

## Understanding Burnout amongst Counsellors Working in HIV Testing and Treatment Settings

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Few studies have focused on understanding the issue of burnout and coping strategies used by the counsellors working in the HIV settings. The broad aim of this study was to focus on factors resulting in burnout among counsellors and to understand how they deal with such issues. The study was conducted in two phases, where Phase 1 employed the qualitative research approach and Phase 2 involved a quantitative approach. In Phase 1 of the study, a semi structured interview guide was administered to 10 key informants and in Phase 2, an interview schedule was administered to 113 counsellors. The findings iterate the need for helping counsellors identify the symptoms of burnout and recommends mechanisms that the counsellor can implement to deal with burnout.

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### INTRODUCTION

The interventions in HIV/AIDS have gained a great deal of importance in the last decade. Although the infection has passed three decades of existence, there has been no reduction of new infections. The growing magnitude of cases for HIV testing and treatment has placed a heavy burden on health care workers working directly with People Living with HIV and AIDS (PLHA). The NACP-3 State Fact Sheet (March 2012) states that Maharashtra is the second most affected state in the country, with an estimated 40,060 people infected with HIV. It also mentions that

the number of persons accessing public health systems for HIV testing and treatment needs has increased to a great extent—due to the relaxation provided in the costs of the same. The counsellors also report of the increasing number of clients seeking their services every year. Mumbai is a commercial centre and continues to draw a large number of migrants, who are among the users of HIV services. Thus there is tremendous pressure on the counsellors to address the needs of every client within the time frame available with the clients. In addition, they have to spend a considerable amount of time in reporting and documentation. As a result, the counsellors could be stressed and thus the process of counselling could be adversely affected.

The overall goal of the National AIDS Control Programme (NACP) III (2006-2011) is to halt and reverse the epidemic in India over the next five years by integrating programmes for prevention, care and support and treatment (MDACS Talks, July 2012). With the widening circle of people affected by HIV/AIDS, the advancements in HIV/AIDS care and treatment has also multiplied (Meirleir, 1992). Besides the large number of persons who come in for testing due to their perceived high risk behaviours, there are more people living with HIV/AIDS needing lifelong extended care and psychosocial support (Thejus, Jeeja and Jayakrishnan, 2009). The National Aids Control Organisation (NACO) module on 'Identification and Management of Burn-out in Caregivers and Counselors' (NACO, 2006) not only recognises the importance of dealing with the stress faced by counsellors, but also focuses on providing support for the counsellors.

Counsellors are often required to spend considerable time as they are intensively involved with people infected and affected by HIV. Their interaction is centered on the clients' current psychological, social or physical problems, which is charged with feelings of anger, embarrassment, fear or despair. It is possible that the ambiguity and unresolved conditions of the client's problems would be emotionally draining for the counsellor and when such a stressful syndrome remains unaddressed, it may lead to burnout.

Counselling people with HIV and AIDS (PLHA) and their families (both infected and affected) is an integral aspect of HIV interventions, as they face a plethora of problems related to health (especially Opportunistic Infections and Sexually Transmitted Infections), social, interpersonal, emotional and financial issues of the family (Motihar, 2006). The Global Fund to fight AIDS, Tuberculosis and Malaria Round 7 (GFATM) through its *Saksham* programme provides training to and helps in the capacity building of HIV counsellors. College of Social Work, Nirmala Niketan

(CSWNN) as one of its sub-recipient, handles the ICTC counsellors' induction and annual refresher training load of counsellors from Mumbai. This paper aims to examine the different issues related to HIV counselling, and specifically the issue of burnout, among HIV counsellors in Mumbai.

## LITERATURE REVIEW

The literature review showed only few research studies in India that have explored the issue of burnout among counsellors working with PLHA in India. Research studies conducted with health care workers show a positive relation between physical activity and reducing burnout, and this can be used as one of the strategies to prevent burnout (Meirleir, 1992).

Additionally, there is dearth of research in India focusing on HIV counsellors' perspectives, their perception of the issue of burnout and strategies used by them to deal with and prevent burnout. A review of literature shows that there is a need for research on the role of hospital based supervisors in managing burnout as they are supposed to provide direct support to the counsellors.

In order to fill in some of these gaps, this paper seeks to provide empirical evidence from the field of HIV/AIDS counselling in Mumbai on the perception of counsellors regarding the issue of burnout. This paper seeks to examine some of the key areas which affect the counselling services such as stress and burnout, coping strategies of the counsellors and their perception, and their expectations from the hospital based supervisors. It is envisaged that this research would further strengthen the existing NACO module, would lead to the development of a more comprehensive module. The ultimate objective of this analysis is to help strengthen the counselling component in the field of HIV/AIDS and increase the efficiency of counsellors as they reach out to PLHA. The Mumbai District AIDS Control Society (MDACS) has also expressed its need to have data to strengthen its counselling component.

## Understanding Burnout

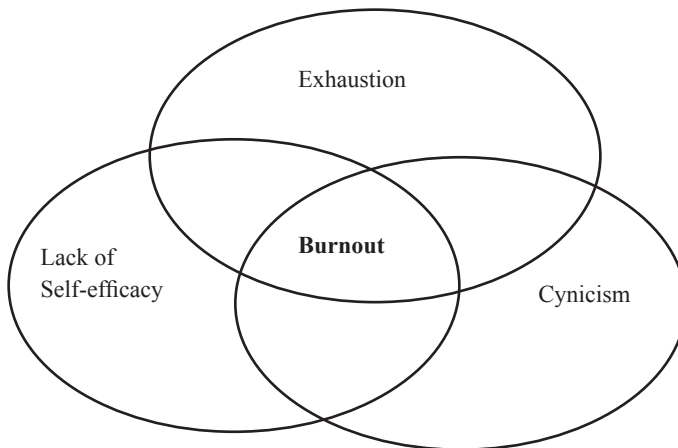
Freudenberger was the first to use the concept of burnout in 1974 in a human service setting (Aiken and Solane, 1997). Burnout has been defined by Gold and Roth (1993) as: "*a syndrome that included symptom of exhaustion, a pattern of neglecting one's own needs, being committed to and dedicated to a cause, working too long and too intensely, feeling pressures coming from within oneself, being pressured from harried staff administrators, and from giving too much to needy clients.*"

Kulkarni (2006), further described ‘Staff Burnout’ as a syndrome of exhaustion, disillusionment and withdrawal experienced by voluntary health workers. There is no general accepted definition of burnout, though most researchers (Dierendonck, Schaufeli and Buunk, 1998; Kulkarni, 2006; Enzmann and others, 1998) agree that it includes three dimensions: emotional exhaustion which focuses on the depletion or draining of emotional resources; depersonalisation, which centers on negative, callous and cynical attitude toward the recipients of one’s care; and reduced personal accomplishments, which refers to the tendency to evaluate oneself negatively with regard to one’s accomplishments at work among individuals who do ‘people work’ of some kind. It is a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems.

The term ‘burnout’ is usually used to describe the feelings associated with long-term job-related stress. Burnout refers to a progressive loss of idealism, energy and purpose experienced by people in the helping professions as a result of the conditions of their work. These conditions may include insufficient training, client overload at work, bureaucratic or political constraints, gap between aspirations and accomplishments, and so on. Burnout has also been related to work overload; role ambiguity; role conflict; time and staffing limitations; lack of advancement; poor work relations; lack of peer support; increased demands by patients and families; and frequent exposure to hopeless situations, and to death and dying (Soderfeldt, Soderfeldt and Warg, 1995).

According to Raija (1999), burnout is a three dimensional phenomenon which includes exhaustion cynicism and lack of self efficacy (see Fig 1).

**FIGURE 1: Burnout as a 3-Dimensional Syndrome**



## Causes of Burnout among Counsellors

In helping professions, there is no single source of burnout. It is a result of interaction between different factors (Shamasundar, 2008). The reasons for burnout as detailed in the NACO handout include patient behaviour, working conditions, emotional depletion, physical and/or psychological isolation, counsellor–client relationship (leading to counter-transference and vicarious trauma) and personal disruptions. Other factors that contribute to burnout include lifestyle and certain personality traits. Burnout causes can be categorised as follows (Smith, Jaffe-Gill, Segal, and Segal, 2008):

*Work-related* causes of burnout include lack of control over work; high job expectations or confusing job expectations; little acknowledgement or rewards for good work; sudden increase in the knowledge-intensity of work; excessive demand, monotonous or less challenging job; high pressure work environment/ chaotic one; and work insecurity/ instability.

*Lifestyle* causes of burnout are taking on too much work and not allotting sufficient time for relaxing and socialising; having to live up to high expectations of other people resulting in doing too much work; multi-tasking with excessive responsibilities and inadequate help from others; inadequate rest and sleep; and not having adequate nurturing and supportive family and social relationships.

*Personality traits* that contribute to burnout include aiming to be a perfectionist; viewing the world and self in a pessimistic manner; feeling a need to do everything on one's own and be in control; displaying an unwillingness to delegate work to others; and being a high-achiever.

Despite a huge body of research on burnout and its causes, there is no consensus on what factors contribute to burnout in human service workers (Aiken and Solane, 1997). One of the problems is that the number of variables that have been studied has produced a universe of factors. Enzmann and others (1998) have listed more than 100 factors which also cover demographic characteristics of workers such as sex, age, education, length of time in their current jobs and workers' personality characteristics including their expectations, motivations and coping strategies. The factors studied in relation to burnout have included a large number of workplace characteristics such as role ambiguity and conflict, workload, social support, lack of control, lack of reward, lack of community, lack of fairness and value conflict. A number of researchers attribute workplace characteristics for development of stress and burnout (Sabo, 2008; Aiken and Solane, 1997).

Burnout may be the result of unrelenting stress, but it is not the same as too much stress. Stress is a result of too much pressure that demands a lot of physical and psychological energy of a person. However, stressed people feel that they will feel better if they manage to control the situation (Smith and others, 2008). Burnout can be defined as the end result of stress experienced, but not properly coped with, resulting in exhaustion, irritation, ineffectiveness, inaction, discounting of self and others and problems of health (Pestonjee and Pareek, 1997). Burnout results when a person feels empty, lacks motivation and becomes indifferent to the situation at hand. People experiencing burnout frequently lose hope of positive change in their circumstances (Smith and others, 2008). If excessive stress is like drowning in responsibilities, burnout is being all dried up. Another difference between stress and burnout is that though usually one is aware of being under a lot of stress, he/she does not always notice burnout when it happens. Freudenberger (1974) explains that a characteristic of a burned-out individual is that they fail to acknowledge their problems and their own situation (Dierendonck, Schaufeli and Buunk, 1998).

In summation, NACO has classified all the above mentioned signs and symptoms of burnout into physical, emotional and behavioural indicators (NACO, 2006).

### **Physical Indicators**

- Frequently feeling drained and exhausted
- Often feeling sick or ill
- Lowered levels of immunity
- Developing headaches, muscle aches and back pain on a regular basis
- Noticing changes in eating or sleeping patterns

### **Emotional Indicators**

- Doubting one's self and one's capacity
- Feeling of failure
- A sense of being trapped, helpless and defeated
- A growing sense of being alone in the world and feeling detached from everything
- Lowered levels of motivation

- Developing an increasingly cynical and negative outlook to life and/or work
- Low levels of satisfaction and
- Feeling a lack of accomplishment with regard to work

### **Behavioural indicators**

- Not wanting to take on new responsibilities and an unwillingness to complete existing ones
- Alienating self from others
- Resorting to procrastination, requiring more time to accomplish tasks
- Increased dependence on food, alcohol or drugs as a crutch for coping
- Venting frustrations on others
- Irregular attendance at work

## **RESEARCH METHODOLOGY**

### **Statement of the Problem**

With large numbers of PLHA and the increasing circle of people affected with HIV, counsellors working in many of the testing centres seem to be over loaded with cases and faced emotional fatigue in addressing problems of PLHA.

### **Study Objectives**

The objectives of this research were as follows:

- i. Develop an understanding of the indicators of burnout as perceived by the counsellors and experts working in the field of HIV/AIDS.
- ii. Study and describe the prevalence and levels of burnout in counsellors working in the field of HIV/AIDS.
- iii. Identify strategies used by the counsellors to cope with burnout.
- iv. Understand the role of the hospital based supervisor in helping counsellors deal with burnout.

### **Research Design**

The researchers focused on understanding the issue from the perspectives of the counsellors in the city of Mumbai and hence followed an Exploratory design. Viewed in this perspective, the study explores the issue of burnout

among counsellors working in the HIV testing and counselling centres, namely, ICTC and ART, employing certain tools to obtain both qualitative and quantitative data. A mixed study enriches evaluation; the open ended comments provide a way to elaborate and contextualise statistical 'facts' (Patton, 2002).

### **Sampling**

This research was a census study as the entire population of counsellors working in the various centres of MDACS was covered. Initially, the data was collected from 10 key informants working in HIV testing centres. These 10 key informants were chosen by the non-probability purposive sampling method. The key informants were medical officers (n=3), assistant professors (n=1), the in-charge of the centre (n=1) and senior counsellors (n=5) having more than three years of experience in the field of HIV/AIDS. Out of these key informants, six were males and four were females. The data gathered from key informants provided a base to formulate the quantitative tool for the second stage of the study. A total of 113 counsellors were covered for the quantitative study. One of the ART centers with five counsellors was not covered due to difficulty in obtaining permission. The data was collected from 66 centres including health posts, maternity homes and major government hospitals located in Mumbai, which are categorised into six zones with a total of 113 counsellors working in ICTC and ART. Herein, the ICTC counselling centres were categorised as 'maternity homes', 'urban health posts' and 'hospital based'.

Maternity home centres provide a wide range of services and care for women during pregnancy and childbirth and for newborn infants. 'Urban Health Posts' are those centres located in the communities where immunisation, DOT services, HIV testing and other facilities are provided. The rest of the ICTCs were included in the hospital based ICTCs as they are located in the peripheral or medical colleges. ART centres are those where Anti Retroviral Treatment is provided to PLHA.

### **DATA COLLECTION AND ANALYSIS**

The data collection was done in two phases:

Phase one included interviewing 10 key informants using the semi structured interview guide. The interview method was chosen to explore the respondents' perceptions and expectations in depth (Boyce and Neale, 2006).



Phase two included administering of the interview schedule. It consisted of closed and open ended questions, focusing on personal profile, work profile, perception of the counsellors about the concept of burnout, assessment of their levels of burnout, its causes and its effects, coping strategies used by counsellors, role of person-in-charge of the centre (hospital based supervisors) in this issue, suggestions of the counsellors with regard to help that they would require from the authorities of the centres to deal with the burnout syndrome among them.

The following inventories were part of the interview schedule.

### **Maslach Burnout Inventory-Human Services Survey (MBI-HSS)**

To assess the level of burnout, MBI-HSS inventory was used. It is a standardised inventory to assess the level of burnout. Three versions of this inventory have been published: the Human Service Survey (HSS), Educator's Survey (ES) and General Survey (GS) (Soderfeldt, Soderfeldt and Warg, 1995). As the respondents for the study were counsellors working in the field of HIV/AIDS and were continuously dealing with clients and their related problems, the HSS was considered for use. This contains 22 job related statements which counsellors had to rate on a six point rating scale, that is, frequency of the feelings. The scoring keys for this inventory along with its cut off points and related interpretation were obtained with the inventory from the concerned author. This test assessed the level of burnout in three aspects—emotional exhaustion, depersonalisation and personal accomplishment. The reliability coefficients for these three scales were 0.86, 0.79 and 0.80, respectively (Kim Wan, 1991).

### **Brief COPE**

Carver's (1997) coping inventory was used to assess the coping strategies used by the counsellors. This inventory has 14 items: active coping, planning, self-distraction, denial, substance use, emotional support, instrumental support, behavioural disengagement, venting, positive reframing, humor, acceptance, religion, and self-blame.

Most of the qualitative data was collected through electronic recordings of the interviews with the key informants, and field notes made during the interactions with them. Two of such interviews were sent to one expert to check for consistency of the data exploration. The remaining interviews were carried out after receiving the expert's approval. Once the recordings were made into transcripts, the analysis process began. The researchers first

practiced open coding of the field notes and later transcribed than to find the themes. The data was then analysed around six broad themes, namely, understanding the concept, signs and symptoms, causes, effects, coping strategies of burnout and supervisory support. No electronic software was used to analyse this data.

The quantitative data from 113 schedules were keyed into the SPSS for analysis. It also enabled to identify measures of tendencies, and tested the significance with correlation and Chi Square tests.

### **SCOPE AND LIMITATIONS OF THE STUDY**

The qualitative data collected by in-depth interviews is limited to the key informants opinions and experiences. The quantitative study covers the universe of counsellors employed by MDACS and the findings can be generalised to the entire population of the counsellors employed by MDACS in Mumbai.

The nature and quality of the data shared by the counsellors may have certain limitations as some of the respondents were highly pressed for time to give interviews. The translation of the technical themes in the tools from English to Hindi and back again to English might have affected the quality of data, as respondents' interpretation of them could have been different despite the researchers' explanations. The stipulated period of study also restricted the possibility of a deeper exploration.

### **MAJOR FINDINGS**

#### **Key Informants Indepth Interviews**

The key informants acknowledge that most of the counsellors were aware of the burnout syndrome and its effects. They felt that most of the counsellors may not be really conscious of their vulnerability to the burnout syndrome due to personal and social factors. The common symptoms of burnout observed were anger, irritation, fatigue, disinterest and feeling of hopelessness. It was felt that the counsellors experienced low self esteem, depression, isolation and lived with the constant fear of contracting diseases. The causes of burnout identified were heavy workload, lack of adequate and comfortable infrastructure, low salary and its non availability in time, non recognition of counselling jobs among the medical fraternity and lack of team spirit. This has resulted in absenteeism from work, job related stigma, impact on counsellors' physical and mental health and absence of effective team coordination.

Only few counsellors would identify coping techniques such as meditation, reading, taking a break from work and hobbies. A strong need was felt for coordination between the MDACS counsellors and medical team in terms of tasks related to counselling and the work with individuals and groups. They expressed that the medical team at the hospitals should also undergo training with MDACS counsellors to understand their concerns and work processes.

## **Counsellors Interview**

### *Personal Profile*

The profile of the counsellors show that most counsellors (56 percent) engaged in the counselling job were males, with only a marginal difference in the mean ages of male (30.7 years) and female counsellors (29.7 years). Most counsellors (85.8 percent) had a Social Work education background and hailed from rural areas with permanent residences in rural Maharashtra, while the female counsellors hailed from urban areas.

### *Work Conditions*

Majority of the counsellors were from hospital based ICTCs and most of them (62 percent) counselled 11-20 patients every day. About 9 percent of them counselled—more than 40 clients in a day. The ART centre counsellors received 50–60 persons every day and they rated the workload as ‘manageable with great difficulty’. The maternity homes employed more male counsellors than female counsellors. The average work experience for the counsellors in the HIV field was three years.

Counsellors in hospital-based ICTCs or ART centres showed higher level of emotional exhaustion and de-personalisation, though not highly significant. Nearly 30 percent of the counsellors, mostly male, lacked adequate interest in the job. The dissatisfaction of salary was very high among most of the counsellors irrespective of their age and gender. Overtime work was less common in the centres despite large client load. Those who did overtime work ‘always’, mostly belonged to hospital based ICTCs and ART centres. Nearly 55 percent of the counsellors found the work manageable in spite of higher client loads. The difficulty in managing the work load was expressed mostly by counsellors from ‘hospital based’ ICTCs and ART centres. Dissatisfaction with regard to available infrastructure was expressed mostly by the counsellors from Urban Health Centres and the hospital based centres.

### ***Burnout Syndrome***

The term 'burnout' was familiar to almost all of the counsellors as they had learned about the term during training. On the MBI-HSS scale, most counsellors scored 'high burnout' in emotional exhaustion (61.1 percent) and de-personalisation (38.9 percent) and majority were at 'low level of burnout' in personal accomplishment (89.4 percent). Statistical analysis did not show any associations of burnout with the 'age' or 'gender' of the counsellor. However, emotional exhaustion was noticed more among male counsellors, while female counsellors suffered more from de-personalisation. Female counsellors were higher in 'personal achievement' than male ones. Also emotional exhaustion was observed to be more among the counsellors in the hospital based ICTCs and ART centres. Factors like extent of time given for hobbies, job interest and salary satisfaction had significant relationship with 'high burnout' in emotional exhaustion.

### ***Coping Strategies***

The strategies of coping commonly used by the counsellors to reduce their stress includes 'active coping' (75.2 percent), emotional support (57.5 percent), planning (76.1 percent), instrumental support (71.7 percent), acceptance (66.4 percent), religion (64.6 percent) and positive reframing (81.4 percent). Male counsellors used 'planning' as a strategy more than female counsellors. Even though very few indulged in substance use, almost all of them were men ( $p=0.000$ ,  $df=1$ ). Use of venting as a technique was prevalent more among the female counsellors as compared to males ( $p=0.031$ ,  $df=1$ ). Only eight percent of the counsellors felt that 'humor' was a 'very effective' strategy. Negative strategies like 'denial', 'self blaming' and 'behavioural disengagement' were used by a lesser number of counsellors. The effective coping strategies that could be considered by counsellors in future for coping include 'active coping' (67.3 percent), self distraction (85.9 percent), positive reframing (79.6 percent) and religion (73.4 percent).

### ***Support of Centre Based Supervisors***

Almost all the counsellors found their centre based seniors who supervised them to be very helpful and supportive. They expressed that their supervisors were closer to them and understood their concerns better. However, they were also helpless at times, as they did not come under the MDACS administration.

An overwhelming majority (93.8 percent) of the counsellors welcomed the idea of a 'counselling mentor' in the enhancement of their performance,

and they expressed the need for increasing the frequency of their visits from 'once a month' to 'once a week'. The major expectation from these mentors was to learn micro skills in counselling.

## **CONCLUSION**

This study presents various factors such as the counsellors' educational background, age, gender, type of centre and clients handled which influence the effective functioning of the counsellors. It is important for the counsellors to identify the symptoms of emotional exhaustion and not allow them to come in the way of their work. It is found that more counsellors are getting de-personalised with their clients, which will be a serious threat in empathising with the clients. The counsellors seem to be happy with their personal accomplishments, which helps them move out of burnout. It is thus important for intervening agencies to also create further platforms that would help acknowledge their personal accomplishments.

With regard to strategies used by counsellors in coping, there were a few who used negative strategies like 'self-blame', 'behavioural disengagement', 'denial', 'substance use' and 'self-distraction'. It is important to help the counsellors replace these coping strategies with positive ones such as 'active coping', 'emotional and instrumental support', 'venting', 'positive reframing', 'humour', 'planning' and 'religion'.

The proactive role of centre based supervisors and counselling mentors in helping the counsellors need to be considered both by the programme and at policy levels.

## **RECOMMENDATIONS**

### **Recommendations for Counsellors**

The counsellors who are social work graduates need to further develop their knowledge and skills related to the psychological needs of the PLHA. Even though the social work training curriculum does cover the basis in human behaviour, mental health and therapeutic counselling, these counsellors also need advanced knowledge on these subjects. Moreover, the knowledge level of counsellors on these subjects may not be at a comparable level as they come from different universities and institutions where there is lack of adequate standardisation and updating of social work curriculum. The hobby of reading professional literature is not very

prevalent among counsellors and has to be inculcated. Special orientation courses on counselling can also be organised. All this will also help mitigate ‘de-personalisation’ of the counsellor to some extent.

Since physical activity like sports, gym, nature trails/walks and other such experiences reduce the chances of burnout, the counsellors are encouraged to take up such hobbies regularly. The counsellors can take an active role in organising case conferences along with their peer team, which can enhance their knowledge and reduce stress levels. Such team activities can also increase their ‘personal achievement’ through recognition gained in the hospital settings.

### **Recommendations on Trainings planned for Counsellors**

On the basis of causes of burnout explored in the study, special attention can be given to refresher trainings, which cover topics related to time management, team work, skills of negotiation and dialogue with the administration for a win-win situation, self-healing methods and personal crisis management. Sessions on increasing the sensitivity of counsellors towards PLHA can enhance attitudes to empathise with PLHAs and thus, reduce their ‘emotional exhaustion’ and ‘de-personalisation’. Success stories and good practices of counsellors in micro skills, workload management, problem solving approach and team functioning can be documented and discussed during the trainings. This could help increase their ‘personal achievement’. More time needs to be allotted during trainings, especially refreshers, to address burnout syndrome. The training institutes should provide a comprehensive understanding of burnout. Aspects related to depersonalisation must be dealt with more intensely so that the counsellors will develop an attitude of empathy while dealing with their clients’ problems. Input on functional coping strategies should be further intensified and their use at the field can be monitored by supportive supervisors of *Saksham*.

### **Recommendations to NACO and SACS<sup>1</sup>**

It has been observed that unhealthy working conditions can reduce burnout among the employees. The following recommendations are proposed:

1. Formulate or review policies that can bring reasonable changes in the working conditions of the counsellors such as manageable workload per counsellor, job stability, career advancement and adequate infra-structural facilities.

2. Offer a competitive salary to attract more skilled counsellors living in the urban area itself.
3. Design programmes for counsellors and the hospital staff which can converge with their interests, for example, interactive sessions can enhance the team functioning and personal accomplishment levels.
4. Provide more attractive incentives for counsellors such as free medical check up, travel and medical allowances and leave.
5. Since the counsellors show a high level of interest in personal accomplishment, there is a need to identify innovative techniques to help channelise their potential by allowing them to participate in operational research studies, present papers in conferences, conduct sessions as trainers, and so on.

#### ENDNOTE

1. National AIDS Control Organisation (NACO), State AIDS Control Organisation (SACS)

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