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Original Research Article

Psychological distress and burnout among counsellors working in health information helplines

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ABSTRACT

Background: PSMRI has large numbers of health workforce working in health information helpline (HIHL) in India. Aiming to understand stress, burnout among counsellors working in HIHLs, India. The study aimed to understand the level of stress and linkages and how the health workforce can go through distress working in helplines.
Methods: Individual study interviews were conducted across six states. Socio-demographic details, medical history and lifestyle information, collected. General health questionnaire (GHQ-28) and Copenhagen burnout inventory (CBI)-tools.
Results: 16.9%- work-related burnout, 15.5%- client-related burnout and more than 1/4th (25.3%) had personal burnout. Level of psychological distress and burnout among counsellors working in helplines was high.
Conclusions: The study shows on how the counsellors working in the helplines go through psychological distress and burnout. It also leads to mechanisms that leads to the awareness of psychological distress faced by mental health professionals, and training for support was initiated to develop a mental health platform.

Keywords: Burnout, Counsellors, Healthcare, Helpline, Mental-health

INTRODUCTION

Healthcare professionals and human service professionals are observed to be at increased risk for stress related disorders. Service provided by human service professionals such as helpline counsellors requires voice-to-voice contact with the public to provide information and/or counselling. Professionals working in human service organizations have the mandate to protect, maintain, or enhance the personal well-being of individuals by defining, shaping or altering their personal attributes.[1] On a routine basis, these interactions could be stressful to the counsellors leading to a number of psychological and emotional problems among them.[2] A state of emotional suffering with symptoms of depression and anxiety is referred to as psychological distress.[3] Psychological distress can impact the social functioning and day-to-day living of individuals.[4] High burden of stress, anxiety and depression has been observed among various health workers such as nurses working in healthcare advice service, social workers in health care settings and even among call handlers working in call centres.[4-7] It is observed that abnormal sleep quality due to night shifts, lack of relaxation facilities contributes to stress and depression among call centre employees.[4] Prolonged stress can also lead to burnout. According to Maslach and Leiter "Burnout is a psychological syndrome

emerging as a prolonged response to chronic interpersonal stressors on the job".[8]

The affective perception that one's affective resources have been completely expended referred to as emotional exhaustion has been identified as the most important component in burnout. Human service professionals who experience burnout internalize the ideal image of their professional role at the cost of their own needs and take a long time to seek help.[9]

There have been studies from India on helplines and the services they provide, but there are limited studies on the mental health status of the counsellors working in these helplines. The present study intends to provide insights into mental health status and needs of the counsellors working in health information helplines. The findings of this study will help in developing intervention programs and strategies for counsellors to cope with their job roles and responsibilities more effectively and help in improving their health status.

With this background, we aimed to study the mental health issues particularly psychological distress and burnout among counsellors working in health information helplines.

Objectives

To assess the level of psychological distress and burnout among counsellors employed in health information helplines; and to study the relationship between psychological distress, burnout and medical illness among counsellors employed in health information helplines.

METHODS

The sample consisted of 41 counsellors working at National HIV/AIDS helpline and 30 counsellors providing mental health counselling through 104 health information helplines across a total of 8 states in India. All these helplines were managed by Piramal Swasthya Management and Research Institute. All counsellors working in the helplines were included in the study. Those who had less than three months' experience in the current position, were excluded from the study.

Study methods

The study was conducted in Piramal Swasthya Management and Research Institute. Counsellors working in 1097 National HIV/AIDS helpline and 104 health information helplines were invited to participate in the study. Informed consent was obtained from each counsellor after explaining the purpose of the study. The counsellors were then administered the socio-demographic and medical illness checklist followed by the general health questionnaire and then the Copenhagen burnout inventory. A pilot was undertaken with all the selected study tools with 10% of the total sample of the study. The pilot helped in preliminary testing of the study tools and the required modifications were made. The study design was cross-sectional study. Purposive sampling was used where all the counsellors were approached for the research study and selections were made accordingly who provided consent for the research study. The research was conducted from the time period of February 2018 to June 2018.

Study tools

A socio-demographics and medical illness checklist, developed for the purpose of this study was used to elicit background information, job profile of the counsellors, presence of any medical illnesses, substance abuse, physical activity levels and sleep quality. In addition, information about their previous occupation and their health status and changes after taking this job was recorded. The job profile included data on the number of hours of work per week, number of shifts, average number of calls handled per day. Anthropometric measurements (weight and height) were taken according to WHO standards.

The general health questionnaire is one of the most widely used questionnaires to detect psychological distress and vulnerability to psychiatric disorders in the general population within community or non-psychiatric clinical settings.[10,11] It assesses the respondent's current state and asks if that differs from his or her usual state. It is sensitive to short-term psychiatric disorders, can assess somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. It has well established reliability and validity and is widely used in Indian studies. It has a four-point scoring system, 0-0-1-1; total of all sub-scales scores provides information about the present mental health status. Cut-off of 5 was taken to identify at risk individuals experiencing psychological distress.

The Copenhagen burnout inventory is again one of the most widely used Burnout inventories used.[12] It consists of three scales measuring personal burnout, work-related burnout, and client-related burnout for use in different domains. All three sub-scales can be sub-totalled into a score of 0 to 100, with a higher score indicating a higher level of burnout. It has been used earlier for studies in India, with reliability of three scales ranging from 0.78 to 0.86.[13]

Data analysis

Data collected on a Microsoft excel spread sheet were exported into "R" software for statistical analysis.[14] Normality of the data was assessed using Shapiro-Wilk Test. Descriptive statistics were used for continuous variables and frequency and percentages for categorical variables. Independent samples 't' test or Chi-square test was used for calculating statistical differences between groups. Correlation was used for bivariate analysis.

RESULTS

The sample comprised of 71 counsellors with a mean age of 28.2±3.1 years. Forty-three of the counsellors were males (60.5%) while the remaining were females (39.5%). About 44% were living with their families while the rest lived alone or with friends (56%). The socio-demographic characteristics of the study sample are tabulated in Table 1.

Table 1: Socio-demographic details of the counsellors (n=71).

Characteristics	N (%)
Education status	
Graduate	3 (4.2)
Post-graduate	68 (95.8)
Academic background	
Social work	52 (73.2)
Psychology	13 (18.3)
Others (nursing, life sciences)	6 (8.5)
Marital status	
Unmarried	40 (56.3)
Married	29 (40.8)
Divorced/separated	2 (2.8)
Living with	
Family	31 (43.6)
Alone/PG/with friends	40 (56.4)

Mean years of experience of the counsellors in the current position was about 21±15 months with a range from 3 to 60 months. Overall, mean experience of the counsellors in the health sector was 35±29 months with a range from 3 to 180 months. Overall, mean work experience was found to be 47±29 months with a range from 3 to 180 months.

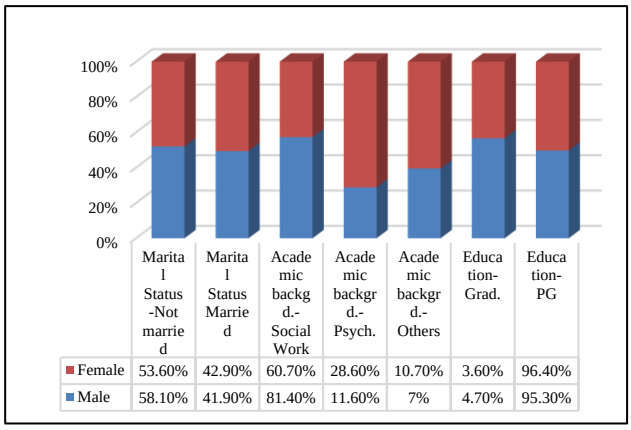

Figure 1: Socio-demographic details of the Counsellors segregated gender-wise.

Most common comorbidities reported by the counsellors include back, neck and shoulder pain (20; 28.2%) followed by frequent headaches (13; 18.3%) and digestive problems (9; 12.7%). None of them had diabetes or hypertension. More than 2/3rd of the counsellors were found to have a normal nutrition status (66.2%) while more than 1/4th of the counsellors were either overweight (22.6%) or obese (5.6%) (Figure 2).

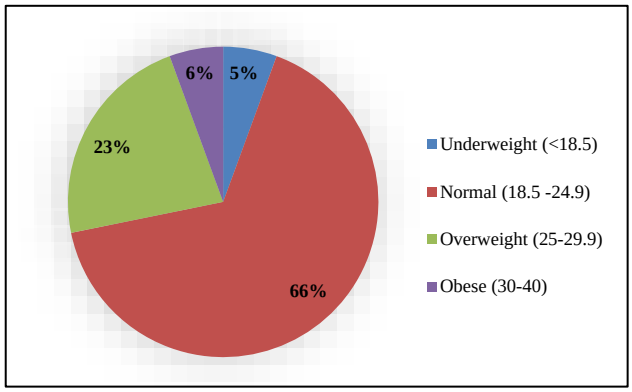

Figure 2: Pie-chart showing nutritional status of the counsellors.

Two people complained of insomnia (2.8%) while one person reported that she was diagnosed with probable depression (1.4%). Eight counsellors regularly used nicotine (11.3%) while four others used nicotine in the past (5.6%). Thirteen counsellors reported consuming alcohol once-a-month or less (18.3%) while four counsellors reported that they consumed alcohol 2-4 times a month (5.6%). The mean number of cups of caffeinated drinks consumed daily by the counsellors was found to be 1.8±1.4 (Range= 0-6). Only 26 counsellors reported that they were involved in moderate to vigorous physical activity (Figure 3).

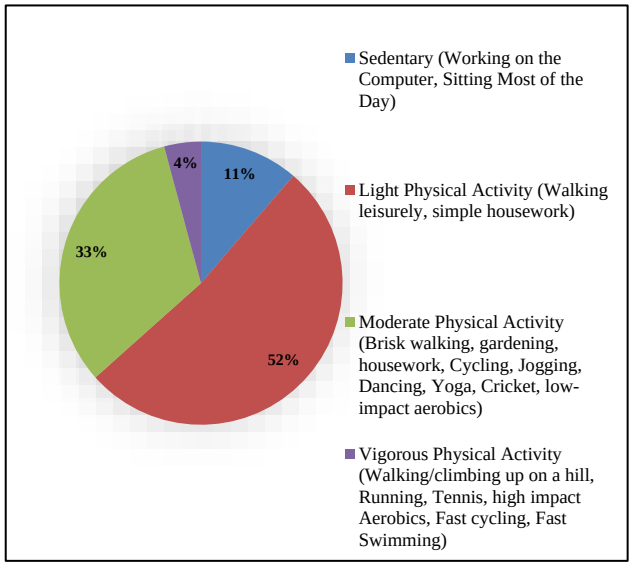

Figure 3: Physical activity by the counsellors,

As mentioned earlier, the general health questionnaire- 28 (GHQ 28) was used to detect psychological distress and vulnerability to psychiatric disorders among the counsellors. It was found that the counsellors were at

higher risk of psychological distress and psychiatric disorders in their current position as against their previous occupation and this difference was found to be statistically significant (Figure 4). However, when asked about their general health, a higher proportion of the counsellors (39.45%) reported that their health status in the current position had improved compared to their health status during their previous occupation while a similar proportion of the counsellors reported their health status had remained the same (39.45%). Just over a fifth of the counsellors reported that their general health status had worsened (21.1%) (Figure 5).

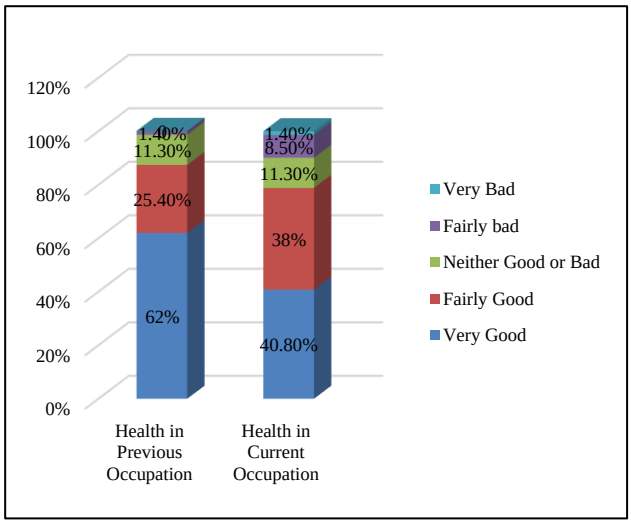

Figure 4: Graphical representation showing the findings of the general health questionnaire.

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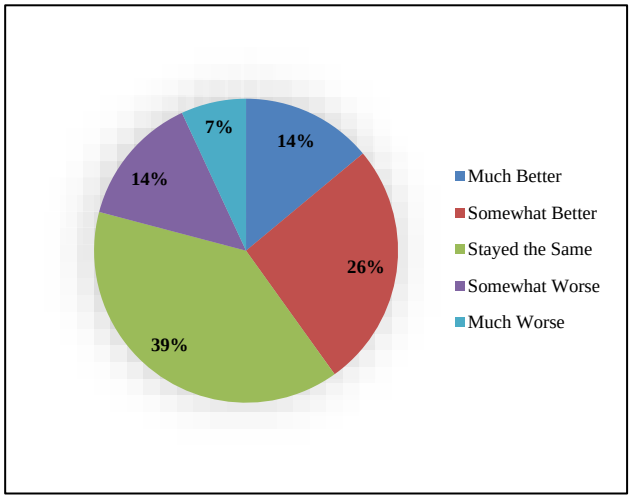

Figure 5: General health of the respondents.

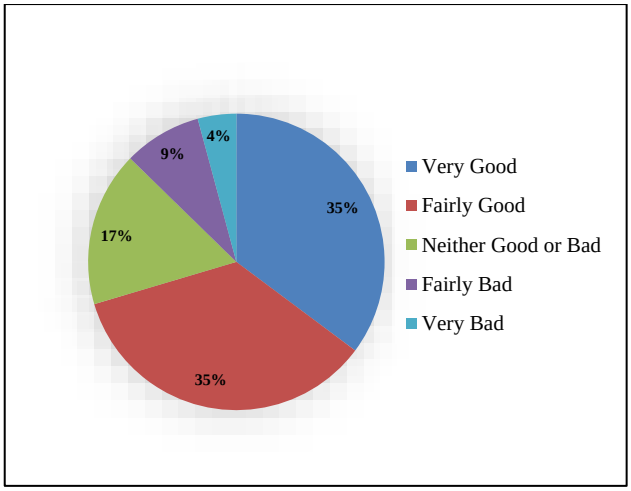

Figure 6: Quality of sleep of the counsellors.

Sleep is important to maintain the health of people in general and more so in the case of counsellors. More than one-fourth of the counsellors (26.8%) reported that they had trouble sleeping at night. In the previous month, four counsellors (5.6%) had difficulty falling asleep on more than five nights a week while nine counsellors (12.6%) had the same problem on at least 3-4 nights a week. Also, nine counsellors (12.6%) reported that they had fairly bad or very bad quality of sleep overall, during the past one month (Figure 6).

Burnout findings

As mentioned earlier, the Copenhagen burnout inventory was used to measure 'burnout' on three fronts namely personal burnout, work-related burnout and client-related burnout. A higher score indicates a higher level of burnout (Figure 7). All the scores above 100 show a higher level of burnout for different types of burnout. Therefore, the scores are exhibiting high level of burnout.

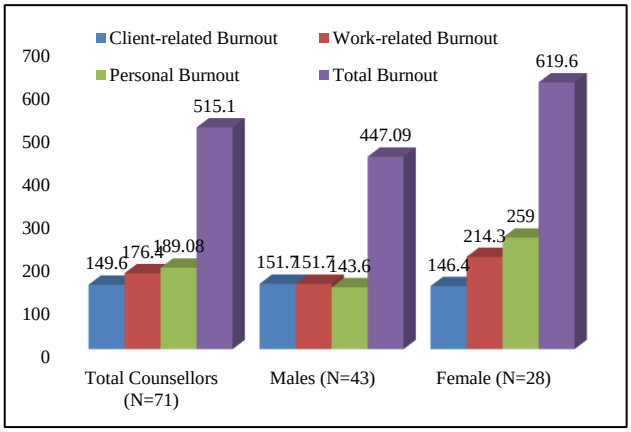

Figure 7: Copenhagen burnout inventory (CBI) scores for the counsellors according to total counsellors and gender-wise segregation.

We have tried to analyse the relationship between medical comorbidities, psychological distress and burnout for the counsellors (Table 2).

Burnout and psychological distress have a significant correlation value at 0.67 which was significant at 0.01 level of significance, showcasing the relationship between the level of psychological distress and burnout level for the counsellors at the health helplines. This shows that there is a significant impact on burnout by psychological distress and both are interrelated. Hence, they share a positive correlation. There could not be found a significant relationship of medical illness with psychological distress and burnout. This shows the results of our second part of our objective where we wanted to understand the relationship of medical illness, psychological distress and burnout. Except medical illness the other two variables did exhibit a positive correlation.

Table 2: Pearson correlation coefficients- medical illness, psychological distress and burnout for the counsellors.

		Medical illness	Burnout	Psychological distress
Medical illness	Pearson correlation	1	0.145	0.233
	Sig. (2-tailed)		0.227	0.050
	N	71	71	71
Burnout	Pearson correlation	0.145	1	0.675**
	Sig. (2-tailed)	0.227		0.000
	N	71	71	71
Psychological distress	Pearson correlation	0.233	0.675**	1
	Sig. (2-tailed)	0.050	0.000	
	N	71	71	71

**Correlation is significant at the 0.01 level (2-tailed).

DISCUSSION

The aim of the study was to understand psychological distress and burnout among counsellors in health information helplines. For studying this, the sample of 71 counsellors from 8 states in India were taken. These mental-health counsellors were working at National HIV/AIDs helpline and 104 Arogyavani helpline.

To further understand the other factors involved to impact psychological distress, other sub-fields were addressed. Therefore, a medical illness checklist and socio-demographic details were undertaken of the sample. Socio-demographic details as age, gender, education, academic background, marital status, their work experience, BMI and any further physical or mental health ailments were undertaken. The mean age of the counsellors was found to be 28.2±3.1 years. 60.5% were males and 40.8% were married. About 44% were living with family and remaining 56% were staying away from family in rented accommodation as paying guest alone or with friends. 73.2% were from social work background, followed by psychology background (18.3%). Mean years of experience in the current position was about 1.7 years (21 months) and total experience in health sector was about 2.9 years (35 months) among these counsellors.

As seen in Figure 1 that indicates the medical co-morbidities reported by the counsellors. The BMI was normal for 66.2% of the study participants while 22.6% were under Overweight category. Under medical ailments, 18.3% suffered from frequent headaches, 12.7% from frequent digestive problems while 28.2% from back, neck and shoulder pain complaints. The present mental health problems were for insomnia (2.8%) and probable depression (1.4%). Nicotine use was presently being done by 11.3% and in the past 5.6%. Alcohol usage never done was 76.1%, mostly usage was 76.1%, monthly usage was 18.3% and regularly 2-4 times a month was 5.6%. By understanding the demographics and lifestyle being followed by the counsellors we need to understand how it lays an impact on their mental health. As in the further discussions we understand about the impact of psychological distress and burnout. The quality of sleep also has an impact and has fund to predict fatigue, and poor psychosocial functioning while increasing pain.[5]

The physical activity and caffeine intake by the respondents have been shown in Figures 3 and 4. This shows that 11.3% of the counsellors followed sedentary lifestyle, 52% with light physical activity and only 4.2% went for rigorous physical activities. The caffeine intake on routinely basis was with a mean of 1.8.

Table five discusses the significant differences between the health at current position and previous occupation of the counsellors. The GHQ-28 showed significant differences between these groups at 0.004 value significant at 0.001 level of significance. Compared to the statements on general health at previous occupation for very good was 62% and at the current role was 40.8%. For fairly good at the previous occupation was 25.4% and at current work role was 38%. Though for fairly bad the previous occupation was 1.4% and for current role was 8.5%.

For the general health of the respondents 25.4% experienced somewhat better changes in the health status while 14% experienced somewhat worse changes in health status in current status at current position. The sleep intake responses by the respondents at Figure 7 showed 26.8% with troubles sleeping at night while for overall sleep disturbances shows the number of night shifts over sleep quality. The overall sleep quality was very good for 35.2% and fairly good for 35.2% and fairly bad for 8.5%. These all can have certain implications for psychological distress and burnout for the counsellors. The working in shifts, abnormal sleep patterns and continually addressing caller's concerns is challenging for the counsellors.

In understanding the psychological distress and burnout for counsellors at the helplines the Copenhagen burnout scores were discussed. Earlier the various disturbances at the physical and psychological level were laid to get a clear picture regarding their distress levels. Hence, the physical distress can cause psychological impact. The Copenhagen burnout inventory findings at Figure 7 giving total work-related burnout as 176.41, personal burnout at 189.08, client related burnout at 149.65 and total CBI burnout at 515.14 for all counsellors. The CBI mean scores for male for client-related burnout was 151.74, work-related was 151.74, personal burnout at 143.6 and total burnout at 447.09 has been given. The CBI mean scores of females for client-related burnout was 146.43, work-related was 214.29, personal burnout at 258.93 and total burnout was 619.69. The burnout amongst females was much higher for all burnout except for client-related burnout, where males score more compared to females.

In further analysis the relationship between psychological distress and burnout be determined through correlation can be seen in Table 2.

The CBI scores are higher in range for most of the counsellors in the health helplines, with the average mean score for all counsellors higher in range. The correlation lays an emphasis on understanding the relationship between psychological distress, burnout and medical illness among counsellors employed in health information helplines**.** The sample consisted of 71 counsellors working at National HIV/AIDS helpline and mental health counsellors providing counselling through 104 helplines across 8 states in India. As we can see there is a significant relationship between psychological distress and burnout. No significant correlation can be found between medical illness checklist and other variables at a significant level. The table shows that there is a positive relationship between psychological distress and burnout with 0.675** significant at 0.01 level of significance.

Limitations of this study are the sample was not large and in later researches larger sample can be used; variables as stress, emotional intelligence, interlink with psychiatric disorders could not be assessed with psychological distress and burnout.

CONCLUSION

The level of psychological distress and burnout among counsellors were found high in the health helpline counsellors. There are various factors leading to burnout that came into the consideration as working in shifts, abnormal sleep patterns and continually addressing caller's concerns is challenging. Counselling is a tedious mental task that requires lot of subjective understanding regarding the psyche of the mind. More supportive work environment and policies are essentially required, particularly for women as the personal and work-related burnout is higher among females. Hence, after the conduction of this study a psychologist specialising in clinical psychology was hired who started working on building the mental health platform, focusing on building supporting counsellors and healthcare workforce that helped to take this research further in the implementation on improving the mental health of counsellors. Work regarding this has started to support the psychological well-being of the counsellors. Hence, this research acts as a forerunner for the planning of mental health policies that will improve the mental health of health workforce.

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Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee at Piramal Swasthya, Hyderabad

REFERENCES

1. Wieclaw J, Agerbo E, Mortensen PB, Bonde JP. Risk of affective and stress related disorders among employees in human service professions. Occupat Environ Med. 2006;63(5):314-9.
2. Farquharson B, Allan J, Johnston D, Johnston M, Choudhary C, Jones M. Stress amongst nurses working in a healthcare telephone-advice service: Relationship with job satisfaction, intention to leave, sickness absence, and performance. J Adv Nurs. 2012;68(7):1624-35.
3. Drapeau A, Marchand A, Beaulieu-Prévost D. Epidemiology of psychological distress. Mental Illness Understand Predict Control. 2012;69:105-6.
4. Jeyapal DR, Bhasin SK, Kannan AT, Bhatia MS. Stress, anxiety, and depression among call handlers employed in international call centers in the national capital region of Delhi. Indian J Public Health. 2015;59(2):95.
5. Jeyapal DR, Bhasin SK, Kannan AT, Bhatia MS. Stress, anxiety, and depression among call handlers

employed in international call centers in the national capital region of Delhi. Indian J Public Health. 2015;59(2):95.
6. Lloyd C, King R, Chenoweth L. Social work, stress and burnout: A review. J Mental Health. 2002;11(3):255-65.
7. Machado T, Sathyanarayanan V, Bhola P, Kamath K. Psychological vulnerability, burnout, and coping among employees of a business process outsourcing organization. Indust Psychiatr J. 2013;22(1):26.
8. Maslach C, Leiter MP. Understanding the burnout experience: recent research and its implications for psychiatry. World Psychiatr. 2016;15(2):103-11.
9. Putnik K, de Jong A, Verdonk P. Road to help-seeking among (dedicated) human service professionals with burnout. Patient Educ Counsel. 2011;83(1):49-54.
10. Goldberg D, Williams P. A User's Guide to the General health Questionnaire. Windsor: NFER-Nelson; 1988.
11. Wancata J, Krautgartner M, Alexandrowicz R, Meise U. General Health Questionnaire (GHQ) in general hospitals: selecting a set of items using a stepwise hierarchical procedure. Int J Methods Psychiatr Res. 2001;10(2):108-17.
12. Kristensen TS, Borritz M, Villadsen E, Christensen KB. The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. Work Stress. 2005;19(3):192-207.
13. Gupta R, Bakhshi A, Einarsen S. Investigating workplace bullying in India: psychometric properties, validity, and cutoff scores of negative acts questionnaire–revised. Sage Open. 2017;7(2):2158244017715674.
14. Fox J. Getting started with the R commander: a basic-statistics graphical user interface to R. J Stat Softw. 2005;14(9):1-42.

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