, not only does one's coping ability have implication for mental and physical health, but the person's state of health can also affect one's ability to cope.

Lazarus (1977) divides coping into two main categories, direct action and palliation. Direct action refers to the individual's attempt to change the environment or stressor. Palliation, on the other hand, refers to the individual's attempt to moderate the demand by the stressor or tolerate the subjective symptoms produced by the stressor. Lazarus (1977) further divides palliation into two subgroups. One subgroup is directed at the symptoms and includes the use of alcohol, tranquilizer or muscle relaxation techniques. The second

subgroup is termed intra-psychic modes and refers to the use of unconscious defense mechanisms such as denial or distancing. Consequently, the individual may deal with stress through several methods including removing the stressor through manipulating the environment, developing specific responses to help deal with stressor or seeking diversion from stressor.

Lazarus and Lanier (1978) further studied the concept of coping and divided the coping choices into instrumental coping (problem-focused) and palliative (focused on regulating the emotional response). Instrumental choices included information gathering, problem solving, communication, social skill training, time management, mobilizing support and direct efforts at changing the environment. Palliative techniques included denial, diverting attention, searching for meaning, emotional distancing, expressing affect, cognitive re-labeling and relaxation training (Schmitz, 1995).

Studies by Pearlin (1990) and Pearlin and Schooler (1978) were among the first to address the interaction of the individual and the environment. They identified coping as a behavior that is a protective mechanism that functions in three ways. First is by attempting to eliminate or modify the situation that is giving rise to the problem. Second is to perceptually control the meaning of the experience in a manner that neutralizes the problematic character of the situation. The third is to attempt to keep the emotional consequence of the situation manageable. These researchers believe that all coping behaviors can categorized into these three areas.

The research by Roth and Cohen (1986) on coping identified two basic orientations to stress -approach and avoidance. These orientations refer to the cognitive and emotional

activity that is oriented either to or away from a threat. Approach strategies refer to attempting to take appropriate action either change a situation or to make it more controllable. On the other hand, avoidance strategies attempt to protect the individual from the overwhelming power of the stressor by distancing the individual from the experience.

Neither approach nor avoidance is determined to be the most effective coping style. According to the authors, the coping behavior must be matched with the potential rewards available in relation to the demands. Approach strategies allow for action and attempting changing the situation, allowing the individual to take more control.

Avoidance or distancing are behavior patterns that are thought to be more passive and are often thought of as weak or ineffective, on the other hand, approach strategies generally seem to be more effective when individual has more control or power over a situation (Smitz,1995). In some cases, avoidance can be important to allow assimilation of a stressful situation until the individual can gain more control or acceptance. This can be especially effective in a situation where an individual has no control such as disease (Roth & Cohen. 1986) or if the stressors involve chronic, high stress difficulties (Lennon, (1987). It is important, however, avoidance or denial is used only to facilitate assimilation since denial can cause negative consequences. First denial may cause the individual to not perceive or take advantage of opportunities to correct stressful situation.

Second, denial can lead to unconscious build up of pressure in active memory, which can cause psychological intrusion such as nightmares, foreboding thought or negative

feelings (Roth & Cohen, 1986). So it important for administrator and organizations to understand the types of stress VCT- Counselors perceive and to implement strategies to deal with this stress.

2.2.1. **Coping Strategies**

These are ways of responding to what has been appraised as stressful. Different authors suggested different methods of coping. For example Williams and House (1991) say

> "..Coping describes the strategies used in responding to potential stressor. These strategies can be cognitive and/ or behavioral responses that attempt to manage or control the psychological and physiological arousals caused by the stressors. This is accomplished by modifying the situation, modifying the meaning of the stressor, or managing the emotional responses to the situation" (p.159).

The idea of these authors goes along with Folkman & Lazarus' (1988) description of coping strategies as a wide range of cognitive and behavioral processes. Lazarus and Folkman describe coping as only as effort. It is strategy directed towards the problem whether or not it fails or succeed in alleviating the stressful situation. Cox (1995), however, states coping strategies to be relevant and applicable to the situation at hand. Coping strategies, for Cox, are attempts to manage demands. The attempts are either by altering the demands, redefining them, or adapting to them.

Engle and Snellgrove (1984) also outlined seven strategies of dealing with problems.

1. Getting away from the stressor: this goes along with Lazarus & Folkman's escape-avoidance strategy.
2. Exercise: helps one by putting his or her muscles in their proper shape which in turn relaxes his or her psychological make-up.
3. Relaxation: unlike exercise, relaxation eases the body by, for example, taking deep breaths, counting numbers, etc.
4. Biofeedback: is known for taking away, not the stress, but its harmful effects.
5. Social support: is having friends and /or family members to turn to for care, support, understanding, and encouragement.
6. Drugs: since there would be change in one's chemical make-up after having taken drugs or alcohol, there could be some relaxation of the body. Use of drugs, however, could make people be dependent on them both physically and psychologically. It should be therefore be the last resort to adopt.
7. Preventing stress: involves appropriate budgeting of time, self assurance, catharsis, step-wise problem solving, and positive interpretation of encounters.

The most commonly used and the commercially available "Ways of Coping Questionnaire" describe eight types of possible coping strategies. Folkman and Lazarus (1988) outlined:

1. Confrontive coping: are aggressive efforts to alter the situation. E.g. "stood my ground and fought for what I wanted."

2. Distancing: are cognitive efforts to detach one-self. They are also efforts to minimize the significance of the situation. E.g. "I went on as if nothing as happened."
3. Self- controlling: are efforts to regulate one's feeling and actions. E.g. "I tried not to act too hastily or follow my first hunch."
4. Seeking social support: are efforts to seek informational, tangible and emotional support. E.g., "talked to someone who could do something concrete about the problem."
5. Accepting responsibility: are an effort to acknowledge one's own role in the problem to try to put things right. E.g., "I apologized or did something to make up."
6. Escape-avoidance: are efforts of wishful thinking. E.g., "Wished that the situation would go away or somehow be over with."
7. Planning problem solving: are deliberate problem-focused efforts to alter the situation. It is also an analytic approach to solve the problem. E.g." came up with a couple of different solution to the problem."
8. Positive reappraisal: are efforts to create positive meaning by focusing on personal growth. It also has a religious dimension. E.g., "I changed something about myself." Or "I prayed."

These strategies have two categories: problem-focused and emotion-focused. Strategies one, three, and seven belongs to problem solving while strategies two, five, six, and eight belong to emotion-focused category. Social support strategies belong to both categories. This is so because, if we seek somebody's help to get information and useable advice. it

serves a problem-focused function. If we seek understanding and sympathy from somebody, it satisfies emotion-focused function.

2.2.2. The Work of Social Support in Coping

According to transactional theory, social support serves both problem and emotion-focused functions. But the work of social support is argumentative. This could be why it is separately dealt with different literature (e.g., William & House, 1991; Ashford, 1988; Rohde, Lewinsohn, Tilson & Seeley, 1990; Costanza, Derelega & Winstead,1988; Billing& Moos,1984; Jayarante, Himle, Chess, 1988.)

House and Kahan (1985) as cited in William & House (1991) say that there is a high correlation between health and social support. The mere perception that there are people around to turn to in times of problems makes one both physically and psychologically health. So social relationships do provide a lot of support. They also decrease depression in times of stress. The presence of others also has three ways of reducing stress as stated by Williams and House (1991).

> " first, social ties can directly improves health by meeting basic human needs for affection, social contact, and security, second, supportive social relationship can reduce interpersonal conflict and tension , thereby reducing stress. Increases in social ties lead to improvement in health independent of the level of stress by these two mechanisms. The third mechanism is a buffer or interactive one. The buffering hypothesis holds that mobilizing social ties in the presence of stress protects the individual from the pathogenic consequence of stress. Social relationships thus modify the relationship between stress and health such that risks to health decline as levels of support increase" (p.155).

Social support as a coping mechanism is also said to have both positive and negative impacts. When social support is used as a way of solving the problem (like getting concrete information about the problem, or discussing as possible solution, it will have positive impacts). It is even argued that people with several social ties like spouse, friends, relatives, and group membership live longer and healthier. Such close persons are concerned to provide information, financial and material help, and to give love in spite of an individual's problems. But when social support is used only for disclosure of feeling, it is argued that it rather intensifies the problem. This means that the more we talk about a certain problem, the more it gets strengthened in us.

In this case, social support has a negative impact. Constanza, Derlega, & Winstead (1988) reported on the findings of Hobfoll & London (1986) about the negative impact of talking with friends and neighbors. The study was made on Israel women whose husband and boy friends had gone for military mission during the 1982 Israel- Lebanon conflict. They found that talking with people of the same difficulty has a "pressure cooker effect." It rather exaggerates the actual accounts of the problem and intensifies psychological distress.

When talking with friends involves unrelated talk with the problem, it is said to help in decreasing stress. But this is effective when the talk is made after (not before) the appearance of stress.

The work of social support is also believed to have difference in sex. Women are said to be more giving and support providing (Williams & House, 1991; and Billings& Moss, 1982). But this difference in sexes is not inherited. It rather socially learned and may have its impetus from the caring behavior of the mother to her child.

2.2.3. **Coping and Control**

Perception of control on stress encounters facilitates coping. People who believe those situations are controllable make use of stressful situations as learning experiences. Their appraisal of the stress is therefore challenges not threats. On the other hand, people with perception of lack of control for stress appraise situations as threats. Ashford (1988) took ideas from Folkman (1984) and said,

> "Perception of personal control may… be self-reinforcing over time. The individual who feels in control may generate fewer negative emotions requiring attention. This person thus may subsequently undertake more problem-focused coping strategies, there by, brings the situation under control" (p.31).

2.2.4. **Coping Along with Social Variables**

1. Coping and Socio-economic Status (SES) - people of lower socio-economic status have relatively lower communications and interrelationship with others. This is in contrast to people in higher socio-economic status where there is relatively higher education, interaction and exercise of social support. It is also said that spouse of higher socio-economic status support each other well than spouse of lower SES.
2. Coping and Sex differences – Rohde, Lewinson, Tilson and Seeley (1990) and Dolan and White (1988) found that women make use of problem –solving, self-controlling, and social support seeking coping mechanisms more frequently than do men. Men, on the other hand, were found to employ ineffective escapism (like wishful thinking) and self- blames strategies. Generally, however, the coping response employed by both sexes is found to be similar in the study by Tanck &

Robin (1979) as quoted in Hamilton and Fagot (1988). This is apart from the stereotypical beliefs that females are more expressive (emotion-focused) while males are more instrumental (problem-focused).

3. Coping and Age – in their studies on younger and older subjects, Folkman and Lazarus (1988) found difference by age. Younger subjects employ more of positive reappraisal. It was observed to increase pleasure and confident for them. In the older group, people use more of social support which showed on difference in the younger group. Positive reappraisal was found to make the older group experience worry and fear. Older people are also said to be passive and less flexible in their coping repertoire.
4. Coping and Education – higher levels of cognitive complexity and realistic appraisals of stressful situation are used by people of higher education status. Ineffective escapism is employed by people of less formal education.

CHAPTER III

Methodology

3.1. Research Design:

The study is quantitative and a one time survey. This method was chosen as it enables to compare the difference among the existing demographic variables and also to make conclusions that could be generalized at least to some extent across age groups, religions, and marital status or even across contexts or settings.

3.2. Study Area:

According to Addis Ababa HIV/AIDS Prevention and Control Office (AAHAPCO) in 2008 there were 110 VCT service sites in the different sub-cites of Addis Ababa mostly integrated with other medical services. All centers provide pre- and post test counseling and HIV testing. Addis Ababa is structured in to 10 sub-cites and 99 kebeles (the lowest level of administration of the city). HIV VCT service was given for 193, 600 (44.3 % male and 55.7 %) from July 2007 to June 2008 (Published Document from AAHAPCO).

3.3. Sampling Frame and Sample:

The study involved full time working VCT counselors within sites in Addis Ababa. At the end of June 2008 there were a total of 110 VCT service sites. A list showing the number of VCT clients served within these VCT was obtained from Addis Ababa Prevention and Control Office (AAHAPCO). Since it was very difficult to cover all with in the time and resources available for the study , only 'Major VCT sites', selected based

on daily flow of clients, were involved in the study. Based on the report compiled by AAHAPCO from the June 2007 up to July 2008, daily client flows of each setting were estimated. Sites were stratified as Highest (>10 clients per day), Average (5-9 clients per day), and Lowest (< 5 clients per day). Highest and Average flow sites were part of the study so as to be time and cost effective, moreover, these sites would be methodologically sound since the research deals with work related so increased caseloads could help better to identify. Accordingly, 31 VCT sites found to fulfill these criteria; however, one VCT sites had to be excluded because permission was not granted All full time working VCT counselors in the selected sites were included in the study. This is the recommended way of selecting counselors for such purpose according to the UNAIDS evaluation tool. The number of VCT counselors included in this study were in accordance with UNAIDS instruction, which states all should be included. Accordingly it was found out that 58 VCT counselors were working in the selected VCT sites on full time (regular) base.

3. 4. Demographic characteristics of respondents

The Majority of VCT counselors were females, 38 (65.5 %) in their early twenties to end of thirties. Thirty- two (55.2 %) counselors were married and orthodox Christian religion followers (Table 1).

Table 1: Demographic Characteristics of Respondents (N = 58)

Characteristics	Frequency	percentage
Age		
20 -29	21	36.2
30 – 39	20	34.5
40 and above	17	29.3
Gender		
Male	20	34.5
Female	38	65.5
Marital Status		
Married	32	55.2
Single	25	43.1
Divorced	1	1.7
Religion		
Orthodox Christian	32	55.2
Muslim	1	(1.7)
Catholic	2	(3.4)
Protestant	22	37.9)
Others	1	1.7

Data Collection Instruments:

The data is obtained through structured questionnaire. Questionnaire is utilized because it is the most economic and efficient method for collecting data.

The questionnaire consisted of the following three sections.

The first section asks about personal characteristics of respondents including age, sex, marital status and religion. Besides, it also asked professional background. selection, training, support and supervisions and job characteristics. This questionnaire was developed by the researcher from different literature reviews.

The second section asks participants to identify sources of work related stress. The questionnaire covers different areas of VCT counselors' stressor. It has a 4 point Likert scale with 1= never, 2 = seldom. 3 = sometimes, and 4 = often.

This questionnaire is also developed by researcher from different literature reviews, especially, UNAIDS' for Evaluating HIV Voluntary Counseling and Testing documents (2000). Four factors of possible source of VCT counselors stress were identified. These factors which consist of 14 items and categorized as, interpersonal factors, job conditions, professional self doubt and organizational structure and processes.

The Cronbach alpha for overall stress questionnaire was 0.73.

The third questionnaire used in this research was WCQ -SF (Ways of Coping Questionnaire Short Form) originally developed by Folkman and Lazarus (1988). This tool was used to measure the cognitive and behavioral coping strategies that individuals use in stressful experiences. This tool used 26 – items self – report measure of coping responses. Ways of Coping Questionnaire Short Form was designed to measure eight different types of coping responses in stressful circumstances. The respondents answer the question on 4- point Likert scale with 0 = not used, 1 = used somewhat, 2 = used quit a bit, 3 = used a great deal.

The reliability coefficient alpha estimates of the WCQ – SF ranges .53 to .79 indicating moderate to high for all of the scales.

The scale has been used in published research that was conducted in several countries and with different ethnic groups. The WCQ was classified as well established assessment that broadens understanding and has been used extensively by researchers (Vtalino, Russo. Carr, Maiuro & Becker 1995) .Therefore; the instrument is sound and believed to be psychometrically sound and applicable to this study.

All questioners were pre- tested on sites which were not included in the study and were used after making the necessary correction.

3. 6. The Content Validity for Coping Scale

'Ways of Coping Questionnaire – Short Form' is used in this study. It has 8 categories and consisted of 26 score-able items. In the process of reviewing the questionnaire, one item is believed to be inappropriate for Ethiopian context (i.e. Took a big chance or did some thing very risky). Hence it was discarded. One item which is believed to work for Ethiopian context as coping strategies is added (i.e. I enjoy exercise or sport of any kind) Some items were rephrased to change their English dialectic; E.g. ' make light of the situations ' was changed in to ' I simplify the situation', ' I came out of the experience better than when I went in' was changed in to ' I learn and draw strength from experience'.

All items in the scale were worded in past tense. In outlining informal criteria for attitude statements, Edwards (1957) recommends avoiding statements that refers to the past. So, all items were put in the present tense. In this study, the Cronbach alpha score for this scale was 0.76.

3.7. Data Analysis

The professional background characteristics of VCT counselors was assessed using the proportion of counselors who were self motivated during selection, number of counseling courses attended, duration of courses, proportion of counselors with access to supporting and supervising body and job characteristics.

In this study the dependent variables are 'Stress and Coping'. The total score of individual's cases summed across the items is worked out. The demographic variables (age, sex, marital status and religion) are the independent variables on overall stress, overall coping and the twelve categories of stress and coping.

The statistical analyses employed were:

a) Descriptive statistics like percentages, frequency, and standard deviations were used to describe some of the findings.

b) Mean was used to identify the major sources of perceived work related stress. Each category was divided by its own number of items. Then to get the average score per person, the mean of each category was worked out. The same statistical procedures were used to identify the major coping strategies VCT counselors use.

c) Univarite Analysis of variance was used to work on how the demographic variables explain: overall stress, overall coping, categories of stress and categories of coping.

d) Only main effects and two way interactions is reported. Since the SPSS displays empty output.

e) Post –hoc test is not performed for religion and marital status because, one group has fewer than two cases, for independent variable sex, because there are fewer than three groups.

CHAPTER IV

RESULTS

The major purpose of this study was to identify the major sources of work related stress and coping strategies used among VCT counselors in Addis Ababa. This chapter contains the major findings.

First, professional background of VCT counselors will be presented. Second, the chapter will present identification of work related stressor. Third, identification of coping strategies. Finally, the chapter will present how demographic variables (age, sex, religion, and marital status) explain overall stress, overall coping, categories of stress and categories of coping.

4.1. The Professional background Characteristics of the VCT Counselors.

Within 30 VCT sites, a total of 58 individuals involved in HIV counseling were identified. Of those who responded, 48 (82.8%) were clinical nurse before they became VCT counselors. Majority of the counselors, 39 (67.2%) were self motivated during selection for counselor.

Majority of the counselors 40 (69 %) have taken 2 or more counseling training throughout their practices. More than half (53.4%) of the counselors had taken counseling courses for < 3 weeks.

Thirty-eight (65.5%) VCT counselors had been counseling for more than 3 years. 33 (56.9 %) rated the quality of counseling training they received as very good. Forty-five (77.6%) admitted that they have access to a designated counseling supervisor to provide them with support and technical backup. 42(72.4%) VCT counselors had been

counseling for 6 – 8 hours per day. Of the 28 (48.3%) counselors who have other than HIV counseling, only 6 (10.3%) said that they have shortage of time to do counseling. Almost 57 % of VCT counselors had to work for long hours. 34 (58.6%) have moderate worry about loosing their job and only for 18 (31.0%) counselors was counseling was highly stressful (Table 2, See Appendix F)

4.2. Identification of Stressor

Research question one:

What are the major sources of work related stress as perceived by VCT counselors in Addis Ababa?

By computing Mean the writer checked which categories of stress are more stressful to subjects in this study.

Table 3: Mean, standard deviation, and No of cases in stress categories

Category	N	Mean	Std. Deviation
Job conditions	58	1.8448	.57702
Organizational structures and processes	58	1.6494	.60027
Interpersonal factors	58	1.3836	.56626
Professional self doubt	58	1.1724	.41531
Valid N (list wise)	58		

The categories are put in their order of importance based on their Mean. Accordingly, 'Job Conditions' category has the highest Mean. This category includes items like overburdened at work, time pressure, poor job promotion and not suitable counseling space. The second stressing contributing factor is the category of 'Organizational structure and processes' which constitutes items like lack of consistent and sufficient information from superiors, staff members interfering during counseling and others take decisions on one's duties. 'Interpersonal factors' is found to be the third stressful category. This category includes items like, lack of respect from co-workers, communication problem with colleagues, isolation at work and undervalued by clients. While 'Professional self doubt' has the minimum mean. This category includes items like, not confident in counseling skill, difficulty to communicate test results to clients and problems in maintaining confidentiality about client.

4.3. Identification of Coping Strategies

Research question two:

What major strategies do these counselors use to overcome their stress?

Mean are computed to identify which categories of coping are more employed. Here, too the Mean is the base to place the categories in their order of importance. (Table 4)

Table 4: Mean, standard deviation and No of cases in categories of coping

Category	N	Mean	Std. Deviation
Planful – Problem Solving	58	2.2543	.51190
Positive Reappraisal	58	2.1897	.77419
Seeking Social Support	58	1.9095	.70353
Self –Controlling	58	1.6000	55060
Confrontive –Coping	58	1.5776	.99031
Distancing	58	1.3793	.68384
Accepting Responsibility	58	1.1293	.60379
Escape –Avoidance	58	.4914	.58107
Valid N(list wise)	58		

Accordingly, 'Planful Problem Solving' category has the maximum Mean. This category includes items like make plan of action and follow it, think what I will do or say, I change some thing so things would turn out alright. and try to come up with alternative solution to the problems. The second cop-up strategy employed is, 'Positive Reappraisal' which constitutes items like I pray, I put all my trust in God, I look some thing for what is happening and I seek God's help. The category of 'Seeking Social Support' has the third successive highest mean. This category is the combination of items like I talk to someone to find out more about the situation, I talk to someone who could do something concert about the problem, I ask a relative or friends I respect for advice and I get sympathy and understanding from someone. The fourth cop-up strategy is 'Self Controlling 'this category includes items like I try to keep my feelings to my self, try to

act too hastily or quickly, I think about a person I admire would handle the situation and use that as a model, try to find comfort in religion and enjoy exercise. The fifth category is, 'Confrontive Coping' constitutes items like I fight for my right and for what I want, and I express my feeling directly. The sixth category 'Distancing' includes items like I go as if nothing happen, and I try to forget the whole thing. Seventh category is 'Accepting Responsibility' this contains items like I tend criticize my self and I apologize or do some thing to makeup. Lastly, the category of 'Escape –Avoidance' has the minimum mean with least employed coping strategies among VCT counselors. This category includes items like avoid being with people in general and I use alcohol or drug to make my self free.

4. 4. The Stress Scale along with Demographic Variables

Research question three:

How the demographic variables (age, sex, religion, and marital status) explain overall stress, overall coping, categories of stress and categories of coping?

Overall stress was analyzed using four demographic variables by the method of univarite analysis of variance.

The result is as follow.

(A) No statistically significant main effect is observed.

(B) There is a statistically significant interaction effect on overall stress with age and marital status. More stress is seen among age group of 30 – 39 years and single ($F (2, 38) = 4.285$, $p < 0.05$. (Table 5) (See Appendix G for descriptive statistics)

Table 5: Univarite Analysis of variance for overall stress scale

Source	Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	2.708[a]	19	.143	1.879	.048	.484
Intercept	41.294	1	41.294	544.389	.000	.935
Age	.388	2	.194	2.556	.091	.119
Sex	.251	1	.251	3.306	.077	.080
Marital Status	.037	2	.019	.246	.783	.013
Religion	.691	4	.173	2.277	.079	.193
Age * Sex	.080	2	.040	.527	.595	.027
Age * Marital Status	.650	2	.325	4.285	.021	.184
Age * Religion	.061	1	.061	.800	.377	.021
Sex * Marital Status	.144	1	.144	1.905	.176	.048
Sex * Religion	.053	1	.053	.705	.406	.018
Marital Status * Religion	.010	1	.010	.128	.723	.003
Age * Sex * Marital Status	.000	0	.	.	.	.000
Age * Sex * Religion	.000	0	.	.	.	.000
Age * Marital status * Religion	.312	1	.312	4.108	.050	.098
Sex * Marital Status * Religion	.000	0	.	.	.	.000
Age * Sex * Marital * Religion	.000	0	.	.	.	.000
Error	2.882	38	.076			
Total	140.847	58				
Corrected Total	5.590	57				

a. R Squared = .484 (Adjusted R Squared = .227)

4.5. The Coping Scale along with Demographic Variables

Overall coping strategy is considered along with demographic variables by employing Univarite Analysis of Variance.

(A) There is a statistically significant difference among the three age groups. More use of coping strategy is observed among age group of 30 – 29 years ($F (2, 38) = 7.849$, $p < 0.05$).

(B) There is statistically significant difference among the three classification of marital status. More use of coping strategy is observed among married counselors, ($F(2, 38) = 4.043, p < 0.05$).

(C) There are statistically significant interaction effects on the use of coping strategies with age and religion. More use of coping is observed among age group of 20 – 39 years and Muslims ($F(1, 38) = 12.735, p < 0.05$) one hand, and with marital status and religion on the other hand. More use of coping is observed among single and Muslims ($F(1, 38) = 13.130, p < 0.05$). (See Table 6) (See Appendix H for descriptive statistics)

Table 6 Univarite Anaysis variance for overall Coping Scale

Source	Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	4.147[a]	19	.218	3.471	.001	.634
Intercept	46.146	1	46.146	733.843	.000	.951
Age	.987	2	.494	7.849	.001	.292
Sex	.100	1	.100	1.589	.215	.040
Marital Status	.508	2	.254	4.043	.026	.175
Religion	.599	4	.150	2.381	.069	.200
Age * Sex	.035	2	.018	.282	.756	.015
Age * Marital Status	.124	2	.062	.987	.382	.049
Age * Religion	.801	1	.801	12.735	.001	.251
Sex * Marital Status	.112	1	.112	1.788	.189	.045
Sex * Religion	.009	1	.009	.148	.702	.004
Marital Status * Religion	.826	1	.826	13.130	.001	.257
Age * Sex * Marital Status	.000	0	.	.	.	.000
Age * Sex * Religion	.000	0	.	.	.	.000
Age * Marital Status * Religion	.702	1	.702	11.165	.002	.227
Sex * Marital Status * Religion	.000	0	.	.	.	.000
Age * Sex * Marital Status * Religion	.000	0	.	.	.	.000
Error	2.390	38	.063			
Total	177.759	58				
Corrected Total	6.537	57				

a. R Squared = .634 (Adjusted R Squared = .452)

4. 6. Independent Analysis of the Twelve Categories

Using univarite analysis of variance, independent analysis was made on each of the four categories of stress and the eight categories of coping with demographic variables.

4.6.1. Categories of stress

(A) Interpersonal Factors

No statistically significant main effect as well as interaction effects is observed.

(B) Job conditions

i). By Sex: the result is statistically significant. Job condition as perceived source of VCT counselors work related stress is more manifested among male respondents than female respondents ($F (1, 38) = 7.664, p < 0.05$).

ii) By Religion: the result is statistically significant. Job condition as perceived sources of VCT counselors work related stress is more manifested among catholic religion follower ($F (4, 38) = 4.602, p < 0.05$).

iii) There is a statistically significant interaction effect of sex and marital status on this category of stress. More stress is manifested by male counselors who are single ($F(1,38) = 4.954, p < 0.05$)

iv) There is also statistically significant interaction effect by sex and religion. More by female counselors who are Muslim ($F(1,38) = 6.999, p < 0.05$)

(C) Professional self doubt.

i) There are three statistically significant main effects

- By age: there is a statistically significant difference among three age groups classification. Counselors whose age range from 30 – 39 years are more stressed by professional self doubt ($F (2, 38) = 18.654, p < 0.05$)

- By sex: the result is statistically significant. More stress by professional self doubt is observed among male counselors ($F(1, 38) = 12.679, p < 0.05$)
- By marital status: the result is statistically significant. More stress by this category is observed among singles ($F(2,38) = 21.238, p < 0.05$)

ii) There is statistically significant interaction effects

- By age and sex: more stress is manifested by male respondents, whose ages are 40 and above years ($F(1,38) = 10. 016, p < 0.05$)
- By age and marital status: more stress is manifested by married and whose ages between 30 – years ($F(1,38)= 9.805, p < 0.05$)
- Sex and marital status: more stress on this category is manifested by male and single respondents ($F(1,38) = 13.437, p < 0.05$)

(D) Organizational structure and process.

i) There are two statistically significant main effects.

- By age: there is a statistically significance among three age group classifications. Age group between 30 – 39 years are more stressed by organizational structure and processes ($F(2, 38) = 8.432, p < 0.05$)
- By religion: there is statistically significant difference among five religion classifications. More stress is by organizational structure and process is observed among catholic respondents ($F(4,38) = 3.884, p < 0.05$)

ii) There are two statistically significant interaction effects

- By age and Martial Status : more stress is manifested between age group of 30 – 39 years and who are single($F(1,38) = 7.377, p< 0.05$)
- By age and religion: more stress is manifested among age group of 30 -39 years and who are protestant religion followers ($F(1,38) = 12.509, p < 0.05$)

Table 7, Summery of "F" and "P" values of the categories of stress along with demographic variables

Category	A	S	MS	R	AXS	AXMS	AXR	SXMS	SXR	MSxR
Interpersonal factors										
Job conditions		7.664 (0.009)		4.602 (0.004)				4.954 (0.032)	6.999 (0.012)	
Professional self doubts	18.654 (0.000)	12.679 (0.001)	21.238 (0.000)		10.016 (0.000)	9.805 (0.000)		13.437 (0.009)		
Organizational structure and processes	8.432 (0.001)			3.884 (0.010)		7.377 (0.002)	12.509 (0.001)			

(A = Age, S = Sex, MS = martial status, R = Religion)

❖ P values are shown in parenthesis.

4.6.2. Categories of Coping

A) Accepting Responsibilities

No statistically significant main effect as well as interaction effect is observed on this coping category.

B) Escape –Avoidance

j) By Religion: The result is statistically significant and more use of this method of coping is reported among those who are Catholics followers ($F (4, 38) = 4.734$, $p < 0.05$)

iii) There is no other statistically significant main or interaction effect observed.

C) Planful Problem Solving;-

i) By age: There is statistically significant difference among the three age group classifications. More use of this method of coping is reported among age group of 30 – 39 years ($F(2, 38) = 4.184, p < 0.05$)

- By religion: the result is statistically significant. More use of this method of coping is reported among those who are orthodox religion follower ($F(4,38) = 2.898, p < 0.05$)

ii) There is a statistically significant interaction effect on planful problem solving coping by marital status and religion. More use of this method of coping is reported by those who are single and orthodox ($F(1, 38) = 8.090, p < 0.05$)

D) Positive – Reappraisal

i) By age; the result is statistically significant and more use of this method of coping is reported by age group of 40 and above ($F(2, 38) = 4.108, p < 0.05$)

* By sex: The result is statistically significant and more use of this method of coping is reported by female counselors ($F(1, 38) = 6.906, p < 0.05$)

* Marital status: The result is statistically significant and more use of this method of coping is reported by married counselors ($F(2, 38) = 4.325, p < 0.05$)

ii) There is a statistically significant interaction effect on positive reappraisal coping by age and religion. Respondents whose age's range from 30 – 39 years and Protestants employ positive reappraisal coping strategies more ($F(1, 38) = 11.837, p < 0.05$)

E) Confrontive coping.

i) By age: The result is statistically significant and the more use of contrastive coping is reported by age group between 20 – 29 year ($F(2, 38) = 5.900, p < 0.05$)

ii) There is a statistically significant interaction effect on confrontive coping by sex and marital status. Female VCT counselors, who are either single or divorced, employ confrontive coping strategies more ($F (1, 38) = 5.013, p < 0.05$)

* By sex and Religion: The result is statistically significant. More use of this method of coping is reported by female counselors, who are Catholics or Muslim ($F (1, 38) = 8.401, p< 0.05$)

F) Distancing

i) By age: There is statistically significant difference among three age group classification. More use of this method of coping is reported by age groups of 30 – 39 years ($F (2, 38) = 6.188, p < 0.05$)

ii) There is a statistically significant interaction effect on distancing coping by age and religion. Respondents Counselor's whose age range from 30 – 39 years and Catholics employ distancing coping strategies more ($F (1, 38) = 5.123, p < 0.05$).

G) Self – Controlling

i) By age; there is statistically significant difference among the three age group classification. More use of this method of coping is reported by age group of , 30 – 39 years ($F(2, 38) = 6.974, p < 0.05$).

* By sex; the result is statistically significant and more use of this method of coping is reported by Female counselors ($F (1, 38) = 6.201, p < 0.05$).

ii) There is a statistically significant interaction effect on self controlling coping by age and religion. It is observed that VCT counselors whose age range from 20-29 years and Catholics employ self controlling coping strategies more ($F (1, 38) = 8.333, p < 0.05$).

* By sex and marital status; the result is statistically significant and more use of this method of coping is reported by single and female counselors (F (1, 38) = 8.564, p < 0.05).

* By sex and religion; the result is significant and more use of this method of coping is reported by female VCT counselors who are catholic (F (1, 38) = 5.019, p < 0.05).

* By marital status and religion; the result is statistically significant. More use of self controlling coping is reported by single and Catholics respondents (F (1.38) = 12.343, p < 0.05).

H) Seeking Social support.

No statistically significant main effect as well as interaction effect is observed

Table 8 Summery of "F" and "P" values of the categories of coping along the demographic variables

Category	A	S	MS	R	AXS	AXMS	AXR	SXMS	SXR	MSXR
Accepting responsibilities										
Escape-Avoidance				4.734 (0.003)						
Planful problem solving	4.184 (0.023)			2.898 (0.035)						8.090 (0.007)
Positive reappraisal	4.108 (0.024)	6.906 (0.012)	4.325 (0.020)				11.837 (0.001)			
Confrontive coping	5.900 (0.006)							5.013 (0.031)	8.401 (0.006)	
Distancing	6.188 (0.005)						5.123 (0.029)			
Self controlling	6.974 (0.003)	6.201 (0.017)					8.333 (0.006)	8.564 (0.006)	5.019 (0.031)	12.343 (0.001)
Seeking social support										

(A= age, S= sex, MS = marital status, R= religion)

* P values are shown in parenthesis

CHAPTER V

DISCUSSION

5.1 Professional background characteristics of the VCT counselors

This study assessed the professional background (features) of VCT counselors in terms of their selection, training, support and work characteristics. Among the 30 VCT sites, a total of 58 individuals involved in HIV counseling were identified. Among these respondents most were nurses before they were trained to be VCT counselors. This may be beneficial in that nurse counselors could relatively be more confident with their counseling skills because of their medical background and general counseling experience. Around nineteen (32.8%) of counselors were selected after being proposed by their senior colleagues. The reports of counselors' selection have indicated that this process is inadequate (Miller & Casey, UNAIDS Report 1997). Counselors are often selected by managers who have little understanding of the needs and responsibilities of counselors. It has, however, been shown that health care workers who are self motivated to counsel are more likely to be emphatic and proficient counselors (Lie & Biswalo, 1994). Therefore, counseling training should not be a mandatory part of work, but rather assigned to health care worker who feel committed to counseling.

Although there are several models of counseling training, according to the national guidelines for VCT in Ethiopia, anyone selected to be counselor should be given at least one month training on counseling. A short course (usually 1-2 weeks) followed by practical work, then a further 1 -2 weeks, is recommended time scale. In this study, 40

(69.0%) counselors took two or more counseling courses. However, for more than half of the counselors the duration of the courses was less than 2 weeks.

In this study, 65.5 % of the counselors have a working experience of more than three years. About 57 % of the counselors rated the quality of counseling training they received as counseling training as very good. Majority of the counselors have access to a designated support and supervising body. In order to minimize 'burnout' and avoid losing valuable and experienced staffs, regular support and supervision is necessary (Baggaley, Sulwe, Ndovi-Macmillan, & Godfrey-Faussett, 1996). Forty-two (72.4%) counselors provide service within regular government working hours. Of the 28 (48.3%) counselors who have duties other than HIV counseling, only 6 (10.3%) said that they have shortage of time to do counseling. Out of the 58 counselors, 31% admitted that counseling is highly stressful.

5.2 Work Related Stressing Factors

As stated in the objectives. this study tries to identify the major sources of work related stress as perceived by VCT counselors. To do so Means were calculated for each categories of stress. As it is observed from Table 3 that the category of 'Job Conditions' having the highest Mean. This category includes items that state ideas like overburdened at work. time pressure. poor job promotion, and not suitable counseling space. It is well known fact institutions with excessive workload, less conducive working area and low pay can leads to stress and burnout. They highly impair one's motivation and satisfaction. Similarly, Shinn, Rosario. Morch and Chestnut's (1984) in their survey of mental health practitioners found that job stressors most frequently identified across various institutions was poor job design, involving conditions such as excessive workload. and lack of positive reinforcement.

The second stressing factor is category of 'Organizational Structure and Processes' constitutes items like lack of consistent and sufficient information from superiors, staff members interfering during counseling, and others take decisions on one's duties. This finding is similar with the research conducted by Donat and Neal (1991). They found that 71% sources of occupational stress experienced among psychiatric aides, mental health workers and licensed practical nurses, were by lack of administrative support for duties, staff conflict over duties / treatments decisions.

'Interpersonal Factors' is found to be the third stressful category. This category includes items like, lack of respect from coworkers, communication problem with colleagues, and isolation at work and undervalued by client. Counselors' job satisfaction mainly comes from their clients and coworker but when counselors lack recognition, respect and appreciation of their profession either from the clients or coworker, it is true they would get stressed. Studies by Donat and Neal (1991), and Shinn, et al (1984) also found the respondents of their studies to be stressed by this category.

'Professional self doubt' this category found to be the last stressing factor among VCT counselors. This category includes items like, not confident in counseling skill, difficulty in to communicate test results to clients, and problem in maintaining confidentiality about client. Similarly, Huey (2007) in his review also found that professional self doubt (e.g. feeling inadequately skilled for dealing with emotional needs of clients, difficulty in keeping professional values and fear of mistakes over a clients treatment) to be recurring sources of mental health professional stress.

5.3 Most Employed Coping Strategies

The third task under taken in this study was identifying the most employed coping strategies by VCT counselors. The commercially available 'Ways of Coping Questionnaire Short Form' was used. Here, also Means are calculated for each of the eight categories.

As it is observed from Table 4 that, 'Planful Problem Solving' category, the one with highest Mean. One possible explanation is that many VCT counselors are who attended tertiary education, as result; they are more equipped with knowledge and skills on how to cop-up with their problems. And this may make more use of planning a head of alternative solution to their problems. Here, there could be possible development of buffering mechanism to cop- up with their problems. Koeske et al. (1993) found out that control oriented coping strategies clearly acted as occupational stress buffers in a group of mental health intensive case managers.

The second cop-up strategy is, 'Positive Reappraisal'. It has been demonstrated that most people appear to use positive reappraisal coping in many types real life stressful situations (Lazarus & Folkman, 1984). This category involves items related to religious practice. It is most customary for Ethiopians to give out their problems to Almighty (we say, God knows).

Graham, Furr, Flower. (2001) reported on a survey conducted by American counseling association that indicates counselors view spirituality as an important component of mental health.

'Seeking Social Support' has the third successive highest Mean. Possibly, this is because in trying to resolve the problem, counselors often, talk with each others about the problem to consider different colleagues for handling the problem. This category is known for having high relationship with physical and psychological health (Ebata & Moos, 1994; Simoni & Petrson, 1997; and Strivastava, 1991).

The fourth cop-up strategy is, 'Self Controlling' in general this category describes effort to regulate one's feelings and actions in different stressful encounters. The writer did not find more related literature on this category, however, the study of Connolly and Sandera (1998) have found the second highest employed strategy among teachers.

The fifth category is, 'Confrontive Coping' this category describes aggressive efforts to alter the situation and suggest some degree of hostility and risk – taking. This type of coping style is known for having higher stress, burnout and poorer mental health outcomes (Leiter, 1990; Leiter & Harvie, 1996; Slage, 1996).

The last three (6th, 7th and 8th) coping strategies employed by the VCT counselors in this study are, 'Distancing', 'Accepting Responsibility' and 'Escape- Avoidance'. There is general consensus that coping styles that involves 'Distancing and Escape-Avoidance' were associated with high burnout and greater intension to discontinue working in the AIDS field (Martin, 1991; Breaux, 1998).

The overall coping strategies finding demonstrate that VCT counselors in this study are more inclined to take action to resolve a problem than to avoid it. This is supported by the first and last identified coping strategies (See Table 4).

5.4 How The Demographic Variables Explain Stress and Coping

The fourth task undertaken on this study is how demographic variables (age, sex, religion and marital status) explain the reported stressors and coping strategies.

5.4.1 STRESS

1. Age as the explaining variable in stress

When overall stress is observed, age does not significance contribute in explaining it (p = 0.091). But when categories are taken, age shows statistically significance on two categories of stress, i.e. 'Professional self doubt' (p = 0.000). It is the age's groups of 30 - 39 years are more stressed by this category. Even if the writer did not get supportive literature. It possible that these subjects are more stressed by 'professional self doubt' because they may not received adequate ongoing training, and supervision. This finding is similar with study of Feitler and Toakr's (1982). They found middle aged teachers exhibited more work related stress. Age also shows statistically significance on category of stress, i.e. 'Organizational structure and processes' at (p = 0.001). It is the age group of 30 – 39 years found to be more stressed by this category. It is more likely to be stressed to work in an institution with inadequate supervision, non-participative decision making and rigid environment. This finding is unlike with study done by McMurry (1986) that younger teachers are the most stressed by this category because of lack of experience.

2. Sex as the explaining variable in stress

When overall stress is observed, sex does not haves significant contribution in explaining it (p = 0.077).but categories are taken, sex shows statistically significance on two categories of stress. i.e. 'Job conditions' at (p = 0.009). 'Professional self doubt' at (p = 0.001).

Job condition as a perceived source of VCT counselors' work related stress is more manifested among male respondents than female respondents. Girma (1995) quoted Menagham (1983) who noted that women use selective inattention in work more than men do. It is reported that women pretend to give less importance aspects of situation by focusing on positive attributes. Another possible explanation may be the social expectation and cultural norms in our country. In our society men's are expected to strong, independent, confident and courageous, etc while female wanted to stay submissive and dependent. These factors may make females satisfied with achievement they get. So, their general level of stress may be lower. On contrary, males may make them perceive more stress.

Professional self doubt as perceived sources of VCT counselors work related stress is more manifested among female respondents. Similarly with this finding, Misra and McKean (2000) believes that men may report lower stress levels as they have been socialized to be self-reliant and that a show of emotion is an expression of weakness and not masculine.

3. Marital status as explaining variable in stress

When overall stress is observed, marital status does not significantly contribute in explaining it ($p = 0.783$). But when categories are taken, marital status shows statistically significance on one category of stress, i.e. 'Professional self doubt' at ($p = 0.000$).

Professional self doubt as perceived sources of VCT counselors work related stress is more manifested among single respondents. Maslow's hierarchy of needs most probably explains the why of more stress among these respondents. These subjects, one way or another, have not satisfied their love and belongingness need (the 3rd level) which

relatively detains them from fulfilling their professional needs to full. Thus they tend to develop feeling of inadequacy and failure at work.

4. Religion as explaining variables in stress

When overall stress is observed, religion does not significantly contribute in explaining it (p = 0.79). But when categories are taken, religion shows statistically significance on two categories of stress, i.e. 'Job conditions' at (p = 0.004).

Job conditions and Organizational structure and processes as perceived sources of VCT counselors work related stress is more manifested among catholic religion followers. Even if the writer did not get supportive literature but it seems that the catholic religion followers have more exposure for better work practice through informal lessons, as result this might influenced this respondent to have less tolerance poor job conditions and poor organizational structure and processes.

5.4.2 COPING

As transactional theorist, the author of the 'Way of Coping Questionnaire', Folkman and Lazarus (1980, 1984,1988) state coping as constantly changing cognitive and behavioral effort. It may be successful in overcoming stress or it may fail. What ever the end result, when one tries to deal with stress-inducing situations means one is trying to cope. For this reason therefore, these authors say that the greater number in the instrument only showing more use of the specific method and vice –versa. Bearing these facts, the demographic variables explain coping strategies.

1. Age as explaining variable in coping

When overall coping strategy is observed, there is a statistically significant difference among the three age classification in employing the coping strategy (p =0.001) (Table 6). More use of coping strategy is observed among age group of 30 -39 years. The possible

explanation is, often many individuals get married within this age ranges, and they may more advantage for outlets by having companionship. When categories are considered, age also shows statistically significance on five categories of coping, i.e. 'Planful problem solving' at (p = 0.023), 'Confrontive coping' at (p =0.006), 'Distancing' at (p = 0.005), 'Positive reappraisal' at (p = 0.024) and 'Self controlling' at (p = 0.003). The writer did not get any supportive literature in difference among age's groups in employing coping strategies. However, the finding of Folkman and Lazarus (1988) reported younger subjects employ more of positive reappraisal. It was observed to increase pleasure and confident for them.

2. Sex as explaining variables in coping

In explaining overall coping strategies, sex does not have significant contribution (p = 0.215) (Table 6). But categories are considered, sex shows statistically significance on two categories, i.e. 'Positive reappraisal' at (p = 0.012), and 'Self controlling' at (p = 0.017).

It is the female respondents are found to employ these coping strategies more. The first possible explanation for 'positive reappraisal' could be the nature of woman, because it apparent worldwide, that woman's, compared to men, found to be more religious or believers (superstitious). Since this category have some religious dimensions. Secondly, for 'self controlling', it could be that, these subjects developed confidence, independence and clear views of situations as stressful or not. This finding is similar with study of Rohde, Lewinson, Tilson and Seeley (1990) and Dolan and White (1988) found that women make use of problem solving, self controlling and social support seeking coping mechanism more frequently than do men. Men on the other hand, were found to employ ineffective escapism (like wishful thinking) and self-blame strategies.

3. Marital status as explaining variables in coping

When overall coping strategy is observed, there is a statistically significant difference among three classification of marital status (p = 0.026) (Table 6). More use of coping strategy is manifested among married respondents. Taking the categories, marital status explain positive reappraisals at (p = 0.001). Here also, the married respondents report to use this coping strategy more. This could be because the intimate relationship they are in and the interdependence they have with their spouse would have influenced them to interpret things in positive direction.

4. Religion as explaining variable in coping

When overall coping strategy is observed. there is no a statistically significant difference among five groups of religion (p =0.69). But when categories are taken religion shows a statistically significance on two categories, i.e. Escape-Avoidance' at (p = 0.003) and 'planful problem solving' at (p = 0.035). Orthodox religion followers are found to employ more planful problem solving strategies. The writer did not get supportive literature in difference of coping strategies among different religions. The possible explanation might be because these orthodox religion followers relatively may have encountered various kind of stress in their lives for which they have developed using problem solving coping strategies.

Escape- Avoidance type of coping strategies is found to be more employed by catholic religion followers. This possible because respondents might have limited training and work experience.

Chapter VI

Summery, Conclusions and Recommendations

6.1 Summery

The purpose of this study was to identify the major sources of work related stress and coping strategies used among VCT counselors in Addis Ababa.

The study covered 30 different VCT sites, selected based on daily client flow. Average (5-9 clients per day) and highest (> 10 clients per day) flow sites were part of this study. From these centers all the 58 full time working VCT counselors were included.
The data is obtained through structured questionnaire. The first section, identify the personal and professional background characteristics that might have an effect on the dependent variables of work related stress and coping strategies. The second section, asks participants to identify sources of work related stress. The third questionnaire used in this study was WCQ-SF. This tool used to measure cognitive and behavioral strategies that individuals use in stressful circumstance. Descriptive statistics like mean, frequency, and standard deviation was used for demographic and professional background characteristics and for identification of work related stressor and coping strategies. Univarite Analysis of Variance was also used to work on how demographic variables explain: overall stress, overall coping, categories of stress and categories of coping.

Out of the 58 VCT counselors, 48 (82.8%) were clinical nurses, and 37 (67.2%) were self motivated during selection. More than half (53.4%) of the counselors had taken

counseling courses for < 3 weeks. Majority of counselors admitted that they have access to designated counseling supervisor to provide with support and technical backup. Only for 18(31%) counseling was highly stressful.

The most stressing factor in this study was the category of ' Job Conditions' particularly, time pressure, increased caseloads, poor job promotion, and unsuitable counseling room have lead VCT counselors to experience work related stress. The category of 'Organizational structure and processes', ' Interpersonal factors' and ' Professional self doubt' were found to be the 2nd, 3rd, and 4th stress contributing factors.

The most frequently used coping strategies among VCT counselors was 'Planful problem solving'. The category of 'Positive - reappraisal', 'Seeking social support', 'Self controlling', 'Distancing', 'Accepting responsibility', and 'Escape- avoidance' were found to be 2nd, 3rd, 4th, 5th. 6th and 7th employed coping strategies.

6.2 Conclusions

The majority of VCT counselors professional background (proportion of counselors who were self motivated during selection, number of counseling courses attended, duration of courses and access to supporting and supervising body) goes in line with UNAIDS minimal requirements proposed for VCT counselors. However, there are also VCT counselors who did not have access to support and supervision that could minimize work related stress and improve their counseling skills. Besides, a larger number of VCT counselors took a short course of counseling. Some counselors are also selected by their colleagues.

The most stressing factor in this study was the category of 'Job Conditions' particularly, the combination of increased work load, time pressure, poor job promotion, and unsuitable counseling room lead VCT counselors to experience work related stress. Besides, the category of 'Organizational Structure and processes' which includes items like inconsistent and insufficient information from superiors, staff interfere during counseling, and other take decision concerning ones own duties (work) also found to be the second stress contributing factor.

The most frequently used coping strategies among VCT counselors in this study were positive ones, including planful problem solving, positive reappraisal and seeking social support. This seems that VCT counselors are more inclined to take action to resolve a problem than to avoid it.

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Appendix A

Cover Letter

Dear research participants:

Thank you for agreeing to participate in my research study.

The purpose of the study is to determine the major sources of perceived work related stress and coping mechanisms among VCT counselors.

You will be asked about your work related stress and how frequently you cope or face stressful issues in your work.

By perceived work related stress: We mean an individual response that occurs when the requirements of the job do not match the capabilities, resources or needs of the worker.

By coping Strategies: we mean an individual's perceived response to perceived stress.

Your participation in this study is completely voluntary. Your responses will remain confidential and anonymous. If you choose not to participate in this study it will not affect your work status, promotion towards higher position.

This study is being conducted as partial fulfillment of my M.A. degree in social-psychology. I greatly appreciate your cooperation. Please complete all the self report questionnaires.

Thank you for your cooperation.

Sincerely

Derschilign Awegichew

Appendix B

Consent Form

I undersigned have been informed that the questionnaires (study) is conducted to gather information about perceived work related stress and coping mechanism among VCT-Counselors. The result of the study will help counselors to effectively deal with stress inducing situations and thereby enabling them to provide quality counseling.

I also agreed about the confidentiality of the response to be highest possible level.

Signature ______________________________

Date ___________________________________-

Appendix C

Age __________

Gender ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Single

Religion: ☐ Orthodox

☐ Muslim

☐ Catholic

☐ Protestant

☐ Specify if other _________

In this section items asks about your back ground, selection, and training and job characteristics. Please respond accordingly.

1. What is your professional back ground?

   ☐ Nurse

   ☐ Doctor

   ☐ Health officer

   ☐ Social worker

   ☐ Psychologist ☐ Other

2. How did you become a Counselor?

   ☐ Proposed by senior colleague

   ☐ Self motivated

   ☐ Specify if other ___________

3. How many courses of counseling you have attended?

   ____

4. What was the average duration of each course?

   ____

5. How many years have you been counseling?

   ________ Years

6. How would you rate your counseling training?

- ☐ Very good
- ☐ Good
- ☐ Adequate
- ☐ Inadequate

7. Do you have access to a designated counseling supervisor to provide you with support and technical backup?
   - ☐ Yes
   - ☐ No

8. How many hours per day do you do counseling?

   __________Hours

9. Do you have duties other than counseling?
   - ☐ Yes
   - ☐ No

10. If yes, are you given adequate time in your job to carry out your counseling?
    - ☐ Yes
    - ☐ No

11. Do you have to work long hours?
    - ☐ Yes
    - ☐ No

12. Are you worried about loosing your job?
    - ☐ Not at all worried
    - ☐ Moderately worried
    - ☐ Very worried
    - ☐ Extremely worried

13. How stressful is your job?
    - ☐ Not at all stressful
    - ☐ Little bit stressful
    - ☐ Mildly stressful
    - ☐ Highly stressful

Appendix D

In this section, the items ask you how frequently you have experienced such situation as stressful in your work (job). Please respond by marking a tick (√) on your choice.

No	Questions	Often	Sometimes	Seldom	Never
1	My other staff members/ colleagues don't respect my job				
2	I feel isolated in my work				
3	I have problems in communicating with my colleagues				
4	I am not confident in my counseling skills				
5	My job promotion prospects are poor				
6	Others take decisions concerning my work				
7	I have a constant time pressure due to heavy work load				
8	I am not given consistent and sufficient information from my superiors.				
9	I have problems in maintaining confidentiality about my clients detail				
10	I am overburdened at work				
11	Other staff members interfere during the counseling of my clients				
12	I find it difficult to communicate test results to my clients				
13	I feel the space provided for counseling is not suitable for ensuring privacy and maintaining confidentiality				
14	I feel undervalued by my clients				

Appendix E

In this section, the questionnaire invites you to respond to how frequently you cope in the ways the statements suggest in terms of what you do or feel when you experience a stressful or challenging issue in your work.

Each item has a scale of 0-3. Please respond to each statement by marking a tick (√) on your choice.

No	Questions	Not used	Used some what	Used quite a bit	Used a great deal
1	I talk to some one to find out more about the situation				
2	I tend to criticize my self				
3	I try to keep my feeling to my self				
4	I get sympathy and understanding from someone				
5	I put all my trust in God				
6	I look something good in what is happening				
7	I apologize or do something to makeup				
8	I make a plan of action and follow it				
9	I express my feeling directly				
10	I learn and draw strength from experience				
11	I talk to someone who could do something concert about the problem				
12	I try not to act too hastily or quickly				
13	I try to find comfort in religion				
14	I change something so that things would turn out alright				
15	I avoid being with people in general				
16	I ask a relative or a friend I respect for advice				
17	I fight for my right and for what I want				
18	I try to come up with alternative solution to the problem				
19	I pray				
20	I think about what I will or should say or do				
21	I think about how a person I admire would handle the situation and use that as a model				
22	I enjoy exercise (sport of any kind)				
23	I seek God's help				
24	I use alcohol to make myself free				
25	I try to forget the whole thing				
26	I go as if nothing happen				

Appendix F

Table 2: Professional background characteristics of the VCT counselors (N = 58)

N	Characteristics	Frequency	percentage
1	Background		
	Nurse	48	82.8
	Social worker	10	17.2
2	Selection		
	Proposed by senior colleague	19	32.8
	Self motivated	39	67.2
3	Number of counseling courses		
	Only 1	18	31.0
	2 or more	40	69.0
4	Duration of courses		
	< 3 weeks	31	53.4
	3 weeks and more	27	46.6
5	Years of counseling service		
	< 1 year	9	15.5
	1- 3 years	11	19.0
	> 3 years	38	65.5
6	How would rate counseling training		
	Very good	33	56.9
	Good	23	39.7
	Adequate	2	3.4
7	Access to support and Supervision		
	Yes	45	77.6
	No	13	22.4
8	Hours of counseling per day		
	< 5 hours	7	12.1
	6 – 8 hours	42	72.4
	> 8 hours	9	15.5
9	Duties other than counseling		
	Yes	28	48.3
	No	30	51.7
10	Time given to carry out your job		
	Yes	22	37.9
	No	6	10.3
11	Long hours of working		
	Yes	33	56.9
	No	25	43.1
12	Worry about loosing job		
	Extremely worried	1	1.7
	Very worried	2	3.4
	Moderately worried	21	36.2
	Not at all	34	58.6
13	The stress at work		
	Highly stressful	18	31.0
	Mildly stressful	15	25.9
	Little bit stressful	21	36.2
	Not at	4	6.9

Appendix G

Descriptive statistics table for overall stress scale

1. Participants' age * Marital status

Participants' Age	Marital status	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
20 - 29 years	married	1.548[a]	.112	1.320	1.775
	single	1.470[a]	.086	1.296	1.644
	divorced	.[b]	.	.	.
30 - 39 years	married	1.443[a]	.081	1.279	1.608
	single	1.839[a]	.126	1.585	2.094
	divorced	.[b]	.	.	.
40 and above	married	1.421[a]	.092	1.235	1.606
	single	1.429[a]	.140	1.145	1.712
	divorced	1.214[a]	.275	.657	1.772

a. Based on modified population marginal mean.

b. This level combination of factors is not observed, thus the corresponding population marginal mean is not estimable.

Appendix H

Descriptive statistics table for overall coping strategy

1. Participants' age

participants' age	Mean	Std. Error	95% Confidence Interval Lower Bound	Upper Bound
20 - 29 years	1.760[a]	.069	1.621	1.899
30 - 39 years	1.853[a]	.062	1.727	1.979
40 and above	1.399[a]	.075	1.248	1.550

2. Marital status

marital status	Mean	Std. Error	95% Confidence Interval Lower Bound	Upper Bound
married	1.773[a]	.050	1.671	1.874
single	1.627[a]	.059	1.508	1.746
divorced	1.154[a]	.251	.646	1.661

3. Participants' age * Religion

Participants' age	Religion	Mean	Std. Error	95% Confidence Interval Lower Bound	Upper Bound
20 - 29 years	orthodox	1.870[a]	.084	1.700	2.039
	Muslim	1.885[a]	.251	1.377	2.392
	catholic	1.692[a]	.177	1.333	2.051
	protestant	1.558[a]	.102	1.350	1.765
	others	1.577[a]	.251	1.069	2.085
30 - 39 years	orthodox	1.869[a]	.089	1.688	2.050
	muslim	.[b]	.	.	.
	catholic	.[b]	.	.	.
	protestant	1.837[a]	.087	1.660	2.013
	others	.[b]	.	.	.
40 and above	orthodox	1.599[a]	.089	1.418	1.779
	muslim	.[b]	.	.	.
	catholic	.[b]	.	.	.
	protestant	.901[a]	.135	.626	1.175
	others	.[b]	.	.	.

4. Marital status * Religion

Marital status	Religion	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
married	orthodox	1.789[a]	.064	1.659	1.920
	muslim	.[b]	.	.	.
	catholic	.[b]	.	.	.
	protestant	1.745[a]	.080	1.583	1.907
	others	.[b]	.	.	.
single	orthodox	1.822[a]	.082	1.656	1.988
	muslim	1.885[a]	.251	1.377	2.392
	catholic	1.692[a]	.177	1.333	2.051
	protestant	1.212[a]	.102	1.004	1.419
	others	1.577[a]	.251	1.069	2.085
divorced	orthodox	1.154[a]	.251	.646	1.661
	muslim	.[b]	.	.	.
	catholic	.[b]	.	.	.
	protestant	.[b]	.	.	.
	others	.[b]	.	.	.

a. Based on modified population marginal mean.

b. This level combination of factors is not observed, thus the corresponding population marginal mean is not estimable.

DECLARATION

I, the undersigned, declare that this thesis is my original work and all sources of materials used for this thesis have been fully acknowledged.

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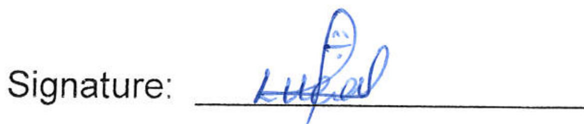
Signature: 

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