

Psychological well-being of volunteer counselling and testing counsellors

by

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A dissertation submitted in fulfilment of the requirements for the degree

MA (Psychology)

in the Department of PSYCHOLOGY at the

UNIVERSITY OF PRETORIA

FACULTY OF HUMANITIES

SUPERVISOR: PROF M.J. VISSER

2013

Acknowledgements

I would like to express my sincere gratitude to the following people for their enduring assistance and support:

- Firstly, I thank God for the guidance He has given me, for carrying me and always lighting my path.
- My supervisor, Prof Maretha Visser, for your patience, advice and belief in me. I am sincerely grateful that you have been by my side throughout this study.
- HCT counsellors for the information you have shared with me. You are making a positive impact in the lives of many of South Africans.
- The Statomet consultant, Ms Joyce Jordaan, for your patience.
- The language editor, Mr Wilhelm Haupt, for making sense of this research.
- My life partner Seja, you have been my pillar of strength; I honestly could not have done this without your support.
- My daughter Mahlatse, you are very special to me. Thank you for understanding when I could not spend time with you because I had to focus on this research.
- My mother-in-law Moditja Rapholo, thank for being a very supportive mother.
- My sister, Penelope Mabota, thank you for making me realize that “Yes I Can.”
- My brothers Thoba and Eugene, thank you for encouraging me through tough times.
- My sons Lwazi and Eugene Jr., thank you for the love you have given me throughout my studies.
- My nieces Makhanana Mhlongo, Prudence Rapholo, nephew Clement Baloyi and dear friend Rueben Galabies, you made the long drive to various clinics bearable.
- The KgoloMmogo and Serithi team, thank you for your support, encouragement and guidance.
- Lastly, I thank everyone who contributed towards this research in any way, your support is appreciated.

This dissertation is dedicated to the living memories of my late parents Jean and Joe Mabota. Your support, encouragement, love and guidance will forever remain in my heart.

Abstract

In the South African public health care system, HIV Counselling and Testing (HCT) has become a function that is routinely entrusted to lay counsellors. These counsellors are expected to educate clients about HIV and AIDS, encourage them to be tested and convince them to change risky behavioural practices. They have to convey the clients' test results and assist those who test HIV-positive and their families to cope with the psychological challenges associated with the diagnosis. The counsellors occupy the front line of HIV and AIDS service delivery, even though they are not formally employed in the health care system. They only have basic training and are not adequately remunerated. The counsellors are confronted with psychological and structural stressors in their work. Psychological stressors include the impact of emotionally challenging work, the lack of appropriate training, debriefing and supervision. Because they are not formally employed in the health care system, there is a lack of formal supervision or channels to discuss their frustrations. This research focuses on the stressors which HIV counsellors experience, how they cope, and the impact it has on their psychological well-being.

As part of the mixed methods approach 50 HCT counsellors working at the City of Tshwane clinics completed the Bar-On Emotional Quotient Inventory, the Maslach Burnout Inventory for Human Services Survey (MBI- HSS), the Centre for Epidemiologic Studies Depression scale (CES-D), and the Brief COPE scale to assess their psychological well-being. In addition, they participated in focus group discussions.

EQ-i scores indicated that counsellors reported below average emotional skills, with the overall group score of (88.76). Scores that indicated average emotional skills were Self-Regard (101), Interpersonal Relationships (100.12), and Impulse Control (102.66). Scores that indicated low emotional skills were Independence (86.66), Self-Actualization (88.28), and Reality Testing

(83.94). Although they reported high levels of Emotional Exhaustion (27.66), they also have a sense of high Personal Accomplishment (38.64) (MBI-HSS). Counsellors reported an overall CES-D score which was indicative of mild depression (26.08). Counsellors used mostly positive coping skills that included religion, planning, and direct action in coping with stressors in their lives. In a regression analysis with depression as the dependent variable, there was a positive relationship between depression and depersonalization and a negative relationship with positive or active coping and assertiveness.

It was concluded that counsellors experienced some depression, emotional exhaustion, and lower than average levels of emotional well-being. Despite that, they reported positive ways of coping and high levels of personal accomplishment. Counsellors were motivated by their sense of altruism, compassion towards their clients, the positive changes they see in client's lives as well as the reciprocal relationships they have formed with their clients. Counsellors thus have strengths to cope with the high level of stressors and challenges related to their work. It can be concluded that their state of mental health is in line with Keyes' proposal that mental health forms a continuum. They fluctuate between mental well-being and mental ill-being. However, it is necessary to assist HCT counsellors to develop their emotional capacities to enable them to enhance their ability to counsel their clients effectively.

Kakaretšo

Ka lenaneong la tlhokomelo ya maphelo a setšhaba ka Afrika Borwa, Keletšo le Teko ka ga HIV (HCT) e fetogile mošomo wo o filwego baeletši ba ka mehla. Baeletši go emetšwe gore ba rute badiriši ka ga HIV le AIDS, ba ba hlohleletše go dirwa diteko le go ba eletša gore ba fetošē ditiro tša maitshwaro a kotsi. Ba swanetše go tsebiša badiriši dipoelo tša bona tša diteko ba be ba thuše bao diteko tša bona di bolelago gore ba na le HIV le ba malapa a bona gore ba kgone go phela ka mathata a ka mogopolong ao a bakwago ke ge ba tsebišitšwe gore ba na le HIV. Baeletši ke bona ba lego ka pele ka kabong ya ditirelo tša mabapi le HIV le AIDS, le ge e le gore ga se ba thwalwa semmušo ka lenaneong la tlhokomelo ya maphelo. Ba na le fela tlhahlo ya motheo gomme ga ba hwetše moputso wa maleba. Baeletši ba kopana le mathata ao a bakago kgatelelo ya mogopolo le a peakanyo ka mešomong ya bona. Mathata ao a bakago kgatelelo ya mogopolo a akaretša seabe sa mošomo wo o hlohlago maikutlo, tlhokego ya tlhahlo ya maleba, go botšišwa dipotšišo le tlhokomelo. Ka lebaka la gore ga se ba thwalwa semmušo ka lenaneong la tlhokomelo ya maphelo, go na le tlhokego ya tlhokomelo ya semmušo goba ditsela tše ba ka ahlaahlago mathata a bona. Dinyakišišo tše di lebeletše kudu mathata ao a bakago kgatelelo ya mogopolo ao balwetši ba HIV ba itemogelago ona, ka fao ba phelago ka mathata a ka gona, le seabe seo a nago le sona go go phela ga bona ga ka mogopolong.

Bjalo ka karolo ya mekgwa ye e kopantšwego ya baeletši ba 50 a bao ba šomago ka dikliniking tša ka Toropong ya Tshwane ba phethile Lenaneo la Kelo ya Maikutlo la *Bar-On*, Lenaneo la *Maslach Burnout* la Dinyakišišo tša Ditirelo tša Batho (MBI- HSS), sekala sa Senthara ya Dinyakišišo tša Kelo ya Bolwetši bja Kgatelelo ya Monagano (CES-D), le sekala sa *Brief COPE* go sekaseka go phela gabotse ga bona ka mogopolong. Godimo ga fao, ba ile ba kgatha tema ka dipoledišanong tša dihlopha tša tebanyo.

Dintlha tša EQ-i di laeditše gore baeletši ba bile le pego ya ka fase ya magareng ya mabokgoni ka ga maikutlo ka (88.76), Dintlha tše di laeditšego mabokgoni a magareng ka ga maikutlo ebile tša Boikwešišo ka (101), Dikamano le Batho ba bangwe ka (100.12), le Taolo ya Go nyaka go dira se sengwe ka (102.66). Dintlha tše di laeditšego mabokgoni a fase ka ga maikutlo e bile tša Boikemo ka (86.66), Boiphihlelelo ka (88.28), le Teko ya Bowena ka (83.94). Le ge e le gore ba bile le dipego tša maemo a godimo ka ga Go lapa ga Maikutlo ka (27.66), gape ba na le maikutlo a Phihlelelo ya Bona ya godimo ka (38.64) (MBI-HSS). Baeletši ba bile le pego ya kakaretšo ya dintlha tša CES-D e lego selo se se laeditšego kgatelelo ya fasana ya mogopolo (26.08). Baeletši ba šomišitše kudu mabokgoni a makaone a go kgona go phela ka kgatelelo ya mogopolo go akaretšwa sedumedi, go beakanya, le go dira se sengwe thwii ka nepo ya go kgona go phela ka dilo tše di bakago kgatelelo ya mogopolo maphelong a bona. Ka tshekatshekong ya poelomorago mabapi le kgatelelo ya mogopolo bjalo ka selo seo se ka laolwago, go bile le kamano e kaone magareng ga kgatelelo ya mogopolo le go dira gore dilo di se be tša gago le kamano ye e sego ya loka le go phela bokaone goba go phela ka mafolofolo le boitshepo.

Go feditšwe ka gore baeletši ba itemogetše kgatelelo ya mogopolo, go lapa ga maikutlo, le maemo a palogare ya go feta a fasana a go phela gabotse maikutlong. Ka ntle ga seo, ba bile le pego ya ditsela tše kaone tša go kgona go phela ka mathata le tša maemo a godimo a phihlelelo ya bona. Baeletši ba filwe mafolofolo ke maikutlo a bona a go thuša ba bangwe, go kwela bao ba ba thušago bohloko, diphetogo tše kaone tše ba di bonago ka maphelong a batho bao ba ba thušago gammogo le dikamano tša tirišano tše ba di hlamilego le batho bao ba ba thušago. Baeletši go realo go ra gore ba na le bokgoni bja go phela ka maemo a godimo a dilo

tše di bakago kgatelelo ya mogopolo le ditlhohlo tše di amanago le mošomo wa bona. Go ka fetšwa ka gore seemo sa bona sa maphelo a mogopolo se sepelelana le tšhišinyo ya Keyes ya gore maphelo a mogopolo a bopa seemo sa kamano ya dilo tše di farologanego tše di tšwelago pele. Di fapanafapana magareng ga go phela gabotse ga mogopolo le go fokola ga mogopolo. Le ge go le bjale, go a hlokagala go thuša baeletši ba Keletšo le Teko ka ga HIV (HCT) go tšweletša botsebi bja bona bja maikutlo go ba kgontšha go matlafatša bokgoni bja bona bja go eletša bao ba ba thušago gabotse.

Mareo a bohlokwa: *Go se šome ga mogopolo, go kgona go phela ka mathata, kgatelelo ya mogopolo, bohlale bja maikutlo, seemo se sekaone sa mogopolo, go phela gabotse*

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Acronyms

AIDS – Acquired Immune Deficiency Virus

ARV – Antiretroviral drugs

ATIC – AIDS Training, Information and Counselling Centre

CES-D – Center for Epidemiologic Studies Depression Scale

CHW – Community Health Worker

CICT – Client-Initiated Counselling and Testing

DOTS – Directly Observed Treatment Short Course

EQ-i – Emotional Quotient Inventory

GIPA – Greater involvement of People living with HIV

HCT– HIV Counselling and Testing

HIV – Human Immune Virus

MBI-HSS – Maslach Burnout Inventory for Human Services Survey

CBO – Community Based Organization

NGO – Non-Governmental Organization

NSP – National Strategic Plan

PICT – Provider-Initiated Counselling and Testing

PMTCT – Prevention of Mother to Child Transmission

STIs – Sexually Transmitted Infections

UNAIDS – Joint United Nations Programme on HIV/AIDS

VCT – Voluntary Counselling and Testing

WHO – World Health Organization

Chapter 1: Introduction to HIV and AIDS counselling and testing strategies

1.1 HIV and AIDS in South Africa

Southern Africa remains the region that is most heavily affected by HIV and AIDS. South Africa is one of the countries with the highest HIV prevalence. It is one of the five countries with the highest prevalence in the world with 17.9% of the population age group between 15-49 years infected with HIV. The National HIV prevalence estimates among antenatal women in 2011 was 29.5%, which represents a slight drop of 0.7% from 2010 (Department of Health, 2011).

The impact of HIV and AIDS in South Africa has left an escalating number of children who have been orphaned by the epidemic. This has resulted in high numbers of child-headed households (UNAIDS, 2009). UNAIDS (2009) estimates that in South Africa there are 1.8 million orphaned children between 0 and 17 years who have lost one or both parents to HIV.

1.2 HIV and AIDS counselling and testing in South Africa

1.2.1 National Strategic Plans

Confronted by a growing epidemic, South Africa had to employ strategies to control the spread of the disease. The South African Department of Health has developed strategic plans and guidelines for the implementation of HIV and AIDS programmes. Amongst the programmes is the National Strategic Plan (NSP) for South Africa 2000–2005, which was followed by the 2007–2011 NSP and the NSP 2012–2016 as well as the National Counselling and Testing Guidelines – 2010 (Department of Health, 2006; 2010). The aims of the NSPs were to outline ways to reduce the number of new HIV infections and also to reduce the impact of HIV and AIDS on individuals, families and communities. Another aim was to increase access and uptake to prevention and care strategies. Voluntary Counselling and Testing (VCT), as it was referred

to prior to the introduction of the National Counselling and Testing Policy Guidelines of 2010, was identified as one of the important prevention and care strategies (Department of Health, 2009).

1.2.2 The Comprehensive Plan – Care, Management and Treatment

A comprehensive plan to scale up prevention strategies, including HIV Counselling and Testing (HCT) was developed in 2003. The comprehensive plan introduced expansions of the AIDS programme which resulted in increased budgetary allocations. This allowed for the inclusion of lay workers as part of the comprehensive care, management and treatment programmes (Schneider, Hlophe & van Rensburg, 2008).

The lay (health) worker infrastructure was originally created in the mid-1990's as part of a pilot project. This involved the training of lay counsellors to promote voluntary HIV testing and to advance the Directly Observed Treatment Short Course (DOTS) programme. (DOTS is a strategy used to reduce the number of tuberculosis cases by observing patients as they take their medicine to ensure that they indeed ingest it (Department of Health, 2006).)

1.2.3 National Counselling and Testing Policy Guidelines (2010)

In 2010 the Voluntary Counselling and Testing programme was re-branded and launched as the HIV Counselling and Testing programme. Subsequently new guidelines were introduced. The HCT Policy Guidelines aim to provide a national framework and guidance for the provision of HIV counselling and testing services in the public and private sectors. As one of the first initiatives, the programme introduced a campaign that aimed to test a total of 15 million people throughout South Africa by the end of June 2011. By the end of the campaign, 10.2 million people had tested for HIV (Health-e News, 2011). The main difference between VCT and HCT is that in the past (with VCT) health care workers recommended testing only if HIV was

suspected. With the new guidelines HIV testing is routinely recommended to everyone as part of routine primary health care (Department of Health, 2010).

The guidelines distinguish between client initiated counselling and testing and provider initiated counselling and testing. Client Initiated Counselling and Testing (CICT or HCT) refers to individuals and couples seeking counselling and testing. On the other hand, Provider Initiated Counselling and Testing (PICT) refers to testing where the health care provider recommends testing (Department of Health, 2010). In essence, the guidelines outline the core deliverables of HCT counsellors as they are responsible for implementing the HCT programme.

1.3 The role of HCT counsellors

1.3.1 The lay counsellor project

In South Africa HCT was initially introduced in 1995 as the Lay Counsellor Project based in KwaZulu-Natal. Due to its success it was rolled out throughout the country (Richter, Durrheim, Griesel & Solomon, 1999) through the local authority based AIDS Training, Information and Counselling Centres (ATICs). By 2004 HCT was available at more than 1 900 service points in the country (Birdsall, Hajiyiannis, Nkosi, & Parker, 2004). At the time of the introduction of the lay counsellor project, HIV prevalence in South Africa was estimated at 2.1% (850,000 people). Since then, the prevalence rate has jumped to 10.8% in 2005 (Department of Health, 2007) and 10.5% in 2010 (Statistics South Africa, 2010). The escalation of prevalence rates changed the situation for HCT counsellors dramatically.

To strengthen and give credibility to the Lay Counsellor's Project, the Department of Health implemented the "Faces" project in 1996. The project was a model of Greater involvement of People living with HIV (GIPA). The aim of the programme was to put a face to the epidemic by employing people living with HIV and AIDS to assist in implementing the

programme. Initially 12 people openly living with HIV and AIDS were employed to work within the national and provincial AIDS programme.

The idea behind employment of people openly living with HIV and AIDS was that this will assist in shaping the perceptions and processes of policy making, add credibility to existing programmes and to curb the growing epidemic and the stigma of HIV and AIDS. It was also aimed to encourage people to undergo HIV testing and create new levels of awareness. The initial programme encountered numerous challenges and the programme was taken over by UNAIDS. The focus was changed to have a workplace-specific element and the programme was extended to other sectors including the private sector (UNAIDS; 2000, 2002). Challenges identified by the initial GIPA fieldworkers included the high level of stigma, lack of support, training and skills and a lack of organizations to involve people living with HIV and AIDS. Fieldworkers identified feelings of hopelessness because at that time there were no treatment, care and support services (UNAIDS, 2002).

As HIV and AIDS funding and programmes expanded, there was renewed interest into the deployment of lay health workers. This was also due to the need for a balance in addressing health worker shortages as well as to increase access to care, support and treatment specifically in the scaling up of antiretroviral therapy (ART) (Schneider et al., 2008).

1.3.2 The community health worker programme

As the lay counsellor project was being implemented, another parallel programme for community health workers (CHWs) was coming to the fore. At that time there was no formal co-ordination between the two programmes. According to Friedman (2005) community health worker programmes had been implemented in South Africa with the help from international donors around the 1980s. Most of these programmes floundered after 1994 when the National

Department of Health became reluctant to support such programmes. Friedman (2005) states that the CHW was replaced by numerous community-based organizations presenting volunteers with less coordination and insecure funding.

According to Friedman (2005), the Department of Health later reversed its decision and encouraged other departments to establish CHW programmes in disadvantaged communities throughout the country. This is when the original VCT programme, which included lay counsellors providing pre- and post-test counselling, re-merged. When the CHW programme was scaled up, the Expanded Public Works Programme – a unit of the Department of Public Works Programme – played a role of supporting the development of the CHW programme as a job creation initiative. The three government departments that were supportive of the CHW programme were the Department of Health, the Department of Social Development and the Public Works Programme (Friedman, 2005; Schneider & Lehmann, 2010).

The implementation of the CHW programme has faced numerous challenges. The governance, remuneration, training and management of lay counsellors varied across provinces as well as within levels of government. This has resulted in many problems, poor systems of remuneration, problematic relationships with health professionals, inadequate training, support and supervision (Schneider et al., 2008). In 2004 there were 19 616 volunteers supported by the Department of Social Development, but only 5 988 of the volunteers received their stipends in that year (Friedman, 2005).

Recently, becoming a CHW has been seen as an easy way of securing employment. This led to poor selection and the employment of people with inappropriate personalities, skills and backgrounds. People appointed as HCT counsellors are therefore not necessarily the best people for the job (Friedman, Ramalepe, Mathijs, Bhengu, Lloyd, Mafuleka, Ndaba & Boloyi, 2007).

Lay counsellors nevertheless occupy the front line of HIV and AIDS service delivery even though they are not formally employed within the health system. At the moment lay counsellors are employed and supervised by Community Based Organizations (CBOs) or Non-Governmental Organizations (NGOs) representing the community they serve. The district health manager has a responsibility of monitoring the quality of services provided by the lay counsellors, but the district is not accountable for employing them. Technical support and management are provided by community facilitators or co-ordinators based at specific NGOs that supervise them (Friedman, 2005). This state of affairs causes many challenges in managing the services. Within one clinic there could be three lay counsellors reporting to two or three different CBOs or NGOs. There may be large discrepancies between the briefs, tasks, privileges and stipends of counsellors that view themselves as colleagues (Personal communication with counsellor, 2011). These complexities have resulted in an unregulated and uncoordinated proliferation of individuals with different skills and orientations (Schneider & Lehmann, 2010) supposedly working together on matters of immense importance. These obstacles and challenges in the system of implementation form the background for this research on the well-being of HCT counsellors.

1.4 The role of HCT in the HIV response

HIV Counselling and Testing forms part of the South African government strategy to curtail HIV and AIDS in the country. HCT acknowledges that individuals have a right to know their HIV-status in order to protect themselves and others from HIV infection and to be free from the anxiety of not knowing one's HIV-status. Early detection of HIV may also improve the health and livelihood of people who are HIV-positive because they can get the appropriate treatment (Meiberg, Bos, Onya & Schaalma, 2008).

The positive impact of HCT has been established and lauded by numerous studies. The HCT efficacy study in Tanzania, Kenya and Trinidad found substantial and significant behaviour changes among both men and women receiving HCT intervention compared to those receiving basic health information. Another study found HCT to be effective in reducing risk behaviours among people living with HIV (Samayoa, Anderson, O'Sullivan, Patricia, Pacheco, Matos, Reyes, Setru & Arathoon, 2010).

HCT contributed to reduced risk of engaging in sexual behaviour which could lead to HIV transmission in a South African study (Kalichman & Simbayi, 2003). Glick (2005) argues that more behaviour change occurred amongst individuals who tested HIV-positive than amongst those who tested negative. He challenges the efficacy of HCT by arguing that there are still HIV-positive, sexually active individuals who may not know their status. He believes that these individuals need to be drawn into the programme in order to reap more benefits from HCT. Richards and Pennymon (2004) also question the efficacy of HCT by pointing out that studies have shown that HCT has not lived up to its promise.

1.5 The counselling aspect of HCT

HCT is defined by UNAIDS (2010) as the process by which an individual undergoes counselling, enabling him or her to make an informed choice about being tested. In addition, it helps clients to learn about their HIV-status, ways to protect themselves and others against HIV infection. It assists clients who test positive, to cope and accept their status (WHO, 2007).

HCT serves as an entry point to HIV prevention, care and support services, such as the prevention of mother to child transmission (PMTCT) (Buskens & Jaffe, 2008; Medley & Kennedy, 2010), antiretroviral (ARV) treatment and the prevention of and management of sexually transmitted infections (Department of Health, 2006; 2010). HIV and AIDS counselling

has become an important element in a holistic model of care in which psychological issues are recognised as integral to patient care and management. HIV and AIDS counselling aim to prevent the transmission of HIV and to alleviate distress amongst those infected and affected by HIV and AIDS (Chippindale & French, 2001; Magongo, Magwaza, Mathambo & Makhanya, 2002). Counselling which is provided at public health facilities consists of pre-test, post-test and follow-up counselling.

Pre-test counselling is counselling given to an individual before an HIV test. The purpose is to ensure that the individual has ample information to make an informed decision about having an HIV test (UNAIDS, 2008). During pre-test counselling it is endeavoured to determine why individuals want to be tested to gauge the extent of their high-risk behaviour and to strongly recommend actions required to prevent them from being infected or from infecting others (van Dyk, 2008). During pre-test counselling, the counsellor gives an individual or couple the opportunity to explore and analyze their situation and consider being tested for HIV (UNFPA, 2004). In essence, pre-test counselling focuses on what an HIV test entails; the meaning of HIV test results and safer sex strategies to reduce risk. Pre-test counselling also prepares a person to cope with an adverse result and to identify support structures. Van Dyk (2008) further states that pre-test counselling is an opportunity to educate people about HIV and AIDS and safer sex practices. Counselling augments AIDS education by making HIV and AIDS related information more relevant to the clients' situations as it focuses on behaviour change initiatives.

Post-test counselling is the counselling provided when an individual receives his or her HIV test results. During post-test counselling, test results are discussed. In the case of HIV-negative results it is important to encourage the client to reduce risk behaviour to stay HIV-

negative (UNAIDS, 2006). In an event of adverse test results it is important to be empathic, compassionate and to normalise any response or feelings that may be evoked by the HIV-positive diagnosis (Rohleder & Swartz, 2005). In addition, it is important to assist the client to understand what a HIV-positive diagnosis means. Issues such as family planning, social support services as well as disclosure of status need to be addressed. Post-test counselling supports people to understand their test results and their implications. Furthermore, it helps clients to consider to whom they might want to divulge their results (Myint & Mash, 2008; van Dyk, 2008).

Follow-up counselling supports clients in coping with issues raised as a result of learning about their HIV-status. According to UNFPA (2004) follow-up counselling is relevant to those who test negative and those who test positive. Counselling has become integral in the provision of HIV and AIDS services in South Africa given that results of an HIV-test have enormous emotional, psychological and social implications. Clients' responses could be affective, cognitive, behavioural or a combination of these reactions (van Dyk, 2008).

1.6 Psychological counselling

Psychological counselling is defined as a process by which clients are invited to look honestly at their behaviour and lifestyle and make certain decisions about how they want to modify the quality of their life (Corey, 2009). It is defined as a private conversation with a specially trained person which encourages an individual to explore possible solutions to his or her problems and to consider the impact that certain decisions may have on a person's life (van Dyk, 2008).

Counselling is a specialized profession, which focuses on the holistic well-being of a person. Through counselling, clients are assisted in developing a sense of self-worth and self-

confidence (Tse, 2010). Counsellors enter the counselling relationship with their own beliefs and values. They must be willing to explore their own values, beliefs and attitudes to enable them to understand and accept the values of their clients. It is the willingness to live in accordance with positive belief systems which enables counsellors to have a therapeutic effect on the lives of their clients (Corey, 2009).

Counsellors aim to facilitate healing through a process of authentic dialogue with clients that leads to a shared responsibility between the client and the therapist. In counselling the process of engagement between two persons (therapist and client) is bound to change because of the therapeutic venture (Corey, 2009). Counselling is a field that emphasizes the emotional growth of clients. It is therefore crucial for the counsellor to possess positive emotional skills, human qualities of compassion, caring, good faith, honesty, realness and sensitivity because these qualities are critical in building the relationship with the client and in promoting change. A counsellor should model a way of being for the client (Corey, 2009), often by acting as a role model.

Qualities of an effective counsellor agree largely with the description of a mature and fully functioning person (Maslow, 1970). The psychological well-being of counsellors is thus an important component of effective counselling.

These definitions and discussions emphasise the professional nature of counselling. In this sense *lay counsellor* is a complete contradiction in terms. It is nevertheless expected of HCT "counsellors" to do counselling with their clients in order to facilitate healing, although they have very limited training in counselling skills. With inadequate training it is possible that they may have difficulty in self-reflection and accepting the clients' value system, if it does not agree with

their own. Without adequate training it is possible that they can even harm the well-being of their clients.

1.7 The well-being of HCT counsellors

Various studies have been conducted regarding the effectiveness of HIV counselling and testing (Myint & Mash, 2008; Richter et al., 1999; Sweat, Gregorich, Sangiwa, Furlonge, Balmer, Kamenga, Grinstead & Coates, 2000). Some studies explored the feelings and experiences of HCT counsellors (Mavhandu-Mudzusi, Netshandama & Davhana-Maselesele, 2007; Richards & Pennymon, 2004; Richards & Marquez, 2005; Rohleder & Swartz, 2005; van Dyk 2008). There is very little research on the psychological well-being and coping skills of counsellors. These are important components in the development of the counsellor as a person and as counsellor. The counsellor's psychological well-being determines his/her ability to engage in an effective counselling relationship.

South African literature on the well-being, particularly psychological well-being of health care practitioners is limited. Studies in the health care field most often evaluate the implementation of programmes and effect it has on *clients*, but have neglected a focus on the implementers of these programmes. HIV and AIDS is a disease associated with many emotions and fears not only for those who are infected and affected, but also for caregivers and counsellors. To perform their role effectively HCT counsellors need to be psychologically well, well trained and supported (Richter et al., 1999). This study will explore the psychological well-being of counsellors by using concepts such as coping, and emotional intelligence as well as experiences of burnout and depression.

1.8 Motivation for the study

There is consensus that HCT serves as the first step to treatment for those who are infected. HCT also provides the uninfected individual with information and motivation to maintain their HIV-negative status (Corbett, Marston, Churchyard, & De Cock, 2006). HCT provides people the opportunity to discuss HIV, potential risk behaviour and to plan for the future (Sweat et al., 2000). Health care, specifically HIV- and TB care, in South Africa would simply be unimaginable without the services of lay counsellors. HCT has become a function that is routinely entrusted to lay counsellors who form a mediating layer between the formal health system and community members (Schneider & Lehmann, 2010).

At the moment, there are generally three HCT counsellors deployed per clinic in Tshwane. If volunteers are not available, the pre- and post-test counselling cannot take place. The quality of the service the counsellors deliver depends to a large extent on their characteristics, competencies and psychological well-being.

In this study the psychological well-being of HCT counsellors from clinics drawn from the City of Tshwane Health Services is assessed. The investigation explores challenges such as depression and burnout that they experience as a result of the nature of their work. In addition positive experiences, strengths as well as rewards that are associated with their work will be assessed. Furthermore this study investigates whether symptoms of depression and burnout occur in conjunction with positive emotional competencies and skills, as inferred by Keyes' continuum of negative and positive well-being (refer to Chapter 2). The coping skills of HCT counsellors will be investigated to determine whether these coping skills contribute to their ability to cope with the stressors they are confronted with in their work environment. The

following chapter will discuss positive psychology as a theoretical perspective used in this research.

1.9 Definitions of key terminology

The following concepts are, amongst others, used in this research:

Burnout refers to a state of emotional exhaustion caused by excessive and prolonged stress which can lead to depersonalization and reduced personal accomplishment. People experiencing burnout have lost meaning of work as a result of prolonged response to emotional, physical, and mental exhaustion they experience (Polikandrioti, 2009). Burnout detracts from quality and quantity of services as well as care rendered, therefore contributing to poor client outcomes (Thorsen, Tharp & Meguid, 2011).

Coping refers to cognitive and behavioural efforts to manage specific external and or internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus & Folkman, 1984). Lazarus and Folkman (1984) have described two general coping strategies. Firstly, problem-focused coping which is an active cognitive behavioural effort to manage stress by changing the situation of the problem. Secondly, emotion-focused coping which is the cognitive management and regulation of the distressing emotions often used in situations where the individual does not have control over the stressful situation.

Depression refers to feelings of extraordinary sadness and disturbed physical functions to the point where any slightest activity requires overwhelming effort (Barlow & Durand, 2009). Depression can be characterized by low mood, persistent sadness, loss of interest in, and withdrawal from regular and pleasurable activities. Individuals diagnosed with major depression

often experience decreased energy, feelings of hopelessness, despair and a decline in self-esteem (Angelino & Treisman, 2001).

Emotional intelligence refers to an array of competencies and skills that determine how effectively individuals understand and express themselves, understand others and relate to them and cope with daily demands, challenges and pressures (Bar-On, 2010). These concepts are components of the psychological well-being continuum as part of positive psychology.

Positive psychology refers to the scientific study of positive experiences, positive individual strengths and the positive institutions that facilitate positive human development and optimal functioning. It is an encompassing term for the study of positive emotions, character traits and enabling institutions. The concept of positive psychology balances knowledge about human abilities and well-being to supplement knowledge about human suffering and disorders (Duckworth, Steen & Seligman, 2005; Seligman & Csikszentmihalyi, 2000). The positive psychology paradigm will be the theoretical framework used in this research.

One of the key concepts of the positive psychology is well-being. **Well-being** refers to an individual's state of emotional health as attained from values of personal growth, development, self-acceptance and understanding, as influenced by the ability to succeed in coping with environmental demands and pressures (Bar-On, 2005; Corey, 2009).

1.10 Overview of the study

This study on the psychological well-being of HCT counsellors will be presented in six chapters. In this chapter an overview was given of the history and role of HIV counselling and testing in health care. A motivation for the study was offered. In **chapter two** the focus will be on psychological well-being as a construct of the positive psychology framework. It will be indicated how it relates to the counselling process.

Chapter three will begin by exploring previous research that identified the challenges affecting HCT counsellors. The chapter will focus on different stressors and situations that HCT counsellors are faced with in their jobs. It will be investigated how these stressors affect their well-being. The chapter will also discuss why it is necessary to investigate the well-being of counsellors.

Chapter four will provide detailed descriptions of the methodologies used to collect data. This study will use both qualitative and quantitative methods. In this research specifically, the combination of research methodologies will provide comprehensive information on the experiences and challenges of HCT counsellors. Data obtained through different strategies will be triangulated to enhance understanding.

Chapter five will consist of the presentation of research results. **Chapter six** will present a discussion of the results which will include a summary of the findings and recommendations as well as limitations of the study.

Chapter 2: Positive Psychology as Theoretical Framework

2.1 The positive psychology perspective

Positive psychology is the study of positive experiences, positive individual strengths and the positive institutions that facilitate positive human development and optimal functioning (Duckworth, Steen & Seligman, 2005). The term positive psychology was crystallized by Seligman who argued that traditional psychology was focusing more on the negative than the positive aspects of human functioning (Seligman & Csikszentmihalyi, 2000; Seligman, Parks & Steen, 2004). Positive psychology grew out of the recognition of inequities and imbalances in psychological research that tended to focus on human distress, suffering and mental illness. Huppert and Whittington (2003) believe that the neglect of positive aspects of psychology could have been due to the prevailing medical model of psychiatry which tended to focus on illness, disease and negative mental states rather than wellness and positive functioning. Cloninger (2006) confirms that the focus of psychiatry has been on mental disorders. The understanding or development of positive mental health has been neglected in these disciplines. Until recently there has been very little research that has explored the role of positive emotions and strengths in the prevention and treatment of mental illness or the therapeutic effect of identifying one's talents and strengths (Duckworth et al., 2005).

Seligman and Csikszentmihalyi (2000) acknowledge that psychology has made great contributions in classification and treatments of psychological disorders. They feel that the complete practice of psychology should have a balanced understanding of the entire spectrum of human existence which includes issues such as well-being, happiness, motivation and positive human strengths (Gable & Haidt, 2005; Helliwell & Barrington-Leigh, 2010; Seligman, Steen, Parks & Peterson, 2005). Positive psychology, according to Seligman et al. (2005), is an all-

encompassing term for the study of positive emotions, strengths, character traits and enabling institutions.

Although the roots of positive psychology can be traced further back, positive psychology has rapidly developed since the Second World War. Duckworth et al. (2005) credit all the psychological traditions from psychoanalysis to existential psychology for contributing to the current understanding of positive aspects of human experience. The client-centred therapy developed by Carl Rogers stressed the principle that humans have the ability to move themselves towards better functioning. Another important figure who contributed to the humanistic way of thinking was Maslow who believed that individuals could become self-actualized (Bar-On, 2010; Corey, 2009; Duckworth et al., 2005). According to Duckworth et al. (2005) Marie Jahoda is credited for developing a framework for understanding mental health. She identified six dimensions that contribute to mental health, which are acceptance of oneself, growth, integrations of personality, accurate perception of reality, autonomy and environmental mastery (Duckworth et al., 2005). These dimensions are central to positive psychology in that they encompass different features of well-being. Ryff and Singer (2005) believe that the dimensions of well-being provide the basis for developing tools for assessment of well-being. Positive psychologists contributed to the field of psychology by championing the constructs of positive psychology as worthy of scientific investigation and to give them significance.

There are many constructs to positive psychology, and the tools to measure and develop these constructs into theories that can be used in scientific studies are still being refined (Duckworth et al., 2005). Duckworth et al. (2005) believe that positive psychology is currently where clinical psychology was in the 1970's. Many constructs and assessment tools are still being development, longitudinal studies have just begun and interventions are still in infancy.

However, positive psychology as a science strives to develop classification systems, stable and reliable methods of assessment and effective studies of interventions (Duckworth et al., 2005).

2.2 Emotional intelligence: a component of well-being

Bar-On (2010) believes that one's emotional intelligence is an important factor in determining one's ability to succeed in life and it influences one's psychological well-being. Bar-On (2010) defines emotional-social intelligence as an array of interrelated emotional and social competencies and skills that determine how well individuals understand and express themselves understand others and relate with them and cope with daily demands, challenges and pressures. Positive psychology and emotional intelligence focus on the same positive human strengths and characteristics, such as self-regard, understanding how others feel, social awareness, self-regulation and the ability to control emotions, effective functioning, self-actualization and the ability to generate happy moods.

Bar-On (2010) identifies the following areas of overlap between positive psychology and emotional intelligence:

- self-regard and self-acceptance based on accurate self-awareness;
- the ability to understand the feelings of others, as well as the capacity for positive social interaction;
- the management and control of emotions;
- realistic problem solving;
- effective decision making;
- self-determination and optimism.

In presenting his model he asserts that emotional social intelligence is an integral part of positive psychology. Bar-On (2005) found happiness to be highly correlated with emotional

intelligence. He concluded that happiness has a positive impact on intelligent behaviour because it monitors one's immediate well-being and maintains positive moods in the way that people cope with challenges and pressures.

In another study on the relationship between emotional intelligence and well-being, Bar-On (2005) found a high correlation between the two constructs and concluded that individuals with an enhanced sense of well-being are the ones who possess high levels of emotional self-awareness, positive self-regard and self-actualization as well as effective reality testing. In addition, the predictors of subjective well-being were found to be the ability to understand one's emotions, the ability to set and achieve personal goals and the ability to verify one's feelings. Bar-On (2010) believes that self-actualization depends on a deep sense of self-awareness and good problem solving which assist the individual in making sound decisions regarding what one wants to do. Bar-On contributed to the theory of emotional intelligence by developing a scale to measure emotional intelligence.

The Bar-On Emotional Quotient Inventory (EQ-i) distinguishes between intrapersonal, interpersonal, stress management, adaptability and general mood domains and defines several components of emotional intelligence as part of each domain. According to Carr (2004) in each of the domains there are specific skills which collectively constitute emotional and social intelligence. In essence, emotional intelligence influences one's overall degree of mental health – which is a concept similar to psychological well-being. Emotional intelligence is not only about being aware of feelings and emotions but it includes abilities and competencies that are used to cope with life effectively. This scale will be used to assess the emotional and social intelligence of counsellors which are constructs of positive psychology.

2.3 Dimensions of well-being within the positive psychology framework

Theorists within this field assert that although individuals live and interact in objectively defined environments, they respond to those environments in a subjective manner (Keyes, Ryff & Shmotkin 2002). According to Diener and Lucas (2000) people evaluate situations differently depending on their expectations, values and past experiences. Individuals often evaluate their life satisfaction based on their level of happiness. According to Snyder and Lopez (2007) happiness is a positive emotional state that is subjectively defined by each person. The definition of happiness according to Diener, Lucas and Oishi (2005) emphasizes pleasure, satisfaction and life meaning through the appreciation of life's rewards. Therefore, importance is placed on the subjective elements of an individual's thoughts and feelings about their own life. Although happiness is useful in understanding well-being, it is not a theoretical paradigm. Happiness is the basis for understanding Marie Jahoda's six dimensions that contribute to mental health (Duckworth et al., 2005). Accordingly, Duckworth et al. (2005) contextualize the concept of happiness in terms of three domains:

- 1) The first domain is the pleasant life which is described as maximizing positive emotions about the past, present and future or emotional well-being.
- 2) The second domain is the engaged life which consists of utilizing positive individual strengths of character and talents or psychological well-being.
- 3) The third domain is the meaningful life which consists of belonging to and serving in positive institutions or social well-being (Duckworth et al., 2005; Gable & Haidt, 2005; Linley, Joseph, Harrington & Wood, 2006). Within the positive psychology perspective, there are dimensions of well-being namely, psychological, social well-being and positive institutions.

2.3.1 Psychological well-being

Psychological well-being is a dimension of positive psychology which was conceptualized by Jahoda and Ryff (Duckworth et al., 2005; Seligman & Csikszentmihalyi, 2000). The dimensions of psychological well-being are self-acceptance, personal growth, purpose in life, environmental mastery, autonomy and positive relations with others (Duckworth et al., 2005; Seligman & Csikszentmihalyi, 2000; Snyder & Lopez, 2007). Psychological well-being draws from human development and developmental processes and challenges in life. The pursuit of happiness which is the reflection of pleasant or unpleasant feelings in one's experience is central to the field of positive psychology (Snyder & Lopez, 2007).

2.3.2 Social well-being

According to Keyes (1998) social well-being is the appraisal of one's circumstances and functioning in society. In understanding optimal human functioning, it is important to investigate human social well-being because it reflects possibilities which are the criteria that individuals use to assess the quality of their lives. Keyes (1998) has identified various dimensions of social well-being. However, two of these dimensions, social integration and social contribution are the most applicable to the present study. He defines social integration as the evaluation of the quality of one's relationship to society and community. Social contribution on the other hand, is defined as the evaluation of one's social value which includes the belief that one has something of value to give to the world. Social well-being is the association of positive states and optimal functioning within one's social network and community. Social well-being is an essential aspect of positive psychology. Individuals deem themselves to be functioning well when they view society to be meaningful, possessing potential for growth, and when they see themselves contributing to society (Keyes, 1998, Snyder & Lopez 2007).

2.3.3 Positive institutions

Positive institutions are central to the discussion of social well-being. Cooperrider (2008) defines positive institutions as systems, procedures and strategies within workplaces that elevate and magnify human strengths. In his description of positive institutions, Wilner (2011) takes the discussion further to include institutions within communities. He believes that positive institutions are resources and infrastructure that enhance the community to be involved in policy decisions. In such institutions there is engagement with the community. According to Duckworth et al. (2005) positive institutions are thought to foster the development of positive traits in individuals, which in turn facilitate the development of experiences of well-being. Duckworth et al. (2005) believe that positive traits and positive emotions flourish within the context of positive institutions because that is where meaning is derived. Meaning derives from belonging and serving something larger than oneself. Wilner (2011) asserts that positive institutions contribute to the community's level of mental health. A community's infrastructure relates to an individual's areas of social responsibility and civic duty.

2.4 The negative and positive well-being continuum

The advancement of positive psychology has presented with discussions regarding the polarity of mental health and mental illness and positive and negative well-being. For the sake of the argument the fact that the terms *positive* and *negative well-being* are tautological and oxymoronic respectively will be ignored here. Positive well-being includes positive energies and moods related to positive emotional states such as joy, interest and confidence, whereas negative well-being includes negative moods such as sadness and fear (Karademas, 2007; Singh & Jha, 2008).

Previous views of mental health and mental illness defined the two constructs as opposite ends of a continuum (Ryff, Love, Urry, Muller, Rosekranz, Friedman, Davidson & Singer, 2006). However, Keyes (2002; 2005) contends that the absence of mental ill health does not imply the presence of mental health. He argues that there are individuals who show high levels of ill-being and well-being at the same time, while others are free from psychological disorders but lack meaningful life satisfaction and engagement (Ryff et al., 2006). This may be an indication that there are other factors at play.

Mental health as defined by Keyes (2007) is a state consisting of the presence and the absence of mental illness and mental health symptoms. He hypothesizes that the mental health continuum consists of complete and incomplete mental health. As a result adults with complete mental health have high levels of well-being, and are functioning well psychologically and socially. Conversely, adults with incomplete mental health have low well-being as they perceive their lives as stagnant and empty despite various levels of mental health or mental illness (Keyes, 2002; 2005; Keyes & Lopez, 2005). The model as proposed by Keyes (Figure 2.1) views mental health as a combination of all facets of well-being. It is multidimensional because it combines extremes of mental health and mental ill health with subjective well-being (flourishing) and low subjective well-being (languishing).

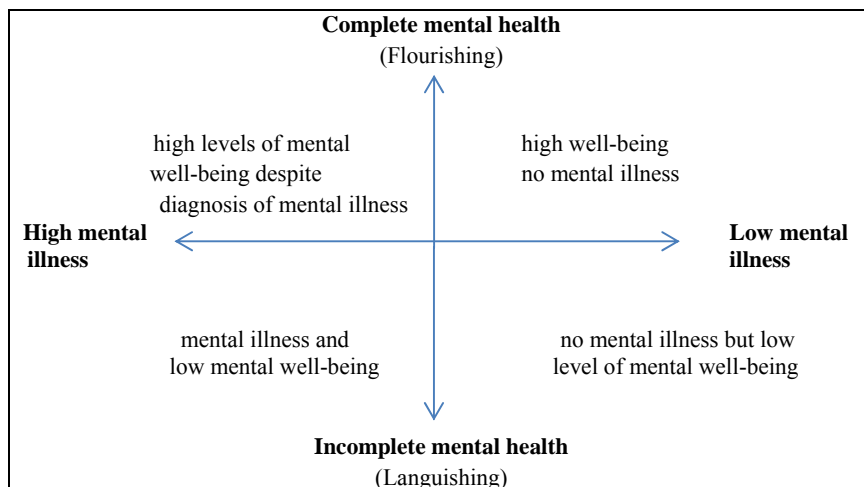


Figure 2.1 A model of mental health (Keyes 2002)

Keyes and Lopez (2005) suggest that within this model mental health and mental illness symptoms may result in fluctuations in states of overall well-being from complete mental illness to complete mental well-being. Keyes believes that flourishing may sometimes occur with an episode of mental illness and moderate mental health and languishing can occur with and without mental illness (2007). Keyes (2002) asserts that there is more to functioning well in life than being symptom free. Troubled people surely care about much more in their lives than just the relief of suffering (Duckworth et al., 2005). They want more satisfaction, contentment and joy and want to build their strengths. That is the fundamental difference between traditional psychology as we know it and positive psychology. Positive psychology has provided a different lens through which to understand human experience.

According to Keyes (2002) individuals are functioning well when they see themselves in a positive light, have trusting relationships, have a level of control over their environments and have a sense of determination, not only when they have no symptoms of psychological disorder.

Psychological well-being is thus an intrapersonal reflection of individuals' adjustment and outlook on their personal lives. The well-being of counsellors can therefore be assessed by evaluating aspects of positive ill-being and positive well-being associated with their experiences and feelings. In the following sections the variables evaluated in this research will be outlined in the context of positive psychology.

2.4.1 Depression

Mental disorders including depression are regarded as the leading causes of disability throughout the world (Cox, Ness & Carlson, 2010). Depression is a common global mental health issue which is the fourth leading cause of disease in the world (WHO, 2007). According to Cox et al. (2010) depression has been conceptualized as emotional states that can range from distress to despondency to melancholy. It is a common condition that affects an individual's physical, emotional and cognitive functioning.

As depression is a condition commonly found in the general population, it is also found in the world of work. Within the workplace, depression presents in the form of poor performance and behavioural deficits including reduced work quality, inconsistent productivity, workplace conflicts and decrease in interest in tasks (Cloninger, 2006; Cox et al., 2010). Workplace conditions may contribute to depressive symptoms which impact on the employee's mental health and functioning. Stressors such as demands, organisational politics and the job environment are factors related to work place depressive reactions (Cox et al., 2010). A study by Myer, Seedat, Stein, Moomal and Williams (2009) examined the impact of AIDS mortality on mental health in the general South African population. They found that individuals who knew someone who died of HIV and AIDS were more likely to have DSM-IV defined disorders including depression, anxiety or substance related disorders. Their findings suggest those who

are not infected also experience significant stress as a result of the impact of the epidemic. These stressors may in turn have negative effects on their mental health. They believe there is a need to also strengthen the population mental health care services especially in high prevalence settings. If this is the effect of AIDS related deaths on the general population, then HCT counsellors will also be affected by the implications of HIV.

A study examining depression amongst caregivers of AIDS orphans in Japan found that two thirds of the study population had scores on the Centre for Epidemiologic Studies Depression Scale (CES-D) of higher than the cut-off point for clinical depression (the cut-off point is 16) (Lv, Zhao, Li, Stanton, Fang, Lin, Zhao & Zhao, 2010). Flaskerud and Lee (2001) found depression scores of caregivers of people living with HIV and AIDS to be higher than that of caregivers of people living with age related dementia. In this study on the psychological well-being of HCT counsellors and depression levels of counsellors will be assessed using the CES-D.

2.4.2 Burnout

The term burnout refers to a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that occurs amongst individuals who work with people in a helping capacity (Aguayo, Vargas, de la Fuente & Lazano, 2011). Iacovides, Fountoulakis, Kaprinis and Kaprinis (2003) assert that burnout is a result of high efforts of time, emotional involvement and empathy and poor satisfaction in addition to highly demanding working conditions. The authors believe that working in human services is stressful because it is difficult to balance concern and detachment (Iacovides et al., 2003). They cite burnout as a cause of the dropout rates of buddies-volunteers who offer emotional support to people living with HIV and AIDS. According to UNAIDS (2008) burnout is not a single event; it is a culmination of everyday stressors and anxieties that are not addressed.

2.4.3 Workplace stress and burnout

Stress is defined as an emotional, physical and psychological response to events that pose a threat or a challenge (Colligan & Higgins, 2006). Stress can have positive and negative outcomes in that it can help individuals to achieve goals, while on the other hand, high levels of stress can cause emotional distress and physical illness. An individual's interpretation of the stressor is related to the characteristics of the stressor and the characteristics of the individual (Colligan & Higgins, 2006).

Workplace stress is of particular focus in this study because it is the study of the well-being of HIV and AIDS counsellors within the context of their work. The workplace can be a source of stress when there are challenges that are perceived as a threat to an individual's well-being. Stress can be described in terms of three components:

- 1) the appraisal of a particular stressor by the employee,
- 2) the emotional reaction evoked when the stressor is appraised as threatening and
- 3) the end results of physical, cognitive as well as behavioural problems (Rothmann, 2008).

Workplace stress may have a significant impact on mental health (Iacovides et al., 2003). Workplace stress can affect productivity and can increase absenteeism and burnout (Colligan & Higgins, 2006).

2.4.4 Coping

Although stress can cause various psychological and physiological problems, the effects of stress and other negative experiences can be mitigated through coping strategies (Lazarus & Folkman, 1984). Coping as defined previously, refers to cognitive and behavioural efforts to manage specific external and or internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus & Folkman, 1984). There are three components to the definition

of coping. Firstly, it is **process oriented**, referring to thoughts and actions that are specific to a stressful encounter as well as the process in which the encounter unfolds. Secondly, it is **contextually oriented**; it is influenced by the person's appraisal of both the demands in the encounter and the resources for managing them. Thirdly, coping is defined as the **efforts** to manage demands whether or not the efforts are successful or not (Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986).

In coping with stress, individuals are said to carry out cognitive appraisal to evaluate whether the event is potentially beneficial or harmful, called primary appraisal. Another form of appraisal is secondary appraisal to evaluate what, if anything can be done to prevent harm or improve possibilities for benefit (Akintola, 2008; Folkman et al., 1986). Coping strategies are divided into **problem-focused** and **emotion-focused coping**.

Problem-focused coping is an active cognitive behavioural effort to manage stress by changing the situation of the problem. Problem-focused coping is used in encounters that are appraised as changeable. Problem-focused coping strategies include gathering information, planning and taking direct action. In a study by Akintola (2008) volunteers reported that they experienced discrimination by family members against patients as stressful. They coped by educating family members about HIV and AIDS. This resulted in improvements in the attitudes of the family members towards patients. Despite the lack of incentives, emotional stressors, and facing issues of death and dying on a daily basis, counsellors used active coping strategies such as learning their tasks and becoming competent counsellors (Akintola, 2008). Others focused on the rewards and positive experiences in order to cope (Akintola, 2010). Akintola (2008) found that some counsellors could not come to terms with the reality of seeing bedridden patients and they therefore requested to be reassigned to patients with less serious conditions.

Emotion-focused coping is defined as a process of coping which is aimed at regulating stressful emotions (Lazarus & Folkman, 1984). The authors believe that emotion-focused coping is used in situations where it is perceived that there are few options to affect an outcome. Emotion-focused coping is an individual's attempt to change negative emotions and it is aimed at normalizing the emotional response to a stressor. According to Lui, Pan, Wen, Chen and Lin (2010) the aim of emotional-focused coping is to ease emotional reactions and accept stress as a part of life. Emotional responses that some health care workers used in response to stress included complaining, blaming, escaping or avoiding the problem, venting emotions, being absent from work without reason, fewer intents of co-operating. In Akintola's (2008) study some counsellors coped by keeping their minds off the situations, talking to colleagues, going to church and praying. This form of coping assists in giving meaning to a challenging situation, therefore an individual is able to cope better with the situation. In later work, Folkman (1997) included meaning-making coping as a third coping strategy. This involves the activation of beliefs, values and goals that help define the positive significance of a difficult situation.

Positive emotions play an integral role in coping. According to Khosla (2006) positive affect increases a range of positive behaviours while enhancing resources (better health, better social networks) including intellectual and psychological well-being. As positive forms of coping are an aspect of psychological well-being, the HCT counsellors' ways of coping will be assessed through the Brief COPE scale.

2.5 Conclusion

The goal of counselling is to promote positive change in clients and that is achieved through fostering a mutual relationship between the client and the counsellor. The characteristics of an effective counsellor discussed in the previous section are key to laying the foundation for effective counselling. These characteristics are related to important aspects of positive psychology. Positive psychology highlights a dimension of psychology which was neglected by the traditional view of psychology which focused on disorders. Positive psychology suggests a balanced approach of well-being and ill-being aspects of human functioning, strengths and capacities. The current research aims to study the psychological well-being of HCT counsellors and will use positive psychology as a theoretical framework. This study will evaluate the well-being of counsellors and investigate the relationship between various constructs of positive well-being and negative well-being. To provide a comprehensive picture of the well-being of HCT counsellors various psychological questionnaires will be used to assess aspects of health and ill-health. The psychological scales used in this study therefore assess the multidimensionality of well-being. The following chapter will explore the experiences and challenges in the work context affecting HCT counsellors which in turn contribute to their negative and positive well-being. Specific emphasis will be on different stressors and situations that HCT counsellors are faced with in their jobs and on how these stressors affect their well-being.

Chapter 3: Challenges and rewards of HIV and AIDS Counselling

3.1 An introduction to challenges affecting HCT counsellors

Positive psychology strives to enhance positive human emotions through promoting meaning, purpose, and engagement in the service of something bigger than the self, such as the service of family or community. As discussed in Chapter 2, positive psychology encompasses the study of positive institutions which also assist in enhancing the well-being of individuals. A study of the work environment of the HCT counsellors is therefore important to understand aspects of their psychological well-being. A number of studies have identified the emotional stressors and challenges HCT counsellors experience in their work context (Mavhandu-Mudzusi et al., 2007; Richards & Pennymon, 2004; Richards & Marquez, 2005; Rohleder & Swartz, 2005; van Dyk, 2007). These challenges faced by counsellors, will be presented in terms of structural and psychological stressors. Structural stressors relate to the nature of the physical work environment including remuneration, lack of training and lack of space to conduct counselling. Psychological stressors are the emotional aspects which relate to the counselling relationship towards their clients and co-workers. In addition to the challenges, positive experiences and rewards of HIV and AIDS counselling will also be discussed.

3.2 Structural stressors

3.2.1 Employment situation

The challenges of lay counsellors cannot be discussed without identifying the problematic nature of their ‘employment’ situation. As outlined in Chapter 1, when HIV counselling was first implemented using lay counsellors, it was part of a pilot project on a small scale (Schneider et al., 2008; Schneider & Lehmann, 2010). Since that time the burden of HIV and AIDS on the health system increased dramatically. This resulted in an increase in the

demand for these services. In reaction several non-governmental organizations and faith-based organizations emerged to train lay counsellors to provide AIDS care and counselling support.

The initial role player in the volunteering strategy was the Department of Health with the concept of the Faces project. That evolved into the implementation of the HCT counsellor programme. With the call for volunteering taking the centre stage, the Department of Social Development developed its own categories of community caregivers to address the needs of orphans and vulnerable children (Schneider et al., 2008; Schneider & Lehmann, 2010). The Expanded Public Works Programme, which is the government's strategy for poverty alleviation and job creation, also became involved. The Department of Labour, whose role was to accredit and standardize the training of all lay community workers, became another partner (Schneider et al., 2008; Schneider & Lehmann, 2010). According to Schneider and Lehmann (2010) a key feature of the community health worker strategy is that it has been developed incrementally rather than through a consultatively formulated policy or strategy from the top. By the time policy frameworks were launched, involvement of community and lay health workers was already established in the country.

The national government is responsible for strategic directives and legislative policy formulations. The provincial government is responsible for implementing all the legislative issues including disbursements of funds (Schneider et al., 2008; Schneider & Lehmann, 2010). The relationship between the levels of government regarding the overall policy for the CHW programme is complex. Lay counsellors are trained within provincial structures and placed in municipal clinics (local government). Policy directives are developed from national structures through the provincial government. Non-government organizations act as facilitators for employing lay counsellors. In addition NGOs are involved in mentoring and co-ordinating

training for counsellors. Anger and frustration of HCT counsellors in the South African context can be attributed to the complex relationship of their employment and the various levels of government involved and the confusing roles that they play in the HCT programmes. In actual fact, they are not considered as employed in the health care system, but they are regarded as volunteers offering lay services.

3.2.2 Remuneration

Under the policy framework of the community health worker programme, community health workers and lay counsellors are employed through government funded non-governmental organizations. The remuneration varies widely. Some volunteers do not receive remuneration, while others are earning up to R1850 per month (Friedman et al., 2007). According to Schneider et al. (2008) community health workers fall outside the public service and regulatory processes which govern employment in South Africa. Community Health Workers are employed by NGOs although government is the perceived employer. Their stipends come from provincial structures through NGOs where they are based. This is because funds are disbursed through the Department of Social Development and the Department of Health (Schneider et al., 2008; Schneider & Lehmann, 2010).

This arrangement has created problems because in principle NGOs receive their funds from government. When the transfer of funds is delayed, the timely disbursement of stipends is compromised. Research at three clinics in Johannesburg revealed that lay counsellors did not receive their stipends for a 6-months period and at times receive their stipends a year late (Woolman, Sprague & Black, 2009). A manager of an NGO reported in an online newspaper that her organization was stuck in a cycle of delayed payments to counsellors because of late transfer of funds from the Department of Health and Social Development. The consequences are

that her organization ends up having to back-date the payments owed to counsellors by a couple of months. This is however not a new phenomenon, as far back as 2007 counsellors threatened to strike because of non-payment of stipends (Lubisi, 2007). While data was being collected for the current study counsellors at four clinics were on strike for non-payment of stipends. As a result HCT was not available at the time, however the situation seem to have been resolved as HCT is currently available at those clinics.

3.2.3 Recognition

The different titles used to describe the work of community lay workers correspond to the specific service they offer such as VCT/HCT counsellors, Lay counsellors, DOTS supporters, ART adherence counsellors, Community Health Workers, HIV/TB worker, Community Caregiver, HIV and AIDS Counsellors (Lehmann & Sanders, 2007). A lay worker may be entrusted with more than one of these roles. This could add to the challenges they face because there is no clear description of job roles, work responsibilities and boundaries.

A study by van Dyk (2007) identified role ambiguity and role discomfort as one of the concerns of HCT counsellors. In another study, counsellors expressed frustrations as a result of nurses who view the work of counsellors as unimportant and the clinic staff and supervisors distancing themselves from any work which involves HIV and AIDS (Mavhandu-Mudzusi et al., 2007). This has the potential to lead to problems of recognition by professionally trained nurses or health workers. In their study, Schneider et al. (2008) found that nurses tended to demarcate their territory in the allocation of roles. They also objected to suggestions that community health workers should wear uniforms. This is an indication of the difficult relationship between professionally trained health care workers and ‘untrained’ community health workers.

Community health workers also undervalued themselves by referring to themselves as volunteers – members of a group of exploited, undervalued labour without employment rights and benefits (Schneider et al., 2008). HCT Counsellors have expressed concerns that they are not given due recognition and appreciation by the health system in general (Schneider et al., 2008; van Dyk, 2007). In a study conducted by Rohleder and Swartz (2005), HCT counsellors expressed concerns and dissatisfaction for not being recognised by both the government and the clinic staff. The counsellors felt that the clinic managers were more interested in the number of people tested than the needs of the counsellor or their clients. Other counsellors felt that the term lay counsellor is perceived as uneducated; therefore, they did not feel respected by their co-workers.

3.2.4 Training

The current requirements to be appointed as an HIV and AIDS lay counsellor do not include any academic qualification in counselling (Kabamba, 2009). In South Africa HCT counsellors generally undergo one week of basic HIV and AIDS training as well as a week of AIDS counselling training. A lack of appropriate skills and information has been identified by community health workers, including HCT counsellors, in a number of studies (Lehmann, 2010; Nulty & Edwards, 2005; Schneider et al., 2008). HIV and AIDS counsellors are not trained to deal specifically with emotional issues. Nonetheless, the nature of their work puts them in a position of providing a service that they are not effectively trained for.

According to Nulty and Edwards (2005) counsellors need on-going training which will equip them with skills to address a variety of challenging issues such as counselling older people, dealing with sexual matters, training in couple and family counselling, fears surrounding death

and dying and skills to address traditional beliefs such as bewitchment vis-à-vis scientific knowledge regarding modes of transmission.

HCT plays a crucial role in the prevention of mother-to-child transmission and treatment of HIV infected individuals. A study by Chopra, Doherty, Jackson and Ashworth (2005) found that the poor quality of counselling affected patients' adherence to infant formula feeding and drug therapy and could seriously compromise the effectiveness of many PMTCT programmes. Birdsall et al. (2004) analysed calls to the National AIDS Helpline. They found that callers who had previously been exposed to the HCT process at a clinic where they were tested, still had limited knowledge of HIV and they also needed clarity about what the results meant and what HIV is. Some callers were dissatisfied with the testing experience and others reported that they received no counselling (Birdsall et al., 2004). Although the Birdsall et al. (2004) study is old, the results are supported by newer research. In a study by Mavhandu-Mudzusi et al. (2007) counsellors expressed feelings of embarrassment about the inconsistencies in information that different counsellors provided for their clients. Some of the inconsistencies were due to out-dated training material. In another study, volunteers cited their own need for educational support systems which will help them to be productive as well as feel comfortable in their environment (Held & Brann, 2007).

In the study by Mavhandu-Mudzusi et al. (2007) it was found that lay counsellors were concerned that they were denied opportunities for training. Counsellors' perceptions were that training was attended by nurses or clinic employees who were not directly involved in HCT. To use counsellors who are not properly trained raises serious concerns about the well-being of the counsellors and the quality of services rendered to all clients. Inadequate training has the potential to compromise services rendered to HIV infected individuals.

3.2.5 Supervision and support

The lack of supervision for the HCT counsellor and the counselling process itself could compromise the service for the people testing for HIV. The success of the HCT project depends on the extent to which the counsellors are guided, managed and supported (Richards & Pennymon, 2004). Lack of support for staff was identified as a significant stressor in HIV and AIDS work (Richards & Pennymon, 2004; Richards & Marquez, 2005). The authors reported that the counsellors who did not have supervision and support found it difficult to carry out HIV and AIDS counselling effectively.

Grinstead and Van der Straten (2000) found that HCT counsellors experience high levels of stress and need support and mentoring to improve their motivation and sustain high quality of service. Counsellors involved in a study by Hunter and Schofield (2006) identified supervision as an important coping strategy which helps counsellors to manage caseloads effectively and affords them the opportunity to be debriefed regarding incidents from client's stories. Daniels, Nor, Jackson, Ekström and Doherty (2010) argue that within the community health worker policy in South Africa, supervision is discussed only in relation to quality assurance. It should be stressed that supervision goes beyond the technical aspects of any job. Daniels et al. (2010) summarize the components of supervision support which they believe HCT counsellors should receive as standard practice:

- Emotional support – the expression of empathy
- Esteem support – positive regard, and encouragement
- Instrumental support – assistance of a specific nature
- Informational support – giving advice, suggestions and feedback

- Network support – providing a feeling of membership.

An important finding of Daniels et al. (2010) is that supervisors working in human service professions needed to be supported. They were strengthened by a person in seniority whom they could turn to for supervision and support.

3.2.6 Physical space to conduct counselling

As has been mentioned, counselling is a private therapeutic dialogue between a client and a counsellor. With HIV and AIDS testing and counselling confidentiality and the protection thereof is very important. Several studies have however identified lack of appropriate space to conduct counselling as a concern for counsellors. In the Mavhandu-Mudzusi et al. (2007) study, counsellors reported that the counselling room is often used as either a store-room or an office with frequent disturbances taking place.

Rohleder and Swartz (2005) identified the clinic staff's lack of understanding of the importance of privacy and the use of shared space to conduct counselling, as a threat to the quality of counselling. In a study by Medley and Kennedy (2010) counsellors pointed out that counselling sessions are frequently interrupted by other health workers retrieving files. In some instances they had to give HIV results in a low voice because some rooms had half walls. In a study by Nulty and Edwards (2005) counsellors reported that there were frequent interruptions by staff reporting telephone messages or calling counsellors for duties elsewhere. This is a clear and outright indication of a lack of understanding and respect for the counselling process. All the interruptions such as a ringing phone while counselling is taking place, affect the process and the value of counselling since the serenity and the atmosphere of the process are disturbed.

The following sections describe the psychological stressors which have an impact on the well-being of HCT counsellors. The stressors are an indication of the emotionally challenging nature of HIV and AIDS counselling.

3.3 Psychological Stressors

3.3.1 The Emotional nature of HCT counselling

The emotional and psychological well-being of someone infected or affected with HIV affects his or her ability to cope with the disease. HIV presents with a multitude of sources of anxiety, depression, and stigma, fear of disclosing and fear of death (Dageid, Sedumedi, & Duckert, 2007; Molefe, 2005). The effect of exposure to illness and death is a significant source of emotional stress among HIV and AIDS caregivers and volunteers (Held & Brann, 2007; Mavhandu-Mudzusi et al., 2007; O'Neill & McKinney, 2003; van Dyk, 2007).

To elaborate on the emotional stressors, Held and Brann (2007) describes three major sources of stress for HIV and AIDS counsellors. The first source is when volunteers become emotionally involved and start to identify and internalize some of the hardships that clients are going through. The second source is the lack of an outlet to communicate and express fear, anxiety and concerns. The third source of stress is uncertainty and being under-prepared for situations that may arise in the counselling relationship. In addition to the stressors, counsellors are faced with personal fears, whether real or perceived, surrounding the personal threat of HIV and AIDS in their own lives.

3.3.2 Personal fears and vulnerability to contracting HIV and AIDS

In her study, Molefe (2005) found that some HIV and AIDS counsellors were themselves vulnerable to contracting HIV because of their own unsafe sexual and behavioural practices, despite the knowledge they have about HIV and AIDS. On the other hand, they might not test because of fear that a positive result will cause their spouse to reject them or become physically and emotionally abusive towards them. Some of the counsellors are afraid to initiate safer sex practices in their relationships although there have been times when they have questioned their partner's faithfulness and this could be because of fear that the partner might blame them for being unfaithful (Molefe, 2005). These results show that HCT counsellors experience the same fears and vulnerability than the clients they counsel.

After a well-known radio personality disclosed his HIV-positive status on live radio, articles appeared in various printed media the next morning with headlines such as 'Mr Safe Sex is HIV-positive'. The reports sent shockwaves through the country with some people voicing their disappointment and dismay that the person who was encouraging people to practice safe-sex was himself not practicing safe sex (Bafo, 2008). HCT counsellors mentioned that a lack of support and acceptance of people living with HIV and AIDS contributed to their reluctance to learn their own status (Koopman, Gore-Felton, Marouf, Butler, Field, Gill, Chen, Israelski, & Spiegel, 2000; Molefe, 2005).

3.3.3 Fear and vulnerability to occupational exposure

Given the nature of their work, which involves coming into contact with blood and blood products, health care workers are prone to HIV infections. In a study by van Dyk (2007) caregivers indicated that in some instances a lack of resources made it difficult to comply with universal precautions which create a risk of accidentally contracting HIV. In the health care

profession there are substantial fears of occupational exposure of HIV (Obi, Waboso & Ozumba, 2005; Rele, Mathur & Turbadkar, 2002). An alarming finding was that in some instances there were no procedures in place to address needle prick injuries. According to the World Health Organisation (2008) recommendations on task shifting, community health workers and lay counsellors are not supposed to handle blood products themselves, but have close contact with the patients.

3.3.4 Counsellors' personal experiences of HIV and AIDS

In addition to having to counsel and support clients faced with emotional challenges, the counsellors themselves have their own feelings to reckon with. Challenges are worse if the person offering the service feels hopeless and helpless because of his or her own personal experiences of HIV and AIDS. As mentioned in the introduction, at the inception of the lay counsellor programme, people living with AIDS were recruited to give a personal face to the AIDS epidemic, although not all community health workers are HIV-positive (Schneider et al., 2008). Nonetheless, some counsellors are people living with HIV who may be experiencing personal challenges of living with the disease while having to confront the same challenges experienced by their clients in their scope of work.

3.3.5 Fear of stigma and discrimination

A study examining the attitudes and fears of HCT counsellors towards HIV testing found that HCT counsellors are not different from the clients they serve. They have similar fears and concerns as their client population (Molefe, 2005). Fears of discrimination, rejection, and breach of confidentiality were identified as some of the reasons why counsellors were afraid to undergo HIV testing. Counsellors did not want to test because they perceived that there was a lack of

confidentiality and trust in their workplaces and this would result in them being discriminated against by their colleagues (Molefe, 2005).

Their work with HIV-positive patients can be another source of stigma. As a result of the stigma surrounding HIV and AIDS, some informal caregivers in the United States concealed their care giving activities by withdrawing from social relationships. Those who acknowledge their care giving roles experienced difficulty to obtain support from family and social networks (O'Neill & McKinney, 2003). Caregivers feared that people in the communities would stigmatize them for working with people who are HIV-positive. Van Dyk (2007) reported that three female nurses were pressured to resign from their jobs and were even refused sexual relations by their partners for fear that they will infect them.

3.4 Burnout amongst HIV and AIDS caregivers and lay counsellors

In the previous section the challenges of HCT counsellors were discussed. These challenges have various effects on the emotional well-being of counsellors. Some counsellors may experience these challenges as contributing to burnout, while others experience positive rewards from doing the kind of work they do.

Burnout has been identified as one of the work-related stressors that has serious consequences for the care giver, the recipient and the health care system (O'Neill & McKinney, 2003). Burnout typically develops in stages. The warning signs may include feeling less motivated and voicing complaints about the care-giving role. In the later stages, physical, psychological and behavioural problems may arise. O'Neill & McKinney (2003) believe that because burnout occurs gradually, caregivers tend to keep working until the downward spiral goes too far and until it affects both their performance and well-being. A study that compared burnout in nurses who provided care for patients with HIV and AIDS and others who care for

patients with cancer, found that burnout amongst HIV and AIDS nurses occurred more frequently (Dorz, Novara, Sica & Sanavio, 2003). Counsellors are at risk of burnout because their work not only involves building therapeutic relationships, but they have to deal with clients who have complex emotional needs.

People experiencing burnout often do not have healthy coping mechanisms. They consequently often do not see solutions to their clients' problems either (Maslach & Jackson, 1981). Caregivers suffering from emotional exhaustion often become insensitive to their clients' feelings and needs, thereby providing lower quality of care (O'Neill & McKinney, 2003). According to Demmer (2004) signs of burnout include tardiness, decrease in general efficiency, increased absenteeism and low job satisfaction. In addition, emotional symptoms include increased impatience and irritation, increased difficulty in empathizing with patients' emotional and spiritual depletion. O'Mara (2006) adds the concept of compassion fatigue to the definition of burnout. She views effective counselling as the ability to join others in their painful journey and to give them strength in their process of recovery. The journey with clients sets the stage for compassion fatigue. O'Mara (2006) explains that compassion fatigue "drives the engine" that leads to burnout. Over-involvement with clients was identified as a leading cause of burnout in health care workers. Caregivers in van Dyk's (2007) study reported that they had to fulfil tasks such as organizing funerals, going to the homes of patients to help out and giving away their own food, money and clothes to needy patients. Clearly, some of these tasks involve going beyond the call of duty and these are significant factors contributing to burnout.

Demmer (2004) believes that health workers who are more likely to experience burnout are those who are depressed and anxious. He adds that those with high external locus of control tend to report higher burnout than those with high internal locus of control. Those who use

external coping strategies do not believe that they have control over work-related stressors. They consequently avoid, deny or passively accept the given situation.

The expansion of HIV and AIDS services resulted in more patients requiring access to the services, which led to clinic and hospital staff experiencing heavier workloads. This contributed to health care workers perceiving their workload as unbearable. At the same time, the lack of staff meant that when a colleague is absent, more work falls on the remaining health care workers. This triggers an avalanche effect.

According to Demmer (2004) the introduction of antiretroviral therapy ushered in an era of hope, but the stressors of HIV and AIDS care did not disappear. Issues such as unresolved grief, work demands, lack of supervision and support remain the primary stressors. However, since the introduction of drug therapies, stressors also include difficulties associated with adherence and the resurgence of high risk behaviours stemming from the perception that HIV and AIDS is less of a threat.

3.5 Emotional challenges of HCT counselling

The HIV and AIDS field is emotionally challenging and exhausting because it deals with death and dying which often result in emotional exhaustion (Dageid et al., 2007; Mavhandu-Mudzusi et al., 2007; O'Mara, 2006; van Dyk, 2008). Mavhandu-Mudzusi et al. (2007) states that in many instances HCT involves breaking of bad news because it includes informing clients about their positive results. Circumstances such as giving HIV-positive results after rape, informing young clients about their HIV-positive status and counselling couples who have discordant results, contributed to the work being emotionally draining.

The emotional nature of HCT and the structural problems experienced in this role often result in negative experiences for counsellors. In a study by Dageid et al. (2007) nurses admitted

to acting rude and shouting at patients and they blamed their attitude towards the patients on the unbearable work load they experience. Health workers expressed feelings of emotional drainage, being exhausted, strained and overwhelmed. Furthermore they described work situations where they felt emotionally exhausted with limited possibilities of personal accomplishment. They described their frustrations to be the result of lack of resources, increasing health provision demands, lack of training and support, limited government involvement, and a constant emotional overload. In addition, they felt emotionally exhausted because of demanding interactions with clients (Dageid et al., 2007).

3.6 Positive rewards of volunteer caregiving

Although much of the previous research focuses on the stressors and negative experiences of HCT counsellors, taking care of or counselling patients living with HIV and AIDS is not only a negative experience. Various studies have also reported the positive experiences of counsellors which include positive feelings such as empathy, hopefulness, compassion, and the desire to help their clients (Dageid et al., 2007; Mavhandu-Mudzusi et al., 2007; Molefe, 2005; van Dyk, 2007). In the study of Richard and Marquez (2005) the counsellors revealed feeling helpful and hopeful because they were providing clients with a sense of hope. The perceived rewards of HIV and AIDS care giving can serve as a buffer against emotional stressors including burnout.

In a study of the rewards of caregivers for people living with HIV and AIDS, caregivers identified self-growth, inner strength and psychological development as rewards they achieved in engaging with terminally ill people (Akintola, 2010). The virtues that they learned in the process of care giving were compassion and patience. In addition, they learned to change their own behaviour. These are the intrinsic rewards of caregiving. Caregivers also indicated that the

reward and satisfaction derived by patients as a result of their services, made them feel they are making a difference (Akintola, 2010). The rewards identified in the study are in line with concepts such as social integration and social contribution as appraisals of levels of connection with the community and the feeling that one has something of value to add to society. Extrinsic rewards that were identified in the study were appreciation and reward shown by family members and the community.

In a study by Crook, Weir, Willms and Egdorf (2006) self-esteem, autonomy, enriched interpersonal relationships and interactions with others were the intrinsic rewards identified by the caregivers; while extrinsic rewards were constructive feedback, appreciation and recognition.

3.7 Conclusion

As discussed in this chapter, HIV and AIDS is a disease that generates many negative emotions and challenges. HCT counsellors continuously experience work stressors which can have an effect on their emotional well-being. Lay counsellors are expected to educate clients about HIV and AIDS, encourage them to test and change their behavioural practices. They also have to assist their clients to cope with a positive diagnosis. In most cases counsellors lack appropriate training, supervision, remuneration and recognition which leads to frustration and feelings of inadequacy. As a result of the nature of their work, counsellors are continuously faced with negative emotions and fears associated with the stigma of HIV and AIDS. The negative emotions may stem from their own fears of contracting the disease and of perceptions and expectations of the community they serve. In the process of providing care and support to clients, counsellors take on an additional burden of extending themselves to their clients which can result in feelings of emotional exhaustion. HIV and AIDS work is associated with issues of death and dying and in many instances counsellors are neither prepared nor supported through

the trauma of losing their clients. There are however positive experiences associated with the work of counsellors. Counsellors have a desire to help their clients. They perceive the work they do as contributing to the common good of helping to manage the impact of HIV and AIDS. It is the desire as well as the willingness to help their clients which serves as a buffer and helps them to cope with the negativity associated with their work.

The goal of this study is therefore to investigate the psychological well-being of HCT counsellors working in the City of Tshwane health clinics. The negative and positive well-being of counsellors will be assessed. Various studies focused on the negative aspects of HIV and AIDS counselling and the stressors and challenges associated with it. Very little research has focused on the positive aspects of counselling or the strengths which counsellors bring into the counselling process. The current study provides an opportunity to understand the challenges and stressors of counsellors as well as their strengths and positive skills and how different aspects of well-being relate to each other. The following chapter will discuss the methods used to collect data.

Chapter 4: Research Methodology

This chapter outlines the purpose of the study, the research design, the research method and the instruments used in data collection.

4.1 Purpose of the study

The purpose of the study is to investigate the psychological well-being of HCT counsellors in the light of the challenges they face in their work situation. Specifically, the research investigates the levels of depression and burnout in counsellors representing negative well-being as well as emotional intelligence and coping which are elements of positive well-being. The study also explores the strengths, competencies and motivation of counsellors. Furthermore the research investigates whether aspects of negative well-being occurs in conjunction with positive emotional competencies, strengths and skills as suggested by Keyes (2005).

It was hypothesized that:

- HCT counsellors have high levels of burnout and depression.
- HCT counsellors have above average levels of emotional intelligence and positive coping skills.
- Aspects of negative well-being such as depressive symptoms and burnout co-exist with aspects of positive well-being such as emotional intelligence and positive coping.

4.2 Design and approach of the study

To enable the researcher to explore and assess the psychological well-being of counsellors, a mixed methods design was used. This design uses a combination of qualitative and quantitative methods in a single mixed design. The collecting and analysing of data incorporate techniques from both methods. The use of qualitative and quantitative approaches in

combination provides a better understanding of research problems (Cresswell & Plano Clark, 2007). Research problems suited for mixed methods are those in which one data source may be insufficient; where results need to be explained and a second method is needed to enhance the primary method (Cresswell & Plano Clark, 2007; 2011).

Advantages of combining types of research are that it enhances research development and increases validity. In this research specifically, the combination of research strategies will provide comprehensive information on the experiences and challenges of HCT counsellors. Data from each research method will be used to explain and interpret data collected through the other method.

4.2.1 Quantitative research methods

In quantitative research there is an established set of procedures and steps that guides the research (White & McBurney, 2011). Within this method of inquiry, the researcher tests a theory by specifying the hypothesis and collecting data to support or refute the hypothesis (Cresswell & Plano-Clark, 2011). The aim of this research method is to understand the relationship among variables or to determine if one group performs better than the other group (Cresswell & Plano-Clark, 2011). The quantitative method is easily divided into discrete stages of instrument development, data collection, data processing and data analysis. This means that responses to carefully formulated and presented closed ended questions are collected, collated, analysed and presented in terms of numerical scores. The validity and reliability of research instruments are assessed mathematically by comparing results. Validity is an indication that scores are meaningful indicators of what is being measured. Reliability indicates that scores are consistent and stable over time. The scores obtained from the analysed data are presented in terms of statistical significance (Cresswell, 2009). Results are usually presented in a visual form

such as charts. The interpretation of quantitative data involves analysing research results to determine whether hypotheses can be accepted or rejected (Cresswell 2007, 2009). In this study quantitative data was collected using various psychological instruments.

4.2.2 Qualitative research methods

Qualitative research as described by Creswell (2009) is a process of enquiry into the meaning individuals or groups ascribe to a social or human problem. The aim of this method of enquiry is to explore a problem, honour the voices of participants and convey perspectives of the participants (Cresswell & Plano-Clark, 2011). In this method of enquiry open ended questions, interview data, observations and transcripts are used. Data is collected in settings where participants experience the problem that is studied (Cresswell, 2009). Analysis of qualitative data involves multiple levels; coding data, dividing text into small units, assigning labels to each unit and then grouping the codes into themes. Creswell (2009) asserts that analysis of qualitative data is a process of continuous reflection on the information and the overall meaning. The presentation of results may involve a discussion of the evidence for the themes that have emerged from the analysis. In qualitative research, validity means to determine whether the researcher's account of the participants' description of a situation is accurate and credible. There are various strategies to enhance the validity of data interpretation. One method is member checking. The researcher presents the summaries of the findings to participants for them to reflect on the accuracy of the presentation of their experiences. Another form of validation is triangulation where data is drawn from several sources and compared (Cresswell, 2009). In this study, focus group discussions were used to collect qualitative data.

4.3 Data collection instruments to assess the well-being of HCT counsellors

Self-report is often used to assess well-being, since the respondents have to report on their subjective experiences. Various scales measuring aspects of well-being have been used to study outcomes in response to life challenges and circumstances (Diener, 2002; Duckworth et al., 2006; Keyes, 2002; Keyes et al., 2002; Seligman & Csikszentmihalyi, 2000; Seligman et al., 2004; Snyder & Lopez, 2007). The rationale behind using self-reports is that it is only the respondent that can experience his or her pleasures and can determine whether his or her life is worthwhile based on those experiences (Diener et al., 2005).

Several authors recommend a multi-method battery to assess subjective well-being (Diener, 2006; Duckworth et al., 2005; Keyes, 2002). Firstly, the multi-method approach for assessing well-being can supplement the information gained from one measurement. Secondly, this approach yields a more comprehensive understanding of psychological processes including possible underlying disorders (Duckworth et al., 2005).

In order to assess the psychological well-being of HCT counsellors and to give a comprehensive picture of well-being, positive and negative variables were assessed. Positive well-being was assessed in terms of emotional intelligence and coping skills, while depression and burnout was used to assess negative well-being. The scales were administered under the supervision of a qualified psychometrist. An overview of the research instrument will be given below.

4.3.1 Demographic questionnaire

A demographic questionnaire was used to collect information about the participants' age, marital status, and educational level. The questionnaire also posed questions regarding the average number of clients each counsellor counsels per day; the type of training they have

received; as well as the number of hours they work per day. These variables were chosen in order to identify and understand their relationship with the well-being of counsellors.

4.3.2 Psychometric scales

4.3.2.1 The Bar-On Emotional Quotient Inventory (EQ-i)¹

The EQ-i was chosen for this study as it examines different aspects of psychological well-being. Thus, it can give a comprehensive indication of the functioning of an individual. Furthermore, the inventory was originally compiled in order to empirically explore the theory of psychological well-being. It is based on the bio-psycho-social model. It thus incorporates all dimensions of an individual's psychological well-being. Bar-On (2002) used an eclectically, theoretical and multi-factorial method of exploration in order to operationalise and define the complex factors of psychological well-being.

The Bar-On EQ-i currently seems to be one of the most reliable indicators of psychological well-being. The EQ-i has been standardised in six countries. The EQ-i has been translated into over 30 languages and has been completed by over 3000 subjects in seven different countries, including South Africa. The EQ-i may be administered to anyone who is willing to complete the inventory honestly, who meets the age requirement of 16 years and older, and has a grade 4 reading ability (Bar-On, 2005; 2007).

The Bar-On questionnaire contains 133 statements, which make up 5 composite scales and 15 subscales outlined in table 4.1 (Bar-On, 2002). The EQ-i has statements such as "I prefer a job in which I'm told pretty much what to do" or "I try to continue and develop those things that I enjoy". In each of the statements, the respondent indicates the degree to which each item

1. As a result of copyright and licencing requirements a copy of the Bar-On EQ-i cannot be included in the annexure.

describes him or her. The responses are given on a 5 point Lickert scale where, 1 = very seldom true of me, 2 = seldom true of me, 3 = sometimes true of me, 4 = often true of me and 5 = very often true of me (Carr, 2004). The Bar-On revealed a reliability coefficient of 0.85. A test-retest reliability of 0.75 was obtained after four months using a sample of South African University students (Bar-On, 2002). In the current study, a Cronbach alpha of 0.85 was obtained. This means that the scale will have an internal consistency and high reliability for the sample of HCT counsellors.

In order to administer the Bar-On EQ-i the researcher obtained permission to use it from Jopie van Rooyen & Partners, the test distributor in South Africa. The researcher also had to attend accreditation training. Data on the EQ-i population norm groups was obtained from Jopie van Rooyen & Partners and based on EQ-i research that has been conducted in South Africa.

Table 4.1 EQ-i scales and subscales

EQ-i subscales	Competencies and skills assessed by subscales
Intrapersonal	
Self-Regard	To accurately perceive, understand and accept oneself
Emotional Self-Awareness	To be aware of and understand one's emotions
Assertiveness	To effectively and constructively express one's feelings and oneself
Interpersonal Relationships	To establish mutually satisfying relationships and relate well with others
Independence	To be self-reliant and free of emotional dependency on others
Self-Actualization	To strive to achieve personal goals and actualize one's potential
Interpersonal	
Empathy	To be aware of and understand how others feel
Social Responsibility	To identify with one's social group and cooperate with others
Interpersonal Relationships	To establish mutually satisfying relationships and relate well with others
Stress Management	
Stress Tolerance	To effectively and constructively manage emotions
Impulse Control	To effectively and constructively control emotions
Adaptability	
Reality Testing	To objectively validate one's feelings and thinking in view of external reality
Flexibility	To adapt and adjust one's feelings and thinking to new situations
Problem Solving	To effectively solve problems of a personal and interpersonal nature
General Mood	
Optimism	To be positive and look at the brighter side of life
Happiness	To feel content with oneself, others and life in general

Source: Reuven Bar-On (2005)

4.3.2.2 The Maslach Burnout Inventory for Human Services Survey (MBI-HSS)²

The **MBI-HSS** is a 21 item inventory that consists of three sub-scales that assess the three components of burnout. The items are written in a form of statements about personal feelings and attitudes such as “I feel emotionally drained from my work” which is a component of Emotional Exhaustion, “I feel I treat some of my recipients as though they were impersonal objects” – a component of Depersonalization and “I have accomplished many worthwhile things in my job” – a component of Personal Accomplishment. A description of each component is given in Table 4.2.

Table 4.2 Components of the MBI-HSS

MBI-HSS Subscales	Aspects of burnout assessed by the subscales
Emotional Exhaustion	Feelings of being emotionally overextended and exhausted by one’s work
Depersonalization	An unfeeling and impersonal response towards recipients of one’s care
Personal Accomplishment	Feelings of competence and successful achievement in one’s work

Source: Maslach, Jackson & Leiter (1996)

The responses are given on a 6 point scale where, 0 = never, 1= a few times a year or less, 2 = once a month or less, 3 = a few times a month, 4 = once a week, 5 = a few times a week and 6 = every day. According to Maslach, Jackson and Leiter (1996), burnout is a continuous variable ranging from low, to moderate to high degrees of experienced feeling, rather than a variable which is either present or absent.

2. As a result of copyright and licencing requirements a copy of the MBI - HSS cannot be included in the annexure.

A high degree of burnout is reflected in high scores on the Emotional Exhaustion and Depersonalization subscale and low scores on the Personal Accomplishment subscale.

- An average degree of burnout is reflected in average scores on the three subscales.
- A low degree of burnout is reflected in low scores on the Emotional Exhaustion and Depersonalization subscales and high scores on the Personal Accomplishment subscale.

The cut-off points for a definition of burnout based on subscale scores are ≥ 21 on Emotional Exhaustion subscale, ≥ 8 on the Depersonalization subscale and ≤ 28 on the Personal Accomplishment subscale.

The Cronbach alpha coefficients for the three sub-scales of the MBI-HSS were found to be 0.90 for emotional exhaustion and 0.79 for depersonalization and 0.71 for personal accomplishment for a sample of mental health workers (Maslach et al., 1996). These demonstrate a high level of reliability. Aguayo et al. (2011) conducted a meta-analysis of 51 MBI-HSS studies which were conducted in North America and Europe to determine the reliability of the MBI-HSS. The analysis yielded an alpha co-efficient of 0.88 for Emotional Exhaustion, 0.71 for Depersonalization and 0.78 for Personal Accomplishment. The authors indicate that the values were lower than those reported by Maslach and Jackson (1981), but were still highly acceptable. Aguayo et al. (2011) concluded that the variability in the values could be the results of specific characteristics of the sample, including the age, gender, and country where the study was undertaken. A study by Naudé and Rothmann (2004) on the validation of the Maslach Burnout Inventory for emergency medical technicians in South Africa found the alpha coefficient for Emotional Exhaustion to be 0.77, 0.68 for Depersonalization and 0.78 for Personal Accomplishment. Although the reliability coefficients are much lower than originally

found, it is still acceptable. In this study the MBI-HSS was used to measure the level of burnout in HCT counsellors.

4.3.2.3 The Centre for Epidemiologic Studies Depression (CES-D) Scale³

The CES-D is a 20-item scale designed to measure depressive experiences in the general population. The scale consists of 16 negatively worded items such as "I felt sad", "I thought my life had been a failure" and 4 positively worded items such as "I felt happy" and "I felt hopeful about the future". The scale assesses how often the participant experiences symptoms associated with depression during the past week. The subscales of the CES-D are outlined in Table 4.3.

Table 4.3 CES-D subscales

CES-D Subscales	Aspects of depression assessed by subscales
Positive Affect	Feelings indicating a general positive outlook about life
Negative Affect	Feelings of sadness
Somatic	Feelings which relate or affect one's body
Interpersonal	Perceived feelings of relationships with others

Source: Radloff (1977)

The response categories range from 0 = less than 1 day, 1 = 1 – 2 days, 2 = 3 – 4 days and 3 = 5 – 7 days in the past week (Radloff, 1977). Positive items are reverse coded so that scores have a potential range from 0 to 60 with a score of 16 used as an arbitrary cut-off point (Radloff, 1977). Interpretations of CES -D scores are presented on Table 4.4.

3. As a result of copyright and licencing requirements a copy of the CES-D scale cannot be included in the annexure.

Table 4.4 Interpretation of CES-D scores

Scores	Meaning
0 – 15	Suggests that the individual is not depressed
16 – 26	Suggests mild depression
27 or more	Suggests major depression

Source: Ensel (1986)

The CES-D has been found to have a Cronbach alpha coefficient of 0.90 (Simoni & Ng, 2000) and 0.88 in a South African study (Makin, Forsyth, Visser, Sikkema, Neufeld & Jeffery, 2008). In this study the CES-D scale was used to measure depression levels of HCT counsellors.

4.3.2.4 The Brief COPE Scale⁴

The Brief COPE is an abbreviated version of the COPE inventory that was developed by the Department of Psychology of the University of Miami to assess a range of strategies for coping with stress. The Brief COPE consists of 14 scales of two items each (Carver, 1997). The scale consists of statements such as “I have been trying to find comfort in my religion or spiritual beliefs” and “I have been turning to work or other activities to take my mind off things”. Possible responses are: "not used the skills at all", "used it a little", "used it somewhat" and "used it a lot" (Carver, 1997). The subscales of the Brief COPE are outlined in table 4.5.

Table 4.5 Subscales of Brief COPE

Brief COPE subscales	Coping skills assessed by subscales
Active coping	Taking action to remove the stressor
Planning	Thinking about how to confront the stressor
Use of instrumental support	Seeking assistance or advice
Use of emotional support	Getting sympathy from someone
Positive reframing	Making the best of the situation

4. As a result of copyright and licencing requirements a copy of the Brief COPE scale cannot be included in the annexure.

Religion	Increased engagement in religious activities
Acceptance	Accepting the fact that the stressful event has occurred
Humour	Making jokes about the stressor
Venting	A tendency to ventilate or discharge the feeling
Behavioural disengagement	Withdrawal from effort to attain the goal
Mental disengagement	Psychological disengagement from the goal which the stressor is interfering with
Self-blame	Criticizing oneself for the stressor
Substance abuse	Using alcohol and other drugs as a way of disengaging from the stressor
Denial	An attempt to reject the reality of the stressful event

Source: Carver (1997)

The reliability of the Brief COPE using Cronbach's alpha coefficient was 0.83 (Hastings & Brown, 2002). In a study on social support and coping style of HIV-positive men and women in California, USA, Turner-Cobb, Gore-Felton, Marouf, Koopman, Kim, Israelski, & Spiegel (2002) demonstrated a Cronbach alpha coefficient of 0.79 on the COPE. In a South African study of HIV+ women the reliability coefficient of the Brief COPE was found to be 0.63 for the scale as a whole. In a factor analysis using data of 293 HIV-positive women, two sub-scales were identified: positive coping (13 items $\alpha=0.75$) and negative coping (8 items $\alpha=0.54$) (Makin et al., 2008). In this study the Brief Cope was used to measure coping skills of HCT counsellors.

4.3.3 Focus group discussions

In this research focus group discussions were used to provide comprehensive information on the experiences and challenges of HCT counsellors. The discussions were semi-structured to encourage participation. The style of interview was flexible so that deeper issues could be explored. In each session, participants were encouraged to speak in vernacular languages to encourage clear and honest discussions. The content of the discussions centred on the role of the

HCT counsellors in the testing process, challenges they face in the work environment, and types of support they receive at the workplace. The following questions were discussed during focus group discussions:

- What motivates you or keeps you going given that HIV counselling is difficult and challenging?
- What would you say is the most rewarding experience in HIV and AIDS counselling?
- What has been the most challenging experience?

4.4 Research procedures

4.4.1 Permission to do research

The study was ethically approved by the Faculty of Humanities at the University of Pretoria's Ethics Committee. As a result of the reporting structure of HCT counsellors, permission to gain access to the clinics, to make contact with the HCT counsellors and to do the research, was obtained from various authorities.

The researcher requested approval from the Gauteng Department of Health to do the research. Thereafter, the researcher had to request permission from the City of Tshwane Health Services to have access to HCT counsellors. After the request was granted, the City of Tshwane's Information, Training and Research Unit sent a letter to clinic managers to inform them about the researcher's request and their approval.

On the strength of the approval letters the researcher obtained a list of clinics in the City of Tshwane where HCT counsellors were based. The researcher contacted 28 clinic managers to request meetings to inform them about the study and ask their co-operation. This process of approval was an indication of the complex relationship within the HCT programme, where

counsellors are based at local municipality clinics but are governed by provincial structures who do not employ them.

4.4.2 Meetings with clinic managers

The researcher met with 26 clinic managers. Two managers indicated that they are not available. Two clinic managers refused to grant the researcher permission to contact or hold discussions with counsellors stating that research would only disturb the flow of the clinic activities. Clinic managers were generally cordial, although some of them mentioned that they would have preferred it if research did not take place. One clinic manager mentioned that she is against the employment of untrained and uneducated people in her clinic. She further stated that she had no choice in the matter as she was not consulted when counsellors were brought to her clinic.

Twenty four managers agreed that the research could be conducted in their clinics. Each clinic had between two and three counsellors.

In cases where the clinic manager refused participation in the research, no further contact was made.

4.4.3 Meetings with counsellors

At the clinics, after meetings with managers, the researcher was briefly introduced to counsellors. The researcher gave a very brief background about the study and requested contact details of counsellors to make follow-up appointments to discuss the study. Five counsellors refused to be part of discussions stating that they were not interested. One of the counsellors indicated that she is tired of talking about problems of counsellors, because serious attention is never given to their problems. The other counsellors who refused did not give any reason for refusing. No further contact was made with counsellors who refused to participate in the study.

4.5 Sampling Procedure

Purposeful sampling was used as a procedure to recruit participants. Cresswell (2007) define purposeful sampling as a procedure to intentionally select participants who have experienced the central phenomenon being explored in the study. In this research HCT counsellors were recruited because it was their work experiences and psychological well-being that was the focus of the investigation.

It was decided to use all the HCT counsellors working in the City of Tshwane Health Clinic who agreed to participate in the study. After the meetings with clinic managers and counsellors, there were 50 HCT counsellors who were willing to participate in the research. They consisted of 44 females and six males. Their ages ranged from 20 to 74 years.

4.5.1 Process of data collection

Before data was collected, the study was discussed at length with the counsellors. The consent form was explained and discussed. Counsellors were given opportunities to ask questions about the study. They were assured that they could withdraw from the study at any point. Those who agreed to participate in the study completed and signed a consent form and appointments were made to administering questionnaires (a copy of the consent form is attached as Annexure A).

Participants were informed about the confidentiality of the data collection process. It was explained that they do not need to write their names on the questionnaires. In addition, they were assured that their questionnaires would be kept in a secure room and that their responses would not be shared with their clinic supervisors in a way that they can be identified.

Counsellors were not paid for participating in the study; however, they were reimbursed for their transport cost. The researcher ensured them that administering of questionnaires and focus group discussions took place in areas that were convenient to the counsellors.

In their approval for conducting the research, the Department of Health specified that the research study should not disturb the work of counsellors in clinics. In order for the researcher to adhere to the request of the City of Tshwane Health Services a schedule was developed. Table 4.6 shows an example of the schedule used to make appointments with counsellors to administer the questionnaires as well as co-ordinating focus group discussions. On the focus group column, the names of clinics were used instead of counsellors' names in order to maintain the confidentiality of the counsellors.

Table 4.6 A sample schedule for data collection

Clinic	Instruments	Date	Focus group	Date
Atteridgeville	Demographics CES-D Brief COPE	2.04.2010	Laudium Atteridgeville Folang	3.09.2010
	EQ-i MBI-HSS	16.04.2010	Saulsville Phomolong Gazankulu Danville	
Mamelodi West	Demographics CES-D Brief COPE	14.05.2010	Mamelodi West Stanza I Stanza II	24.09.2010
	EQ-i MBI-HSS	21.05.2010	Phamameng Silverton Pretoria Street	

As a result questionnaires were administered in two sessions. The demographics questionnaire, Brief COPE and CES-D were administered first in one session of 45 minutes. Follow-up appointments were scheduled for the following week to administer the EQ-i and the MBI-HSS, which took from an hour to an hour and fifteen minutes. When counsellors

completed the questionnaires they were together in small groups at their respective clinics. Questionnaires were completed during counsellor's lunch times and on Fridays, the day of the week when there were fewer clients at clinics. Counsellors who completed their questionnaires sooner, returned to their duties forthwith. This was one way to ensure that the study does not disturb the work of counsellors unduly. Questionnaires were administered in English. The researcher explained words and concepts that the counsellors did not understand in vernacular languages.

When all psychometric scales were completed, appointments for focus group discussions were made. During this process of interviews, clinic managers were familiar with the study and they did not raise concerns.

Two group discussions for counsellors based in Atteridgeville/Saulsville, Olievenhoutbosch and Laudium were held at Kalafong Hospital's Serithi/KgoloMmogo building. Two group discussion for clinics in the Mamelodi area were held at Stanza Bopape Clinic, and the final group discussions for clinics in the North of Pretoria were held at Soshanguve clinic. Five focus group discussions were thus held in a venue central to the clinics where the counsellors were based. Focus group discussions consisted of an average of eight counsellors in each session. To ensure variability in each group, there was a mix of counsellors from different clinics within each group. The researcher made field notes during all focus group discussions.

All discussions were recorded with the permission of the participants. The researcher could understand their vernacular and this enhanced validity of the data gathered. At the end of each focus group discussion a debriefing session was conducted. These debriefing sessions were enriched by coping exercises of relaxation using guided imagery.

4.6 Data analysis

All completed EQ-i answer sheets were sent to Jopie van Rooyen & Partners to be captured on the Multi Health Systems (MHS) platform, an excel data programme. Data sets were then drawn from the platform and forwarded to the University of Pretoria's Statomet division for analysis. Responses to other questionnaires were entered into the Excel spreadsheet for analysis.

Quantitative data was analyzed by using SPSS 20.0 for Windows. The reliability of each scale for the current sample was ascertained first. Descriptive analysis was done by calculating frequencies. Total scores for scales were calculated and the means of scale scores for the group as a whole. Scores of psychometric scales were compared with standardized norms to determine the level of well-being, burnout, and depression of the HCT counsellors, compared to a standardized norm group.

Counsellors were categorized into four age groups, namely 20 to 29 years, 30 to 39 years, 40 to 49 years and fifty and older. The non-parametric Kruskal-Wallis test and non-parametric Mann-Whitney U test were used to compare the scores of participants in different age and gender groups to investigate the significance of differences between groups.

Intercorrelations between and across all variables were calculated to determine relationships across all subscales of the psychometric scales. To understand the intercorrelations and to exclude interaction effects, the variables with significant correlations were entered into a multiple regression analysis, with the Depression score as the dependent variable.

Recordings from focus group discussions were transcribed and integrated with the field observations. The transcribed information was checked against recordings for accuracy. Data was analyzed using thematic analysis, which involved identifying, analyzing, and reporting patterns within data (Braun & Clarke, 2006). Themes were identified through the reported

experiences, meanings, and reality of HCT counsellors. Codes were then generated and collated into potential themes. Codes and themes were placed into different categories and levels to ensure that clear relationships are identified. Themes were then refined until they yielded a thematic map with main themes. This process was conducted for the three questions that were discussed in focus groups.

To enhance the validity of the interpretation of the data, two strategies were followed. After the focus groups discussions, the researcher summarized the responses of the HCT counsellors and confirmed with them that the researcher understood correctly what they said. This was done to ensure that their comments are not misinterpreted. In order to enhance the validity of the interpretation, a second interpreter was requested to check the researcher's interpretation.

The following chapter will present results of the psychological scales as well as focus group analysis that were used to assess the well-being of HCT counsellors.

Chapter 5: Research Results

In this chapter, the results of data analysis will be presented for both quantitative and qualitative data. Results of the analysis of the demographics will be presented first, followed by results of the psychometric scales. Results of the analysis of focus group discussions will then follow.

5.1 Demographic data

The participants in the study comprised of 50 counsellors; 44 females and six males ranging in age from 20 to 74 years. Most of the counsellors had completed grade 11 (42%) or grade 12 (44%). Only 2% (one person) had post-matric qualifications. Three counsellors had incomplete data on their demographic questionnaire.

5.1.1 Analysis of work and remuneration related variables

Work and remuneration related variables are presented in Tables 5.1 to 5.5.

Table 5.1 shows the variation in stipends received by counsellors. The stipend that counsellors received was dependent upon the mentoring or supervising NGO. There were instances where, in a given clinic, counsellors were receiving different amounts because they were being supervised by different NGOs. Fifty percent of counsellors in the study were receiving an amount of R1000.00 per month; while 42% were receiving an amount of R1500.00 per month. There was a counsellor in one clinic who was not receiving a stipend, although he has been a counsellor for a year. He has been promised that he would receive a stipend once he has been allocated to an NGO.

Table 5.1 Stipend amounts

Variable	Frequency	Percentage
Remuneration (Stipend) per month		
1000.00	25	50%
1500.00	21	42%
No stipend	1	2%
No data	3	6%
Total	50	100

Table 5.2 shows that the number of hours counsellors worked ranged from 20 to 40 hours per week (Table 5.2). The number of hours depended upon agreements with the clinic manager and mentoring NGOs.

Table 5.2 Hours worked

Number of hours worked per week	Frequency	Percentage
20	1	2%
30	14	28%
32	2	4%
35	3	6%
36	1	2%
40	26	52%
No data	3	6%
Total	50	100

The number of clients that counsellors counselled ranged from 10 to 30 clients per day (Table 5.3). The majority of counsellors (48%) counselled between 10 and 16 clients, while 20% counselled between 24 and 30 clients per day (this means 16 minutes maximum per client). During focus group discussions counsellors mentioned that general information of pre-and post-test counselling was often conducted in a group setting. Test results were however given in individual confidential sessions.

Table 5.3 Number of clients

Number of clients per day	Frequency	Percentage
10-16	24	48%
17-23	13	26%
24-30	10	20%
No data	3	6%
Total	50	100%

The training that counsellors received varied across clinics. Most of the counsellors received training on the basic information of HIV and AIDS as well as counselling training. Even though the majority of the clinics in the City of Tshwane were offering ARVs only 48% of counsellors had attended drug adherence training (Table 5.4).

Table 5.4 Type of training

Type of training	Frequency	Percentage
Basic HIV and AIDS	41	82%
HIV and AIDS counselling	44	88%
PMTCT	35	70%
Drug Adherence	24	48%

The following section presents results of the analysis of psychometric assessment used to assess the well-being of HCT counsellors. The EQ-i results will be presented first.

5.2 Psychometric data

5.2.1 The Bar-On Emotional Quotient Inventory

Scale scores for individuals were used to calculate the group average scores (Figure 5.1). The average group score on the EQ-i was 88.76. According to the EQ-i South African norms this score is rated as below average (van Rooyen & Partners, 2006). This suggests that there are areas of emotional functioning of the counsellors that require improvement. The highest score of the counsellors was on the Interpersonal scale (97.17) which was within the average range. They obtained low average scores on the Intrapersonal scale (90.68), the stress management (98.26),

and general mood scale (90.22). The Adaptability scale score was low (86.48). This is an indication of markedly under-developed emotional skills.

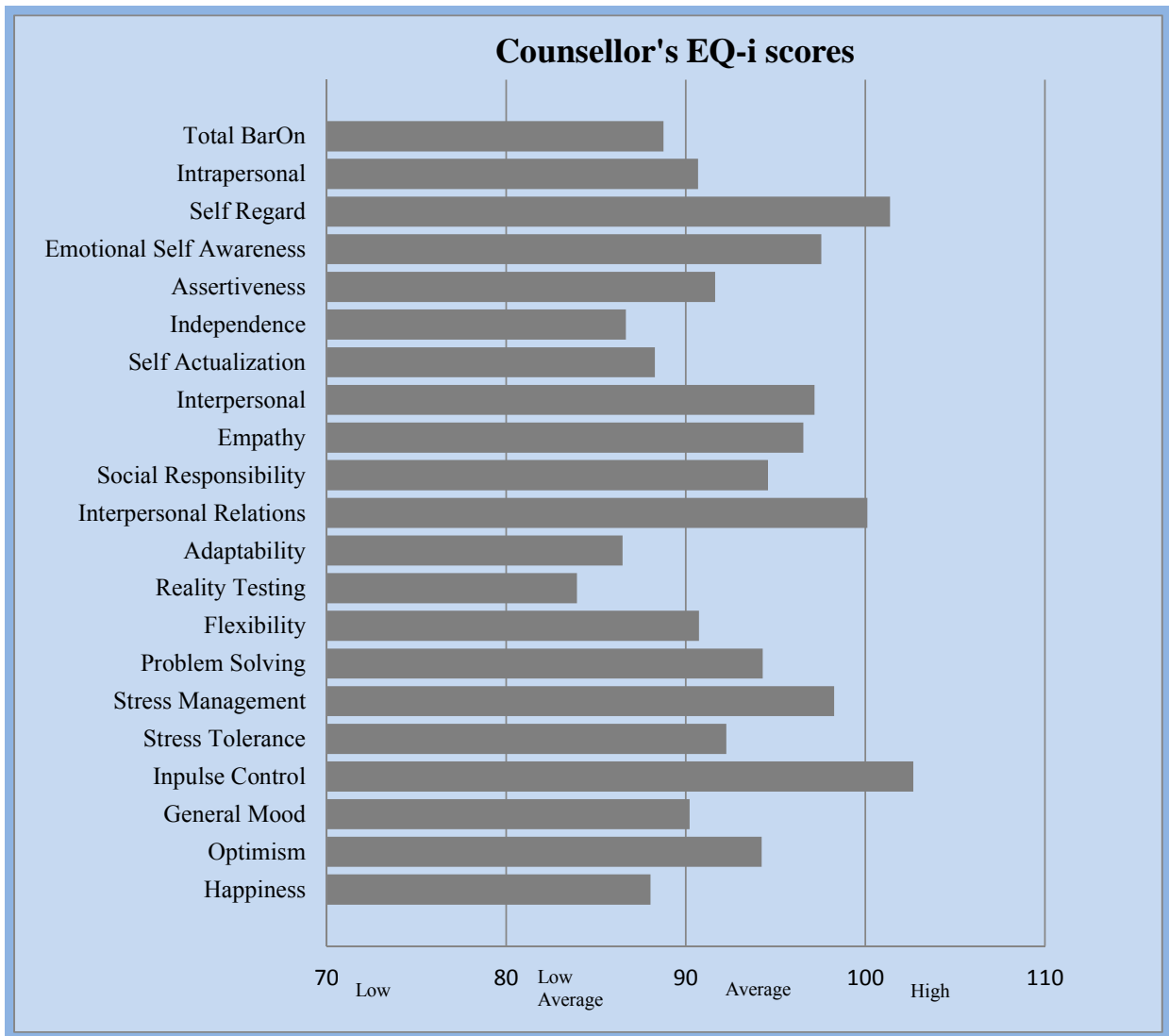


Figure 5.1 EQ-i Composite and subscale scores

Subscales with low scores were Independence, Self-Actualization, Reality Testing and Happiness. The Independence subscale score indicated that counsellors prefer working with others. The low Self-Actualization score was an indication that counsellors are not able

to reach their potential and are not involved in pursuits that lead to meaningful lives. The Reality Testing subscale score indicated that counsellors tended to be unfocused and may at times pursue unrealistic goals. The low Happiness subscale indicated that counsellors have a generally negative mood and have difficulty enjoying life.

The highest subscale scores were for Self-Regard, Interpersonal Relationships, and Impulse Control. The Self-Regard score was close to the population norm indicating that counsellors have an average sense of self-respect and self-confidence. The Interpersonal Relationships subscale score indicated that they have good social and interpersonal relationships skills. The Impulse Control subscale was slightly higher than the average for the norm group. Scores for this subscale indicates that counsellors tend to give proper thought to decisions in an effort to avoid costly mistakes.

When EQ-i scores were analyzed by age categories, younger counsellors in the 20 to 29 year age category had the lowest mean EQ-i scores; whereas older counsellors in the 50 and older group had the highest EQ-i scores (Table 5.5). However, an analysis using the non-parametric Kruskal-Wallis test did not reveal any significant differences between mean scores across age categories.

Table 5.5 EQ-i scores by age categories

Age	Mean	SD	Min	Max	Range
20 to 29	82.08	18.228	53	108	55
30 to 39	88.63	21.636	51	131	80
40 to 49	84.42	12.428	61	104	43
50 & older	102.00	22.906	80	130	50

Male counsellors had higher EQ-i scores than female counsellors (Table 5.6); however, non-parametric Mann-Whitney U test did not reveal significant differences between the mean gender scores.

Table 5.6 EQ-i scores by gender

Gender	Mean	SD	Min	Max	Range
Male	92.67	11.827	80	104	24
Female	88	20.771	51	131	80

Summary: EQ-i

Based on the scoring guidelines, counsellors' EQ-i scores varied from "markedly under-developed emotional skills" to "adaptive (average) emotional capacity". The scores were an indication that counsellors are not handling their emotions effectively. It was particularly younger counsellors that did not function effectively, as their mean scores were considerably lower than the scores of the older counsellors in the 50 and older category. These EQ-i scores indicate that the effective functioning of counsellors could be compromised by a lack of emotional stability. Although a few subscales approached the South African group norm, overall results indicate that counsellors had low levels of emotional functioning.

The following section will present findings of the Maslach Burnout inventory.

5.2.2 The Maslach Burnout Inventory-HSS

This scale was used to assess the counsellors' level of burnout. The counsellors' average scores on the three subscales of burnout are given in (Table 5.7).

Table 5.7 MBI-HSS scores

Subscales	Cut-off Points	Mean	SD	Min	Max
Emotional Exhaustion	≥ 21	27.66	12.671	0	51
Personal Accomplishment	≤ 28	38.64	5.791	22	48
Depersonalization	≥ 8	6.50	5.791	0	20

Counsellors reported the experience of burnout only on the Emotional Exhaustion subscale. Their Depersonalization scores were less than the cut-off point for burnout. They had high levels of Personal Accomplishment. Their overall burnout scale was therefore not indicative of burnout. Perhaps their high sense of Personal Accomplishment is derived from the meaning they find in their work.

Emotional Exhaustion was highest amongst counsellors in the 20 to 29, and 40 to 49 age categories. Counsellors 50 years and older had the lowest Emotional Exhaustion, although slightly above the cut-off point of 21. Personal Accomplishment was high for all the age groups; although the reporting of a sense of personal accomplishment increased with age. The Depersonalization score for the 50 and older age category was (4.75), the lowest of all age categories (Figure 5.2).

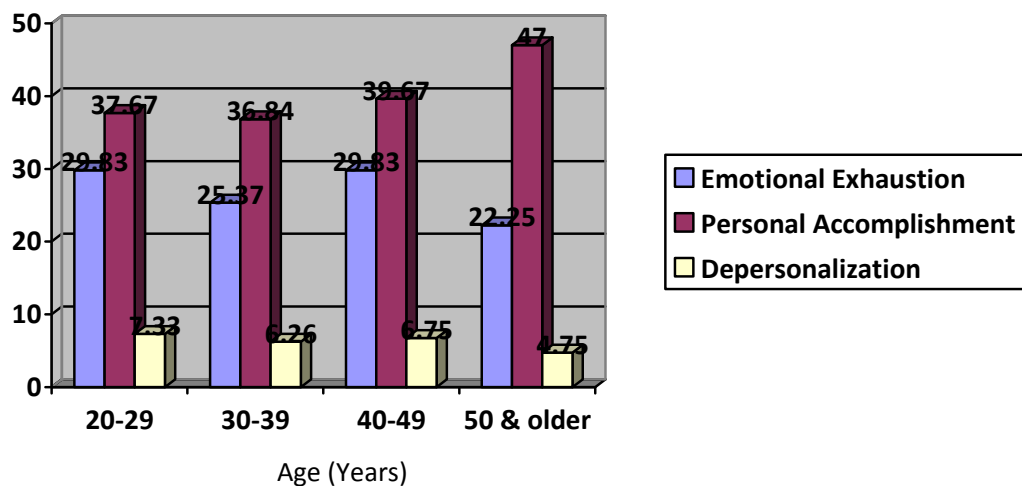


Figure 5.2 MBI-HSS scores by age categories

The non-parametric Kruskal-Wallis test was performed to compare mean scores of the MBI-HSS subscales across the four age categories. The test indicated that Personal Accomplishment scores differed across two age categories (chi square = 9.953; p-value =

0.019). In order to determine which age categories differed, pair-wise comparisons were done by means of the Mann-Whitney U test (Table 5.9). Mean differences for the 20 to 29 and 50 and older as well as the 30 to 39 and 50 and older group was at the 1% level of significance. Mean difference for the 40 to 49 and 50 and older was significant at the 5% level of significance. This means the age group 50+ years thus differed from the other age groups in that counsellors in this age group reported higher levels of Personal Accomplishment than the other counsellors (Table 5.8).

Table 5.8 Mean differences Personal Accomplishment (MBI-HSS) across age groups

Age group	Mann-Whitney U	p-value
20 to 29 vs 30 to 39	110.00	0.880
20 to 29 vs 40 to 49	57.00	0.399
20 to 29 vs and older	0.00	0.001
30 to 39 vs and older	2.00	0.001
40 to 49 vs and older	7.50	0.046

The analysis of burnout scores by gender indicated that males (24.83) had lower levels of Emotional Exhaustion compared to females (28.05). Males had a higher sense of Personal Accomplishment than females and they had a slightly higher Depersonalization score than females (Table 5.9).

Table 5.9 MBI-HSS Subscales' scores by gender

Gender	Mean	SD	Max	Min	Range
Emotional Exhaustion					
Male	24.83	14.190	1	39	38
Female	28.05	12.581	0	51	51
Personal Accomplishment					
Male	40.67	4.320	36	47	11
Female	38.36	5.950	22	48	26
Depersonalization					
Male	6.67	3.011	3	12	9
Female	6.48	5.254	0	29	20

Emotional Exhaustion scores seemed to increase with the number of reported clients counselled per day. The counsellors who counselled more than 20 clients per day suffered more emotional exhaustion than those who counselled fewer clients per day, with those counselling fewer than 15 clients per day suffering the least. Personal Accomplishment, on the other hand, was the highest amongst those who counselled between 16 and 30 clients.

Depersonalization scores were highest amongst those who counselled between 21 and 30 clients per day (see Table 5.10).

The mean scores of each subscale were analyzed to determine the significance level of differences between counsellors with different case loads. No significant differences were found.

Table 5.10 MBI-HSS scores by the number of clients per day

No of clients per counsellor	Mean	SD	Min	Max	Range
Emotional Exhaustion					
10-15	25.27	12.119	0	47	47
16-20	28.57	14.357	4	47	43
21-30	30.09	13.217	1	51	50
Personal Accomplishment					
10-16	37.91	6.746	22	48	26
16-20	39.43	5.064	34	48	14
21-30	39.09	5.166	29	47	18
Depersonalization					
10-15	5.45	3.635	0	12	12
16-20	6.43	6.653	0	20	20
21-30	8.82	5.307	1	18	17

Summary: MBI-HSS scale

Counsellors reported high levels of burnout only on the Emotional Exhaustion subscale. They had high levels of Personal Accomplishment and low levels of Depersonalization. Younger counsellors had the highest levels of Emotional Exhaustion.

Counsellors in the 50 and older category reported the lowest levels of burnout. They had the lowest levels of Emotional Exhaustion and the highest sense of Personal Accomplishment. The following section will present findings of the CES-D analysis.

5.2.3 The CES-D

The CES-D score for the HCT counsellors was 26.08. According to the cut-off points (Radloff, 1977) presented in Table 4.4, the counsellors presented with mild levels of depression.

Younger counsellors in the 20 to 29 and 30 to 39 old age category had the highest depression scores, which can be interpreted as an indication of major depression (scores of 27.58 and 29.05). Older counsellors in the 50 and older age category had the lowest depression score (20.75) see Table 5.11).

The non-parametric Kruskal-Wallis test was performed to compare mean differences on depression scores between age groups. The results indicated that there were no statistically significant differences in the mean scores of depression per age group.

Table 5.11 CES-D scores by age categories

Age	Mean	SD	Min	Max	Range
20 to 29	27.58	9.728	16	49	33
30 to 39	29.05	10.757	12	48	36
40 to 49	23.75	7.225	14	35	21
50 & Older	20.75	6.238	17	30	13

The male counsellors reported lower depression levels than their female counterparts (Table 5.12), but the difference was not statistically significant.

Table 5.12 CES-D scores by gender

Gender	Mean	SD	Min	Max	Range
Male	23.17	6.494	17	34	17
Female	26.48	9.825	12	49	37

Table 5.13 shows that as the number of clients per day per counsellor increased, depression also increased. Counsellors who counselled between 16 and 20 clients per day had the lowest depression scores and those who counselled between 21 and 30 clients had the highest depression scores. The non-parametric Kruskal-Wallis test was performed to test differences in depression between counsellors with different caseloads. There were no statistically significant differences.

Table 5.13 CES-D scores by the number of clients per day

No of clients	Mean	SD	Min	Max	Range
10-15	26.68	10.779	12	49	37
16-20	24.57	8.662	14	41	27
21-30	29.09	7.905	17	43	26

Summary: CES-D scale

The group as a whole scored on a level of mild depression. There was a tendency that younger counsellors reported higher levels of depression (bordering on major depression), while older counsellors had the lowest depression scores. The following section will present scores of the Brief COPE scale.

5.2.4 The Brief COPE scale

The Brief COPE scale was used to assess coping skills counsellors used in coping with the stressors in their work. Positive or active coping was reported more often than negative or avoidance coping (Table 5.14).

Table 5.14 Brief COPE scores

Coping	Mean	SD	Min	Max	Range
Positive or Active	50.90	7.095	37	64	27
Negative or Avoidance	26.90	5.168	16	45	29

Table 5.15 shows the coping skills that the counsellors used mostly.

Table 5.15 Coping strategies

Positive Coping Skills	Mean	SD
Religion	3.67	0.68
Planning	3.44	0.65
Direct Action	3.38	0.79
Emotional Support	3.31	0.79
Instrumental Support	3.29	0.81
Acceptance	3.19	0.70
Reframing	3.19	0.83
Humour	1.98	1.03
Negative Coping Skills	Mean	SD
Distraction	3.23	0.69
Emotional Venting	2.99	0.86
Denial	2.38	0.91
Behavioural Disengagement	1.98	0.98
Self-Blame	1.67	0.78
Substance abuse	1.2	0.47

The counsellors used all the positive coping skills almost equally. Two of the mostly used positive coping skills were religion and planning. Humour as a coping skill was used the least in the positive or active coping category.

In the negative coping category, distraction and emotional venting were reportedly used the most, and self-blame and substance abuse were used the least (Table 5.15).

In table 5.16 the level of positive coping is analysed per age group.

Table 5.16 Positive or active coping by age

Age	Mean	SD	Min	Max	Range
20 to 29	50.33	7.499	37	64	27
30 to 39	50.11	7.086	38	63	25
40 to 49	51.08	6.459	40	62	22
50 & Older	51.75	10.532	42	64	22

It appears that positive or active coping increases with age. However, based on the analysis using the Kruskal-Wallis test, the difference was not statistically significant. An analysis by gender indicated that male counsellors used positive or active coping skills more than female counsellors (Table 5.17). However, the Mann-Whitney U test did not find any statistically significant differences.

Table 5.17 Positive or active coping by gender

Gender	Mean	SD	Min	Max	Range
Male	54.17	6.585	45	64	19
Female	50.45	7.11	37	64	27

Participants' positive or active coping was related to the number of clients they counselled per day. Counsellors who counselled the lowest number of clients per day reported using positive or active skills more often than the others. The observation can be made that as the numbers of clients per day increased, positive or active coping decreased (Table 5.18). However, the Kruskal-Wallis test did not find any statistically significant differences.

Table 5.18 Positive or active coping by the number of clients

No of clients	Mean	SD	Min	Max	Range
10-15	51.36	7.333	37	63	26
16-20	50.93	6.462	42	64	22
21-30	48.45	7.686	41	64	23

Summary: Brief COPE scale

Counsellors reported using more positive or active coping strategies than negative or avoidance coping strategies. The differences observed in coping strategies between ages, gender and case load, were not statistically significant.

The following section will present intercorrelations of variables used to measure the psychological well-being of counsellors.

5.2.5 Intercorrelations of well-being variables

The inter-correlation of all sub-scales of the EQ-i, subscales of burnout, CES-D, positive and negative coping was calculated. All subscales of the Bar-On EQ-i correlated strongly with each other. (These correlations are not given here.) All other correlations with meaningful relationships are presented in (Table 5.19).

Table 5.19 Intercorrelations of scales and subscales

Scale	Subscale	r-value	p-value
CES-D	Depersonalization	r = 0.310	p < 0.05
CES-D	Emotional Exhaustion	r = 0.185	p < 0.05
CES-D	Positive or Active Coping	r = -0.407	p < 0.01
CES-D	EQ-i Emotional Self-Awareness	r = -0.287	p < 0.01
CES-D	EQ-i Assertiveness	r = -0.382	p < 0.01
CES-D	EQ-i Reality Testing	r = -0.294	p < 0.05
CES-D	EQ-i Impulse Control	r = -0.255	p < 0.01
Emotional Exhaustion	EQ-i Interpersonal Relationships	r = 0.361	p < 0.01
Emotional Exhaustion	EQ-i Empathy	r = 0.316	p < 0.05
Emotional Exhaustion	EQ-i Flexibility	r = 0.290	p < 0.05
Emotional Exhaustion	Depersonalization	r = 0.408	p < 0.01

The correlations between depression, Emotional Exhaustion and Depersonalization were quite apparent. These conditions seem to appear in concert with these counsellors. The CES-D score was negatively correlated with Positive or Active Coping. This means that the more

depression one experiences the lower the level of positive coping and vice versa. Positive coping consists of religion, planning, direct action, emotional support instrumental support, acceptance, reframing, and humour.

The CES-D score was negatively correlated with Emotional Self-Awareness and Assertiveness. These variables are subscales of the Intrapersonal scale that assesses the ability to express self-confidence through expressions of feelings, ideas, and beliefs.

The CES-D score was negatively correlated with Reality Testing, a subscale of the Adaptability scale. Reality Testing assesses the ability to evaluate the environment in a realistic manner based on subjective and objective experiences.

The CES-D scale was also negatively correlated with Impulse Control. Impulse Control is a subscale of the Stress Management scale. Impulse Control assesses the ability to withstand stress without becoming impatient or over reacting.

The Emotional Exhaustion subscale of the Burnout inventory was positively correlated with Interpersonal Relationship, Empathy, and Flexibility (subscales of Interpersonal scale). The Interpersonal Relationships subscale assesses the ability to maintain mutually satisfying relationships. The Empathy subscale assesses the ability to appreciate the feelings of others.

Emotional Exhaustion was positively correlated with Flexibility, a subscale of the Adaptability scale. The Flexibility subscale assesses the ability to adjust emotions to changing situations. Emotional Exhaustion was positively correlated with Depersonalization (both subscales of burnout scale).

Stress Tolerance, Problem Solving, Optimism, and Happiness did not correlate with any of the other variables.

It must be cautioned that none of the correlations and relationships that were identified can be regarded as causal without further analysis.

To understand these intercorrelations and to exclude interactive effects, the variables with significant correlations were entered into a multiple regression analysis, with the CES-D score as the dependent variable (Table 5.20). The model fitted the data well ($F = 4.769$, $p=0.001$), and an R^2 of 0.351 was obtained in this model. This means that the model explained 35% of the variance.

Table 5.20 Regression analysis with CES-D as dependent variable

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
MBI-HSS Depersonalization	0.493	0.242	0.260	2.038	0.048
Positive or Active Coping	-0.452	0.169	-0.338	-2.682	0.010
EQ-i Assertiveness	-0.237	0.102	-0.377	-2.315	0.025
Emotional Self-Awareness	-0.058	0.104	-0.099	-0.560	0.578
EQ-i Reality Testing	0.036	0.072	0.090	0.493	0.624

The regression analysis with depression as a dependent variable indicated a positive correlation with depersonalization; a strong negative correlation with positive or active coping and a negative correlation with Assertiveness. This means that high depression scores were related to depersonalization, less active coping, and lower levels of assertiveness.

5.3 Analysis of focus group discussions

Qualitative data was collected to complement the quantitative data. Three questions were presented to counsellors during focus group discussions. Firstly, counsellors were asked

to discuss factors which motivate them or keep them going, given that HIV counselling is difficult and stressful. Secondly, they were asked to describe the most rewarding experience as counsellors and thirdly, they were asked to describe the most challenging experience in counselling. The following section will present the themes that were identified from the responses of counsellors.

5.3.1 Themes regarding the motivation of counsellors

Counsellors see their roles as important; they see themselves as being personally responsible for delivering the service of HIV and AIDS counselling. They feel personally responsible for helping the community and their clients. They hold their responsibility in high regard. In addition, they are motivated by knowing that they also gain valuable information that they can use in their personal lives.

Themes that were identified as motivating factors were:

- Altruism
- Supporting clients
- Learning new skills

Altruism

Counsellors are motivated by the fact that they were putting the needs of their clients ahead of their own needs. This validated their belief that they are making a positive contribution to the community they serve. Their sense of altruism is illustrated by the following quotes:

*“People are struggling out there and they have no one to help them...they are facing a lot of challenges and their families have thrown them away. **It is for me to help them.**”*

*“The thing that keeps me going is that I told myself that I want to **help the community** and when I give up I will be failing my community. Let’s say I decide that on this day I am not going to work and I am not there **the client will be disappointed**; even the trust between myself and the client won’t be there.”*

*“It is indeed difficult. We see a lot of difficult cases and a lot of sad cases but at the end of the day you know that **you are saving someone’s life**.”*

Supporting clients

Counsellors believe that supporting clients is an important component of HIV counselling. In most cases clients have not disclosed their HIV-status to their families and counsellors are their only source of emotional support. They are able to discuss their fears with their counsellors and they receive better support from counsellors than from their families. This is illustrated by the following quotes:

*“Some people come here for **the support we give them**.”*

*“They don’t get the support from home so **here we give them a lot of support** when they have questions or want to talk.”*

*“Even though now there are ARVs, people still **need to be supported** and they know that we are the ones who give them the support. So they come to us even if it is not their follow-up dates.”*

Learn new skills

In their work counsellors learn valuable skills. They learn healthy ways of living. They also learn how to take care of themselves and family members who may be ill. In addition, skills help them to see opportunities for development and furthering their careers.

*“It’s about loving your job and we learn a lot and we want to save the lives of other people in the process. We see it as a **learning opportunity.**”*

*“We also **learn about taking care of our own lives.**”*

*“I have learned a lot since I have been a counsellor; **I have even registered for the auxiliary nursing course.**”*

5.3.2 Themes on rewarding experiences

Counsellors appreciate the work they do because of the intrinsic rewards they get. They do not regard difficulties associated with their work as stumbling blocks; instead they are able to find positive rewards. The themes identified are the following:

- Appreciation by clients
- Compassion towards clients
- Positive changes in clients’ health and well-being
- Hope

Appreciation by clients

Counsellors acknowledged and appreciated the feedback which they received from their clients. In return their clients appreciated the value of counsellors in their lives. Appreciation by the clients was one of the greatest rewards of their work.

*“The **appreciation they give us is amazing and it makes you feel very good-like you matter.**”*

*“Last week there was a client who came looking for me and it is an old client from 2003 and this client had come to thank me. And I said “wena, why?” and **the client said “you have given me my life back.**”*

*“Patients **appreciate the way we talk to them;** especially those of us who have perseverance. When clients leave the room they leave with the strength that: ‘Yeah I am HIV-positive but I*

won't die.' He knows that this is how I should take my medication. I should take care of myself."

*"Sometimes the people **the way they appreciate you** when they meet you somewhere it makes you feel good. You realise that you are doing an important job. In the way that the person is free with you even outside of the clinic, you are doing something good for them."*

Compassion towards clients

The emotional support that counsellors give their clients result in feelings of compassion. It is through compassion that they take on the responsibility of doing all they can to meet the needs of their clients, even if the needs are beyond the boundaries of HCT. As a result they tend to over identify with their clients. Although, the compassion puts them at risk of burnout, they interpret it as one of the positive rewards of counselling.

*"The clinic could not give her milk and I was in such a personal predicament I **decided to buy Pellargon** for the lady."*

*"Sometimes clients come for follow-ups without taxi fare, and **I would end up giving them money** and a little for bread when they get home."*

Positive changes in the clients' health and well-being

Counsellors believe that they are making a difference in communities which they serve. Consequently, they feel good when they see that they are making a difference. This gives them proof that although there are difficulties in their work, the service they offer and the work they do has positive results for their clients.

*"At times a person comes here and they are crying and uncontrollable and **at the end of the day they are alright** and you can see that they are alright."*

“I see myself as doing something that other people are unable to do for instance when a patient comes to you is stressed and immediately after you counsel that person you give them life. He/she sees that life does not end there you have to continue”

*“You can get a client on a wheelchair and you see that aaa! this one is very ill and won’t make it but from just talking **they get life**”*

*“When I see **people coming in numbers**, it makes me realize that people are getting the message about HIV and they are no longer as worried about stigma as they used to.”*

*“And sometimes you get surprised when you see clients because **they have changed and they are well.**”*

5.3.3 Themes on challenging experiences

Counsellors expressed that they are faced with countless challenges in their work. The challenges are associated with the emotional nature of the work as well as the lack of job security. The following challenges were identified:

Psychological experiences

- Poor working relationships with clinic staff
- Emotionally difficult nature of work
- Issues of death and dying
- Compassion towards clients – an emotional burden
- Non-compliance to follow up
- Non-adherence to treatment

Poor working relationships with nursing staff

As a result of their educational and employment status, counsellors believe that they do not get the respect and acceptance from nursing staff. This often results in poor working relationships.

*“One sister **came in to the room as I was trying to talk to the client** and the sister blurted out and said “I am not the one who said the client should not use a condom”. You see! for a counsellor to hear that is painful especially when it is said with the client in the room.”*

*“Most of us here **have been told that we are not educated** and we should go and learn...and when we talk to patients about rights it is hard because we don't have rights.”*

Emotionally difficult nature of work

In some instances counsellors wished they could do more to change the behaviours of their clients. Counsellors felt the need to rescue their clients. In certain cases they carried the burden of worrying about their clients.

*“Young **pregnant high school students** and they have a ‘I know it all’ attitude even if you try to tell her about HIV and treatment they want to tell you that they know and they have all the information.”*

*“The frustrating thing is that these **clients disappear and we worry about them** all the time once they have stopped coming.”*

Issues of death and dying

The most difficult experience for HCT counsellors was the trauma of working in the environment associated with issues of death and dying. An added challenge was that counsellors do not have an outlet for debriefing.

*“I was doing couple counselling and **the husband died** as I was busy with them. You know he was so shocked that **he died in front of me...**that experience is in my mind and it does not come out.”*

*“The husband's family gathered everything that belonged to this lady and set it alight and **they were threatening to kill the lady** because they said she killed their sibling.”*

*“I did not even go to the funeral. I could not accept. Even now I ask myself as to why is it that when I spoke to her on 9th she was fine up and about and a few days later **she is gone.**”*

Compassion towards clients – an emotional burden

Counsellors felt the strain of over-identifying with their clients. In some instances counsellors literally took on the role of family members towards clients. This was also an indication that some counsellors were not able to maintain healthy boundaries between themselves and their clients.

*“There was a client who had stopped coming for follow-ups and when she finally came she needed to take ARVs and **I went to our sister and said that I will be the client’s buddy** just so that she could get treatment.”*

*“I had a client whose child tested positive which meant that she had to stop breastfeeding. The challenge was that she had no money. I had my bank card and I was in such a personal predicament **I decided to buy Pellargon for the lady**, and Pellargon is expensive and I bought her two cans.”*

*“Last week we had a client who was ill. The family indicated to us that the client has not been eating and at our clinic we did not have Morvite (food supplement) and I knew that a clinic in the area had it, so I asked sister to phone the clinic and tell them that **I am coming to fetch morvite.**”*

Non-compliance to follow-up

In most cases, counsellors developed a relationship with their clients and they expected a level of honesty from them. They felt frustrated when they realize that their clients have lied to them or are no longer coming for follow-up visits.

*“The frustrating thing is that **these clients disappear** and we worry about them all the time once they have stopped coming.”*

*“These cases stress us and we are the ones who have to deal with **the stress of not knowing where they are.**”*

*“Sometimes you feel like going to where they stay and bring them back, but the problem is that even the **addresses they have given us are wrong.** When you start going to their residences you find that **the address does not exist.**”*

Non-adherence to treatment

Counsellors felt most frustrated by the actions of their clients of not adhering to treatment. At times acknowledging having TB was easier than accepting to be HIV-positive. Some clients stopped taking medicines as a result of perceiving a HIV-positive status as a death sentence. All these issues resulted in frustrations for counsellors because they genuinely care for the well-being of their clients.

*“All of a sudden the clients would **stop coming for treatment** and you try to call and they don’t answer the phone and then later you hear that the person has passed away”.*

*“She took her TB treatment and after completing her treatment **she did not want to come for her ARV treatment.** She started ignoring our calls”.*

*“Now she comes to fetch her treatment all the time in the clinic but **she is not drinking it.** I had to talk to her, I mean really talk to her until she said she is not going to take the treatment because it is pointless.”*

Structural challenges

Counsellors are constantly faced with limitations in their work environment. The limitations are a result of job demands and lack of physical resources which makes it difficult

to perform their tasks optimally. The limitations of their work environment leave counsellors believing that they have to deal with the challenges on their own.

- Inconsistent remuneration
- Insufficient training
- Lack of supervision
- Lack of recognition
- Insufficient time for sessions
- Fear of becoming infected

Inconsistent remuneration

Counsellors are not considered to be employees of the governmental health sector, however they provide an important service to their clients. The problems surrounding the non-payment of stipends frustrated counsellors. This has led counsellors to lose confidence in the system that has employed them.

“My wish is that we could get stable salaries and be recognized and have personnel numbers because we wake up every day and your family does not understand that you don’t get paid”.

“I met one guy from Mamelodi who said that at their clinic they are getting R1000.00. I was surprised I realised that some get R1000.00 and others are getting R1500.00.”

“The things that happen surrounding HCT counsellors are surprising. You would end up thinking that clinic managers are also involved in this whole mess of us not getting our stipends.”

Insufficient training

Lack of adequate and consistent training was also a major frustration for counsellors. Their frustration was a result of feeling that they were giving their clients conflicting

information. There were instances when they felt incompetent, especially when clients seemed more knowledgeable than them.

*“At our clinic we **are still lagging behind** because they allow only one counsellor to attend training. It is not good because we end up **not having the same information** and we **tell our clients different things**. So they should make sure that we should all have the same information.”*

*“A counsellor should not be expected to come back and give feedback to another counsellor about the training, because **I might not understand the feedback**.”*

*“Sometimes we have clients who tell us about the new treatment they have received and ask about side effects and some complain about side effects and how **are you going to explain to the client if you don’t understand yourself**.”*

Lack of supervision

Counsellors expressed that there was no one who took responsibility for their guidance and supervision. They were left to their own devices and they would refer to one another when they needed clarity on some issues.

*“There is no **one responsible for counsellor’s** because if you ask the region, **the region points you to the NGO** and when you ask **the NGO, the NGO points you to the region**, when they are busy pointing fingers at each other, where are you?”*

*“We have **no one who guides us** or listens to us.”*

*“We have just decided to share problems and challenges amongst ourselves. When a counsellor has a question or needs something clarified, **we share amongst us**.”*

Lack of recognition

Counsellors often felt that nursing sisters were not appreciative of their work. They felt as though they were non-existent. This was something which was incomprehensible to counsellors as they saw themselves doing work which nursing sisters could not do.

*“You will **never get any recognition from a sister** and they get angry when a client comes to thank you.”*

*“At our clinic, **counsellors do not even exist**, we are treated like we are not people; we are just there to do the work they don’t want to do.”*

*“Ooh! It means that they are looking just at the statistics and not the lives of clients...So it means that **they are only interested in stats.**”*

Insufficient time for sessions

A major concern for counsellors was the time allocated for counselling sessions. Even though there are no set time limits, counsellors were concerned that there was not enough time to counsel their clients effectively. They are always pressured to spend less time with clients and they believed that when clients are not satisfied with the quality of counselling they will not return for follow-up visits.

“There are clients who come in and need more time and you have to give them that time. So when I stay with a client, I am told that: ‘Can’t you see that there is a queue outside?’”

*“And **the client leaves very unsatisfied** because he was pushed because of the queue. You should know that chances are that the client won’t come back.”*

Fear of infection

The fear of occupational infection was a real concern for counsellors and it was also a source of stress. Their work environment is a constant reminder of the impact of HIV as well

as the consequences of infection. For some counsellors an added stressor is that they do not qualify for any benefits, therefore they would not be compensated should they be infected as a result of their work.

*“Last time I was thinking about the **risk of working here** and we are not covered. **Pricking can be dangerous** for us. Should you prick yourself by mistake you will end up being HIV-positive for nothing. You will die for nothing.”*

*“You know sometimes when a client comes and find that the client has TB the Sister leaves the room and **you find that you are not wearing a mask** and at the end of the day **you might end up contracting TB** because you are sitting close to the client.”*

*“You know I have learned to ask my clients if they are coughing because **TB is highly infectious** and chances of contracting it are very high. **I am so afraid of contracting TB.**”*

5.4 Summary of focus group discussions

Themes that were identified from the discussions were divided into motivating factors, structural stressors, and psychological stressors. Motivating factors were factors that contributed to the coping skills of counsellors. These factors made it possible for counsellors to continue working despite various challenges and stressors. Psychological stressors included emotionally stressful aspects of the job. Structural stressors were the stressful physical aspects of the job including the work environment, training aspects and remuneration. Both the psychological stressors and structural stressors posed major challenges to the well-being of counsellors. Figure 5.5 shows a graphic representation of the themes.

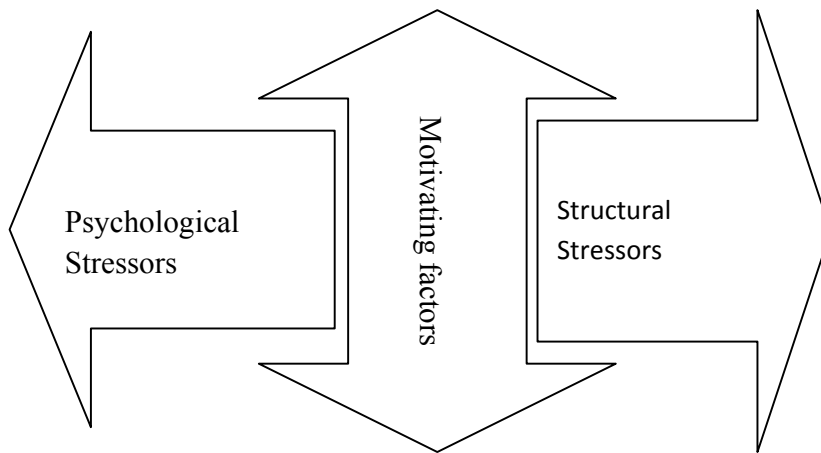


Figure 5.5 Thematic map

5.5 Conclusion

EQ-i scores of the group varied from very low to average capacities, an indication of challenges in the emotional functioning of counsellors. The average total EQ-i score for the group was a low average score (88.76). As a group, counsellors reported high levels of burnout only on the Emotional Exhaustion scale score of (27.66). Older counsellors (50 years and more) reported significantly higher levels of Personal Accomplishment than counsellors in the other age groups. Counsellors reported moderate levels of depression (a score of 26.08). Counsellors used positive coping skills more often than negative coping skills.

Overall, counsellors' scores were a reflection of the difficulties surrounding the nature of their work. As revealed in the focus group discussions, HIV and AIDS counselling is an emotionally challenging task. The emotional functioning of counsellors could be the result of the stressors they face.

In focus group discussions, counsellors gave vivid examples of the trauma and emotional burdens they faced as part of their work. They also indicated that they lack

appropriate training, supervision, and recognition. In spite of the challenges they faced, counsellors developed their own sense of accomplishment and support structures amongst themselves which motivated them to continue doing counselling on a voluntarily basis. Although they reported inadequate emotional competencies (EQ-i), counsellors expressed many positive strengths. Their greatest motivator is the sense of altruism that they have towards their clients and their sense of accomplishment that they make a difference in their community.

The following chapter will discuss the results, recommendations, and implications of the study.

Chapter 6: Discussion and Conclusion

In this chapter, results of both quantitative and qualitative data will be discussed. The chapter will begin by giving a summary of the aims of the study followed by the discussions of the results of the study. The implications of the results as well as recommendations will be explored.

6.1 Summary of the study

The purpose of the study was to investigate the psychological well-being of HCT counsellors in the light of the challenges they face in the scope of their work. Specifically, the research investigated the levels of depression and burnout and psychological well-being of HCT counsellors. The coping skills of HCT counsellors were investigated to determine whether the coping skills and emotional competencies contributed to their ability to cope with the stressors they are confronted with in their work environment.

Purposeful sampling was used to recruit 50 HCT counsellors employed in City of Tshwane Health clinics to participate in the study. Quantitative data was collected using the Bar-On EQ-i, CES-D, MBI-HSS and the Brief COPE scales. In addition to administering the psychological scales, 5 focus group discussions were held to discuss factors which motivate counsellors, rewards and experiences of HIV and AIDS counselling as well as challenging experiences in their work.

In this study, the following hypotheses were investigated:

- HCT counsellors have high levels of burnout and depression
- HCT counsellors have above average levels of emotional intelligence and positive coping skills

- Aspects of negative well-being such as depressive symptoms and burnout co-exists with aspects of positive well-being such as emotional intelligence and positive coping. (This reflects the theory of Keyes of the mental health and mental illness continuum).

6.2 Discussion of results

6.2.1 Dimensions of positive and negative well-being

The results will be discussed using positive psychology as theoretical framework. The discussion will be presented in terms of the dimensions of well-being. According to Diener (2006) the term well-being embraces a broad variety of constructs that include life satisfaction, happiness, positive moods and thriving.

6.2.1.1 Emotional well-being

In this study, HCT counsellors evaluated their emotional experiences, both pleasant and unpleasant. Diener and Lucas (2000) proposed that emotions are a central component in well-being because people experience a range of emotions in their daily lives. The General Mood composite scale of the EQ-i assessed the counsellors' ability to enjoy life and their outlook on life. Results indicated that their general outlook on life was below average or low compared to a South African norm group. This suggested that counsellors did not enjoy their lives and were not happy. As discussed earlier, counsellors were not highly trained and were not adequately remunerated. They also had poor employment prospects as most of them only had matric qualifications. All these issues could contribute to poor quality of life and dissatisfaction towards their lives. The sense of satisfaction related to their work was based on the contribution they are making to the health of their clients. The nature of their employment is a source of frustration to the counsellors and it affected their emotional well-being.

6.2.1.2 Psychological well-being

Psychological well-being as conceptualized by Jahoda (1958) and Ryff (1989) is influenced by abilities to cope with environmental demands and pressures (Duckworth et al., 2005). The following is a presentation of counsellor's skills or abilities which were reflected as *average functioning* on the EQ-i scale. Data from the focus group discussions will be integrated to give a rich description of the abilities. These abilities are an indication of where their strengths possibly are.

- ***Self-regard*** – The EQ-i results indicate that counsellors had adequate self-regard. In focus group discussions counsellors perceived themselves to be important; they viewed themselves as doing work which professionally trained health care workers are not able to do. They were aware of their capabilities as well as their limitations.
- ***Emotional Self-Awareness*** – counsellors tended to understand their feelings and attitudes and possibly realized how these affect their thoughts and actions. As a result they continue to focus on the well-being of their clients.
- ***Empathy*** – they appreciate the feelings of others (their clients) and they will go out of their way to help them. This attitude was reflected during group discussions when counsellors discussed how they would go out of their way to assist and support their clients.
- ***Interpersonal Relationships*** – counsellors are able to establish and maintain mutually satisfying relations characterized by giving and receiving affection. In the group discussions they reported that they care for their clients. Counsellors appreciated the feedback they received from their clients.

- ***Impulse control*** – although they had various frustrations as a result of their work environment, they were able to control their anger and aggression adequately. Focus group discussions indicated that anger and frustrations were never directed towards their clients.

Counsellors had under-developed emotional skills also reflected on the EQ-i. Counsellors had challenges with ***assertiveness***. This reflected an indication that they were passive and unable to express their opinions and feelings. Most of the counsellors are currently working in environments that are not conducive to self-expression. Some of them indicated that they had poor working relations with nursing staff and as a result they are frustrated.

With regard to ***problem solving***, the research results indicated that they were not able to generate and implement effective solutions. They received minimal and inadequate training and as a result they had feelings of incompetency. Counsellors were fearful of any new job that was assigned to them. They were very concerned about the introduction of the HCT programme, some of them were afraid that they might lose their jobs. In addition, administrative processes such as data capturing and data management were introduced with the HCT programme. This resulted in new roles and tasks for counsellors. Some counsellors felt uncomfortable with the new tasks. Their underdeveloped emotional skills on the ***flexibility*** subscale were an indication that counsellors had a preference for performing routine tasks and they may have found the new roles to be challenging. A reflection of markedly under-developed capacities on the ***independence*** subscale may indicate that they lacked the confidence to make decisions. This could possibly be due to feelings of inadequacy as well as poor supervision. Their low **self-actualization** score could reflect that they did not feel that they were achieving their goals in life. Their under-developed scores on

the *reality testing* subscale mean that they tend to be unrealistic and unfocused. Group discussions were an indication that counsellors felt the need to solve the problems of their clients which was often unattainable. In many instances they were over involved with their clients.

Thompson (2005) suggests that high levels of stress reduce an individual's ability to function to full potential. In this case where counsellors are confronted with many adverse events the results indicated that they are averagely able to manage and control their psychological functioning.

6.2.1.3 Social well-being

Qualitative data indicated that counsellors were committed to the service that they are offering to their clients and community at large. By that commitment they acknowledged that they are members of a social group. In essence, they have something of value that they give their clients. The relationship with their clients is very important to them and they feel a sense of reciprocity when clients come back to them to express their appreciation. This provides evidence of the two dimensions of social well-being namely social contribution and social integration. Positive psychology theorists assert that positive traits and positive emotions flourish within positive environments or institutions, because that is where meaning is derived. However, the results from this study have shown that institutions within which counsellors function do not enhance the well-being of counsellors. The physical environment, job resources, and the strategic management of the HCT programme are not indicative of positive institutions. Furthermore, counsellors are expected to function in an institution that excludes them from participating or engaging in day-to-day issues such as meetings with other clinic staff, as a result they do not feel part of their work organizations.

6.2.2 The negative and positive well-being continuum

6.2.2.1 Burnout

Counsellors had high levels of Emotional Exhaustion and high levels of Personal Accomplishment with low levels of Depersonalization. According to Maslach et al. (1996) health professionals who spend more time in direct contact with patients scored high on Emotional Exhaustion. In the current study, counsellors that counselled more than 21 clients per day had higher levels of Emotional Exhaustion and Depersonalization than those who had less clients per day (though the difference was not statistically significant). In other studies there was an observed pattern between high case loads and high scores on Emotional Exhaustion and Depersonalization subscales (Iacovides et al., 2003; Maslach & Jackson, 1981).

Iacovides et al. (2003) found Positive Accomplishment amongst health care workers to be associated with positive feelings towards their clients including feelings of sympathy. The high level of Personal Accomplishment in this study is an indication that counsellors valued their work despite of the undue structural and work related challenges they face. They indicated in focus group discussions that they attained a high sense of purpose and some of them view their work as a higher calling. Counsellors in the study reported positive ways of coping; their level of positive accomplishment and positive coping skills help them not to develop burnout.

6.2.2.2 Depression

Counsellors had depression scores which were indicative of moderate depression. HIV counselling is associated with various stressors and challenges such as issues of death and dying as well as other work related stressors. These could have the potential to lead to

depressive symptoms in counsellors. According to Iacovides et al. (2003) depression is a disorder that affects aspects of life and may cause problems at work. High levels of psychological demands, low levels of social support at work and stress due to unsuitable jobs are possible predictors of depression.

6.2.2.3 Coping

Scores from the Brief COPE indicated that counsellors used coping skills which were oriented towards positive coping, and they included religion (emotion-focused coping), and planning and direct action (problem-focused coping). Other coping mechanisms expressed in focus groups were love for the work they do and the belief that they were making a difference in their communities. Religion was the mostly used coping skill. In this instance, it could be that when counsellors are most depressed religion becomes a source of support. Dean (2005) says religious beliefs and practices are predictive of virtues such as altruism and volunteerism. He asserts that a religious or spiritual problem solving style can affect one's ability to cope with adversity.

Amid the challenges they faced, counsellors were hopeful that the circumstances surrounding their employment would change. Although they acknowledged the stressors, they focused on positive aspects of the jobs and positive outcomes in the lives of their clients.

Quantitative results indicated that counsellors used positive coping skills to cope with the stressors. Similarly, the motivators, such as personal relationships with their clients and personal achievement assisted them to cope with challenges which they faced. The motivators played an important role in the work of the counsellors.

6.2.3 Age and gender

Results of subscales used in this study indicated a relationship with age. Scores for younger counsellors indicated poorer or negative emotional skills. Younger and female counsellors tend to experience depression more than other groups (although the differences were not significant). The same groups also experienced more emotional exhaustion and lower emotional strengths. Scores for older counsellors were generally more positive. Older counsellors reported significantly more personal accomplishment than younger counsellors. The decreasing depression scores with age in the current study conforms with the findings of Ehrlich and Isaacowitz (2002) who found depressive symptoms to be highest in young adults aged between 18 and 25 years. Maslach and Jackson (1981) also found a pattern in relation to age. In their research younger people had higher Depersonalization and Emotional Exhaustion scores while older people had higher Personal Accomplishment scores (Maslach & Jackson, 1981). This could be due to a lack of life experience. Younger people may have not yet learned life skills to respond appropriately to challenging stressors.

There were no significant differences between the psychological well-being as measured in the study between male and female HCT counsellors. It must be kept in mind that there were only six males that participated in the study.

6.3 Correlations amongst variables

Depression and Emotional Exhaustion were two variables that emerged to be correlating with scales and subscales of the different instruments used in this study. There was an indication that the more depressed counsellors were, the higher the likelihood of being emotionally exhausted and of having depersonalizing attitudes towards clients. Similarly, the more depression counsellors experienced the lower the level of positive coping skills

reported. In the same way, the more depression counsellors reported the less were their sense of self and self-confidence.

Furthermore, the more depression the counsellors experienced the less they are able to evaluate the correspondence between what they experience (subjective) and reality (objective). Similarly, the more depression counsellors experienced, the lower the ability to resist or delay their impulses to overreact. This means that depression reduced the counsellors' ability to manage stress.

It seems that having close relationships and high levels of empathy with others contributed to Emotional Exhaustion.

The regression analysis indicated that depression was related to higher depersonalization, lower positive coping and lower assertiveness. This means that depression affects the counsellors' abilities to positively cope with stress; their confidence as well as their attitudes towards their clients.

6.4 Discussions of the hypotheses

Hypotheses which were investigated for this study were partially supported and they are discussed below.

- The hypothesis that counsellors have high levels of burnout and depression was partly accepted. Even though the counsellors had high levels of emotional exhaustion, they reported high levels of personal accomplishment as well. Counsellors reported moderate levels of depression which had a significant correlation with emotional exhaustion and the depersonalization aspect of burnout.
- The hypothesis that counsellors have above average levels of emotional intelligence and positive coping skills was partially supported. Counsellors had inadequate

emotional capacities as evident from the EQ-i scores. They did however use more positive coping skills than negative or passive coping.

- The hypothesis that negative well-being can exist in the presence of positive aspects of well-being was supported. This was mainly found in the high depression scores that were accompanied by high levels of personal accomplishment and positive or active coping skills. Aspects like self-regard, empathy, stress tolerance, problem solving, optimism and happiness were not correlated with scales measuring negative well-being. This is an indication that the structure of well-being is not on a single continuum. However, it fluctuates on a continuum between states of complete mental illness to complete mental wellness as Keyes (2002) had proposed.

Based on the literature review, the researcher expected that counsellors would have significantly high levels of depression and high levels of burnout given the myriad of challenges that they experience. The researcher did not expect that counsellors would have inadequate emotional skills as assessed by the EQ-i. The expectation was that they would have higher emotional capacities and that those capacities would be useful in coping with the stressors. The researcher did however expect the counsellors to be motivated and committed to their work. The implications of the findings of the study are discussed in the following section.

6.5 Implications of the study

The aim of counselling is to facilitate healing through a therapeutic relationship between client and counsellor (Corey, 2009). The well-being of the counsellors is therefore an important component of effective counselling. This study contributes to the understanding of the well-being of HCT counsellors that form an important part of the HIV/AIDS health care

system. There have been limited studies which assessed the emotional capacities and skills of HCT counsellors.

It was found that the counsellors were functioning on a low to average emotional level, that they experience high levels of emotional exhaustion and depression as well as high levels of stress and challenges. This study has implications for the HCT programme since the perceived lack of management of the programme is a precursor to the challenges and stressors expressed by counsellors.

- Although the HCT programme is a national programme, spearheaded by the Minister of Health, there is lack of clear directives regarding the administrative and management process of the entire programme. There is also lack of ownership of the programmes from various levels of government.
- The government is placing itself at risk for being regarded as exploiting counsellors. Legislative frameworks governing employment such as the Labour Relations Act and the Basic Conditions of Employment Act are silent on the issue of volunteers. HCT counsellors are seen as volunteers even though some counsellors have been ‘volunteering’ for over five years and they consider themselves to be employed because they provide a service generally full-time and eight hours a day.
- Counsellors serve a vital role in the health system. Given the burden of HIV and AIDS in the country their role cannot be disputed. They are expected to counsel patients with very serious problems and they are not trained to so.
- There is a need to place emphasis on selection procedures for those interested in becoming lay HCT counsellors as well as formally recognizing their work.

- It is important for counsellors to be provided with incentives such as training, personal development, and appropriate skills for them to be able to implement the HCT programme.
- Counselling is a profession which is governed by guidelines requiring appropriate training. The training that HCT counsellors receive is minimal and not standardized across the entire HCT programme. There is a need to formalize the training of counsellors so that the information they give to clients is accurate, uniform and consistent across clinics. Counsellors also need to be trained in various aspects of counselling so that they are able to enrich the counselling process.
- Counsellors need a combination of personal development training and supervision which would help them to be in control of their personal issues so that they are not overwhelmed by the emotions of their clients. They should also receive training in setting up and dealing with boundaries in professional relationships. They should learn skills of how not to over-identify with or get too involved in the issues of clients.
- It is important for all counsellors to have debriefing sessions where they can address stressors and traumatic experiences which they face.
- Younger counsellors need a combination of various forms of support such as mentoring and coaching to help them to cope better with the stressors they face in their work.
- The most positive aspect from this research is the finding that counsellors find rewards and purpose in their work and experience a high level of personal achievement. That is what helps them to stay committed to their work.

- The results of the study provide opportunities to enhance the skills of HCT counsellors and to optimize the HCT programme.

This study indicates that within the positive psychology paradigm, the well-being of individuals depends inter alia upon the well-being of organizations and institutions. Therefore, to enable counsellors to move towards positive well-being, the HCT programme as an institution, its policies, strategies and infrastructure need to be enhanced to become a positive institution.

6.6 Limitations of the study

The results should be understood in the light of the following limitations.

- The questionnaires used in the research were completed in English. The questionnaires specified that functional knowledge of English (at least a Grade 4 reading ability (Bar-On, 2005; 2007)) was necessary. The counsellors had a functional knowledge of English and they all had secondary school training at least up to Grade 11, but English was not their vernacular. The researcher encouraged the counsellors to ask if they did not understand the questions. Despite these efforts, there could still have been items which they did not understand completely. Checks of validity and reliability nevertheless indicated that this is not a major cause for concern.
- The researcher was denied access to some of the clinics and a few counsellors did not agree to participate in the research. This could have affected the homogeneity of the sample and generalizability of the data, but to a large extent the researcher succeeded in involving most of the original target population.

- When the study was conducted some counsellors had not received their stipends for a few months. They were frustrated and angry and that could have led to possible bias in responding.
- The role of the researcher in this current study was to facilitate a process where counsellors could have an opportunity to share their experiences. This was done through asking probing questions in order to get a thorough understanding of their experiences. As a result some participants might have responded in a manner which they think will please the researcher.
- The interpretation of qualitative data is a process where the researchers' ideas and understanding are incorporated. This is a subjective process. To enhance the validity of the data interpretation, the researcher reflected on her understanding of the responses directly after the discussion to make sure she understood them correctly. Additionally, a co-researcher was used to interpret the data. Despite these measures, there could have been some subjective interpretation of the data.
- Developments after the final contact between the researcher and the counsellors (March, 2011) could have altered the employment, stipend and/or training conditions of the counsellors already.

6.7 Conclusion

The HCT counselling process places considerable demands on counsellors. This could negatively affect their mental well-being. The aim of counselling is to facilitate healing and counsellors should model a way of being for their clients (Corey, 2009). Therefore, the counsellor should be a fully functional individual (Maslow, 1970). Although counsellors in this study had positive qualities, deficiencies in their emotional capacities and skills cannot be

underestimated. It is important that their emotional skills are enhanced. This study and previous research identified training, supervision and debriefing as missing components in the HCT programme. Daniels et al. (2010) stress that counsellors should receive support which include emotional, esteem, instrumental, informational and network support. It is the type of supervision that would also enhance their emotional capacities and skills. In addition to supervision, the employment and remuneration issues of counsellors need to be prioritized because discrepancies have a negative impact on the service delivery of the HCT programme.

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ANNEXURE A: CONSENT FORM

CONSENT FORM

1. TITLE OF THE STUDY

Psychological well-being of volunteer counselling and testing counsellors.⁴

2. INVITATION TO PARTICIPATE

You are invited to participate in a research study that is aimed at investigating the psychological well-being of VCT counsellors. The role of VCT counsellors is a critical one because they are the implementers of the strategies and programmes to the communities which they serve. The VCT counsellors have the task of educating clients about HIV and AIDS, encouraging them to test and to change their behavioural practices.

They have to convey the clients' test results and have to help clients who test positive and their families to cope with the psychological challenges associated with the disease. The nature of the work of VCT counsellors is very emotional and the entire delivery of HIV and AIDS counselling and testing service is dependent upon them.

3. DESCRIPTION OF THE RESEARCH

There are two formats which the study will follow; the first one is in the form of questionnaires to measure areas like burnout, depression, coping, and well-being. There will be someone to explain the consent form as well as concepts in the questionnaires that counsellors might not understand. The questionnaires are long however there are a number of ways to ensure that you are not uncomfortable. The second format will be a focus group where you will be asked to share with other group members experiences and challenges being VCT counsellors.

4. RISK REGARDING CONFIDENTIALITY

There are no known risks to being in the study except those that relate to confidentiality. All information obtained from the participants will be kept strictly confidential.

4. The name of the programme changed from VCT to HCT after counsellors had been consented.

The identity of participants will not be revealed in the writing up of data or publication of the research results. Once information is collected, your name and other identifying information will be removed and will be identified by a code number only.

During the focus group discussions some members may reveal personal information to others in the group. Everyone in the group will be requested to keep private all the information that has been shared. All the information including tape recorded information will be kept in a locked cabinet.

5. BENEFIT

The study is designed to identify challenges and experiences of VCT counsellors. It is envisaged that the findings will highlight the needs of the counsellors which will result in better conditions for them.

6. PARTICIPANTS' RIGHTS

Participation in the study is voluntary; you may withdraw from participation in the study at any time without negative consequences.

7. CONSENT FOR PARTICIPATION

I _____, voluntarily agree, without being coerced or pressured, to participate in the study and feel comfortable to share my experiences with the interviewer. I understand that the information that I will provide for this study will be disseminated and shared with other researchers and that my identity will not, under any circumstances, be disclosed during publication without my consent.

Name and surname of participant _____

Signature of participant _____ Date _____

Signature of researcher _____ Date _____