# International Journal of
# Psychology and Counselling

Academic
Journals

# ABOUT IJPC

International Journal of Psychology and Counselling **(IJPC)** will be published monthly (one volume per year) by Academic Journals.

International Journal of Psychology and Counselling **(IJPC)** is an open access journal that provides rapid publication (monthly) of articles in all areas of the subject counter transference, Clinical psychology, Professional practice of behaviour analysis, Behavioural model etc.

The Journal welcomes the submission of manuscripts that meet the general criteria of significance and scientific excellence. Papers will be published shortly after acceptance. All articles published in IJPC are peer-reviewed.

**Contact Us**

# Editors

**Prof. Ahmed Awad Amin Mahmoud**
*Faculty of Education and Higher Education*
*An-Najah National University,*
*Nablus.*
*Palestine.*

**Dr. R. Joseph Ponniah**
*Department of Humanities (English)*
*National Institute of Technology*
*Trichirappalli, Tamil Nadu*
*India.*

**Dr. Kanwar Dinesh Singh**
*# 3, Cecil Quarters,*
*Chaura Maidan, Shimla:171004 HP*
*India.*

**Dr. S. D.  Sindkhedkar**
*Head, Department of English,*
*PSGVP Mandal's Arts, Science & Commerce College,*
*Shahada: 425409, (Dist. Nandurbar), (M.S.),*
*India.*

**Dr. Marta Manrique Gómez**
*Middlebury College*
*Department of Spanish and Portuguese*
*Warner Hall, H-15*
*Middlebury, VT 05753*
*USA.*

**Dr. Yanjiang Teng**
*801 Cherry Lane, APT201*
*East Lansing*
*Michigan State University*
*MI 48824*
*USA.*

**Prof. Radhakrishnan Nair**
*SCMS-COCHIN*
*Address Prathap Nagar, Muttom, Aluva-1*
*India.*

**Prof. Lianrui Yang**
*School of Foreign Languages, Ocean University of China*
*Address 23 Hongkong East Road, Qingdao,*
*Shandong Province, 266071 P*
*China.*

# Editorial Board

# International Journal of Psychology and Counselling

## Table of Contents:    Volume 7    Number 2   March 2015

## ARTICLES

### Research Articles

# International Journal of Psychology and Counselling

## ARTICLES

**Research Articles**

*Full Length Research Paper*

# Relationship between self-efficacy, task value, self-regulation strategies and active procrastination among pre-service teachers in colleges of education

**Ali Abdullahi Taura[1*], Maria Chong Abdullah[1], Samsilah Roslan[1] and Zoharah Omar[2]**

[1]Department of Foundations of Education, University Putra Malaysia; Jigawa State College of Education, Gumel, Nigeria.
[2]Department of Professional Development and Continuing Education, Universiti Putra Malaysia.

This study examined the relationship between self-efficacy, task value, self-regulation and active procrastination of pre-service teachers enrolled in the colleges of education in Northern-western Nigeria. Samples of the study consist of 426 (223 males, 203 females) pre-service teachers with a mean age of 22.12 years. A descriptive correlation research design was employed to address the research objectives. Two research instruments were utilized to obtain the research data. Active Procrastination Scale (APS) was used to assess respondents' level of procrastination, while the Motivated Strategies for Learning Questionnaire (MSLQ) was used to measure the level of their self-efficacy, task value beliefs, and self-regulation strategies. Pearson correlation and structural equation modelling (SEM) were performed to determine the relationship between the research variables. Findings indicated that all the variables of the study were significantly correlated. Furthermore, mediation analysis using SEM showed that there were indirect effects of self-efficacy and task value beliefs on active procrastination through self-regulation strategies as mediator. Recommendations in addition to the theoretical and practical implications of the study have been offered.

**Key words:** Procrastination, active procrastination, self-regulated learning, pre-service teachers.

## INTRODUCTION

Procrastination, a behaviour that involves postponing or delaying decisions or tasks that ought to be done to a later time, has attracted researchers' attention in the past few decades. It is characterized by voluntary delay in beginning or completing an intended course of action despite expecting to be worse off for the delay (Steel, 2007). Procrastination is a common practice among college and university students. Estimates show that 80 to 95% of college students are found to be procrastinating, with about 50% of them procrastinate consistently

and problematically (O'Brien, 2002; Onwuegbuzie, 2000; Steel, 2007). Research indicates that procrastination negatively affects progress as it limits the quality and quantity of students' work (Rakes and Dunn, 2010). It results in a number of negative consequences on students' academic performance and subjective wellbeing (Cao, 2012; Klingsieck et al., 2012).

As a result of its undesirable effect on students' academic achievement, procrastination has been extensively studied in academic realm. Research demonstrates that procrastination is associated with low levels of academic self-efficacy and self-esteem (Hannok, 2011; Wolters, 2003), lower task value beliefs (Gropel and Steel, 2008), fear of failure and perfectionism (Brownlow and Reasinger, 2000), and lower life satisfaction (Klingsieck et al., 2012). From self-regulated learning perspective (Pintrich, 2000; Zimmerman, 2008), procrastination is now viewed as the lack of self-regulated performance which involves cognitive, affective and behavioural components (Cao, 2012; Wolters, 2003). In this regard, Steel (2007) viewed procrastination as an embodiment of self-regulation failure. In spite of considerable efforts in describing its negative and harmful consequences, and curtailing this problem, the prevalence of procrastination appears to be increasing (Cao, 2012; Klassen et al., 2010).

From 1990s, some researchers considered alternative approach to procrastination research by investigating its beneficial and adaptive values (Ferrari, 1993). In line with this alternative perspective, Chu and Choi (2005) believed that not all procrastination behaviours are harmful or are precursors of negative consequences. In this regard, they identified 'positive' form of procrastination – active procrastination – which is characteristically different from traditional negative and passive procrastination. The purpose of the present study, therefore, was to examine self-regulation and motivational beliefs variables of self-efficacy and task value as predictors of active procrastination; and whether self-regulation plays mediating role in these relationships.

### *Self-efficacy*

Bandura (1986) defined self-efficacy as "people's judgements of their capability to organize and execute courses of action required in attaining designated types of performances" (p.391). Self-efficacy theory (Bandura, 1997) assumes that what one believe about their ability to learn and achieve success strongly influences one's task choice, level of effort, persistence, resilience, and subsequent performance. Research has shown that self-efficacy is a strong and consistent predictor of procrastination (Hen and Goroshit, 2014; Steel, 2007; Van Eerde, 2003). Hannok's (2011) study found significant inverse relationship between self-efficacy beliefs and procrastination. From positive or active procrastination perspective,

Chu and Choi's (2005) study established that active procrastinators, who see procrastination as a positive learning strategy, have higher levels of self-efficacy in comparison to passive procrastinators who view procrastination in a traditional negative way.

### *Task value*

Eccles and Wigfield (2002) considered task value as an incentive for engaging in different task. That is, individuals' beliefs about the value and importance of the task determine why they engage in such task. Pintrich et al. (1991) defined task value as the student's evaluation of how interesting, how important, and how useful the task is. It relates to asking oneself "*What do I think of this task*?" In academic realm, for instance, task interest connotes students' personal interest or liking of the course material. Task utility refers to students' perception of how useful the course material is to them. Task importance involves students' beliefs about how significant the course content is for them and their future goals. For some students, according to Sokolowska (2009), procrastination may reflect lower task value – decreased interest and limited priority placed on a particular task and its final outcome. Specifically, "procrastination is particularly susceptible to how aversive, especially boring, we find tasks" (Gropel and Steel, 2008, p.407). That is to say, the more unpleasant is a task, the more likely one will put it off. The findings of Sokolowska (2009) study revealed that task-value affects motivational outcomes such as choice and/or level of intensity of a particular task.

### *Self-regulation*

Zimmerman (2008) regarded self-regulation as self-generated thoughts, feelings, and behaviours that are oriented toward the attainment of personal objectives. From academic realm, self-regulation involves the degree to which students are metacognitively, motivationally, and behaviourally active participants in their own learning process (Zimmerman, 2008). This is further enunciated by Pintrich (2004) in which self-regulation is referred to students' monitoring, controlling, and regulating their own cognitive activities and actual behaviour. From self-regulated learning perspective (Pintrich, 2000), self-regulatory activities serve as mediators between personal and contextual characteristics and actual achievement or performance. Wolters (2003) opined that deficits in self-regulatory behaviours, such as cognitive strategy use and monitoring important aspects of learning, result in an avoidance of tasks. Thus, students' motivation and the extent to which they engage in procrastination behaviour were also significantly related with their learning strategies (Pintrich, 2000; Zimmerman, 2008). Research

indicates that students who tend to procrastinate were found to be not able to effectively manage their learning (Ferrari, 2001) by being unable to select and use effective strategies that required effort and time to develop (Howell and Watson, 2007; Steel, 2007; Wolters, 2003). Hence, they experience low academic achievement (Onwuegbuzie, 2000).

### *Active procrastination*

Introducing a new idea into the area of procrastination research, Chu and Choi (2005) address the possibility that not all procrastination behaviours have negative consequences.They conceptualized and distinguished two different types of procrastination: active and passive procrastination. Active procrastinators are type of procrastinators who use their strong motivation under time pressure to make intentional decision to procrastinate, to be able to complete tasks before deadlines, and achieve satisfactory results (Chu and Moran, 2009). In contrast, passive procrastinators are procrastinators in traditional way, who postpone tasks that ought to be done until the last minute because of the inability to act in a timely manner.Chu and Choi (2005) assumed that active procrastinators differ from passive procrastinators in cognitive, affective, and behavioural dimensions. In essence, active procrastination is a positive kind of procrastination that results in satisfactory or desirable outcomes, as against passive procrastination described in the traditional sense. Choi and Moran (2009) asserted that active procrastination is characterized by individual's affective preference for time pressure, cognitive decision to procrastinate, behavioural capacity to meet deadlines, and ability to achieve satisfactory results. Chu and Choi (2005) suggested that active procrastinators actually possess behaviours that correlate positively with self-efficacy and personal outcomes such as life satisfaction and higher grade point average (GPA). Research shows that passive and active procrastinators differ from each other in their degree of purposive use of time and perceived time control, self-efficacy, task value, test anxiety, GPA, and in level of self-regulation skills such as, elaboration, organization, time management, and effort regulation (Chu and Choi, 2005; Corkin et al., 2011; Shin and Goh, 2011). For instance, Seo's (2013) study shows that external regulation, on the one hand, was found to be a significant positive predictor of passive procrastination; on the other hand, it was significantly and negatively predicts active procrastination.

### **The present study**

The present study examines self-regulation, self-efficacy, and task value in relation to active procrastination from self-regulated learning perspective. Based on the previous research findings, this study hypothesized that self-efficacy, task value, and self-regulation would be positively related to active procrastination. Again, since most of the models of self-regulated learning assumed that self-regulatory activities are mediators in the relationships between personal and contextual characteristics and actual achievement or performance (Pintrich, 2000), this study hypothesized that self-regulation would mediate the relationships between self-efficacy, task value and active procrastination. Therefore, the study aimed to attain three objectives. First, is to determine the level of all the variables involved among pre-service teachers in colleges of education in North-Western Nigeria; second, to establish the relationship between self-efficacy, task value, self-regulation strategies and active procrastination; and third, to determine the mediating effect of self-regulation strategies on the relationship between self-efficacy, task value and active procrastination.

### METHOD

### *Participants*

Four hundred and twenty-six pre-service teachers from three colleges of education in North-western Nigeria participated in the study. The respondents included 223 males (52.3%) and 203 females (47.7%). Their ages ranged from 19 to 33 (*M*=22.12, SD=2.67).

### *Sampling procedure*

A multi-stage cluster sampling was used to select the sample for this study. In the first stage, from the existing twelve colleges of education in the North-west zone of Nigeria, three colleges were randomly selected from which the sample was drawn. Thus, the three colleges were randomly selected by the use of drawing number from a hat. The second stage involved proportionate random sampling from which participants for the study were also randomly selected with the help of table of random numbers.

### *Measures*

Motivated Strategies for Learning Questionnaire (MSLQ; Pintrich et al., 1991) was used to measure the participants' levels of self-efficacy, task value and self-regulation. It is a self-report instrument designed to assess college students' motivational orientations and their use of different learning strategies for a college course (Pintrich et al., 1993). All items are scored on a 4-point Likert type scale, from 1 ("Strongly Disagree") to 4 ("Strongly Agree"), which was a slight modification of the original scale.

   The 8-item self-efficacy scale, a component of the MSLQ, was used to assess participants' levels of self-efficacy. Example of the items includes "I am confident I can understand the most complex material presented in this course''. The reported coefficient alpha reliability of the scale is .93. The alpha reliability for the self-efficacy scale for this sample is .81.

   Likewise, the 6-item task value scale of the MSLQ was employed to measure the respondents' level of task value. Sample items for this scale include "I think I will be able  to  use  what  I learn in this

course in other courses". The coefficient alpha reliability of the scale is reported at .90, while the alpha reliability of the task value scale for this sample is .80.

Furthermore, the self-regulation level of the participants for this study was measured by the use of the items from metacognitive, time management and effort regulation subscales of the MSLQ. Thus, the self-regulation scale used for this study consists of 22 items some of which include "When I study for course, I set goals for myself in order to direct my activities in each study period" (Metacognitive); "I make good use of my study time for courses" (Time Management); and "Even when course materials are dull and uninteresting, I manage to keep working until I finish" (Effort Regulation). For this sample, the Cronbach's alpha reliability estimate for self-regulation scale is .83.

Choi and Moran's (2009) Active Procrastination Scale was used to assess the participants' level of active procrastination. It is a 16-item scale designed to measure four defining characteristics of active procrastinators. These four dimensions are outcome satisfaction (e.g., "I don't do well if I have to rush through a task" [Reversed]), preference for pressure (e.g., "It's really a pain for me to work under upcoming deadlines" [Reversed]), intentional decision to procrastinate (e.g., "I intentionally put off work to maximize my motivation"), ability to meet deadlines (e.g., "I often fail to accomplish goals that I set for myself"[ Reversed]). All the items were scored on 4-point Likert type scale, from 1 ("Strongly Disagree") to 4 ("Strongly Agree"). Composite measure of these four subscales was used to assess the overall level of the tendency of individuals towards active procrastination. The reported reliability coefficient of the scale is .80; and in this study the reliability was .77.

## RESULTS

This study was carried out to examine relationships between self-efficacy, task value, self-regulation and active procrastination; and looked into the mediating role of self-regulation in the relationship between the predictors and the outcome variables. In doing this, structural equation modelling (SEM) using Analysis of Moment Structure (AMOS) software was used. The use of inferential statistics requires that certain assumptions, such as assessment of normality, must be met. Structural equation modelling, as other statistical procedures, assumes multivariate normality (Byrne, 2010). The assumption of normality was assessed by examining the values of skewness and kurtosis in the distribution of scores of the major variables (Field, 2009). Byrne (2010) observed that since SEM is based on the analysis of covariance structures, evidence of kurtosis is always of interest. Byrne further suggests that values equal to or greater than 7 to be indicative of early departure from normality; and Kline (2005) offered that skewness value of less than 3 is acceptable. Therefore, the values of skewness and kurtosis for the variables of this study were checked and they are found to be within the acceptable range.

To address the first objective, the mean scores of the respondents' levels on the variable involved in the study have been analyzed and presented. According to Table 1, frequency distribution of the respondents' levels on

active procrastination shows that 1.2 or 5% of the respondents were at the low level, 264 or 62.0% were in the moderate level, and 157 (36.9%) respondents were found to be at the high level. This, therefore, shows that majority of the respondents for this study were at the moderate level of active procrastination ($M$ = 49.18, SD = 8.76). Likewise the respondents' levels on self-efficacy indicate that 28 or 6.6% of the respondents were at low level, 182 (42.7%) were in moderate category, and 216 (50.7%), in high level. This indicates that majority of the respondents were at the high level of self-efficacy ($M$ = 26.09, SD = 3.85). For task value, the distribution shows that 9 (2.1%) of the respondents were at the low level, 150 (35.2%), at moderate level, and 267 (62.7%), at high level. Thus, it indicates that majority of the respondents were at high level of task value ($M$ = 21.00, SD = 3.22). Lastly, distribution of the respondents' levels on self-regulation strategies revealed that 44 (10.3%) were at low category, 165 (38.7%) were at moderate level, while, 217 (51.0%) respondents were in the high level. The analysis further shows that majority of the respondents were in the high level of self-regulation strategies (M = 73.33, SD = 11.18).

To attain the second objective, that is to establish the relationship between self-efficacy, task value, self-regulation strategies and active procrastination, correlation analysis was conducted. Based on the analysis, as Table 2 indicates, active procrastination scores were significantly associated with self-efficacy ($r$ = .17), task value ($r$ = .16), and self-regulation ($r$ = .38). Furthermore, self-regulation was found to be significantly and positively related to both self-efficacy and task value ($r$ = .59 and .55 respectively), and the correlation between task value and self-efficacy was significant and positive ($r$ = .48).

To examine whether self-regulation mediates the relationships between the predictor and the outcome variables, as the third objective of the study, SEM using AMOS programme was employed. SEM was selected for its ability to simultaneously estimate multiple dependence relationships (Hair et al., 2010). The overall structural model provided a good model fit with fit indices in an acceptable range: $\chi^2$= 322.926; DF= 164; $\chi^2$/DF= 1.969; GFI = .93; CFI = .96; NFI = .93; and RMSEA = .05.Thus, the mediation analysis focused on the estimation and interpretation of the indirect effects as well as the inferential tests to determine the significance of the effect.

The standardized regression weights for the indirect effects are presented in Table 3. The estimate, as indicated by the standardized regression weight, shows that there is significant effect of self-efficacy on self-regulation ($\beta$ = .252, $p$ < .05); and that self-regulation, in turn, significantly affects active procrastination ($\beta$ = .370, $p$< .05). Also, task value is shown to be indirectly related to active procrastination through self-regulation. The standardized regression weight shows that the causal paths between task value and self-regulation ($\beta$ = .180,

**Table 1.** Distribution of the respondents' levels and mean score for the variable of the study.

|  | Frequency | Percentage (%) | Mean Score | Std. Deviation |
|---|---|---|---|---|
| Active Procrastination |  |  | 49.18 | 8.76 |
| Low (20.00-34.66) | 5 | 1.20 |  |  |
| Moderate (34.67-49.32) | 264 | 62.00 |  |  |
| High (49.33-64.00) | 157 | 36.80 |  |  |
|  |  |  |  |  |
| Self-Efficacy |  |  | 26.09 | 3.85 |
| Low (14.00-20.00) | 28 | 6.60 |  |  |
| Moderate (20.01-26.00) | 182 | 42.70 |  |  |
| High (26.01-32.00) | 216 | 50.70 |  |  |
|  |  |  |  |  |
| Task Value |  |  | 21.00 | 3.22 |
| Low (10.00-14.66) | 9 | 2.10 |  |  |
| Moderate (14.67-19.32) | 150 | 35.20 |  |  |
| High (19.33-24.00) | 267 | 62.70 |  |  |
|  |  |  |  |  |
| Self-Regulation Strategies |  |  | 73.33 | 11.18 |
| Low (41.00-56.66) | 44 | 10.30 |  |  |
| Moderate (56.67-72.33) | 165 | 38.70 |  |  |
| High (72.33-88.00) | 217 | 51.00 |  |  |

**Table 2.** Correlations among the variables of the study.

| Variables | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| 1. Self-efficacy | 1 |  |  |  |
| 2. Task value | .48*** | 1 |  |  |
| 3.Self-regulation | .59*** | .55*** | 1 |  |
| 4.Active procrastination | .17** | .16** | .38*** | 1 |

Note. ***$p <$ .001, **$p <$ .01.

**Table 3.** Standardized regression weights for the indirect effects.

| Structural path | β *a*-path | β *b*-path |
|---|---|---|
| Self-Regulation <---- Self-Efficacy | .252* |  |
| Self-Regulation <---- Task Value | .180* |  |
| Active Procrastination <---- Self-Regulation |  | .370* |

Note: *$p <$ .05.

$p <$ .05) and between self-regulation and active procrastination (β = .370, $p <$ .05) are significant.

**DISCUSSION**

This study investigated the relationships between self-efficacy, task value, and self-regulation on active procrastination among pre-service teachers in colleges of education, and tried to look into the mediating role of self-regulation in these relationships. Based on the findings, the correlation analysis of the predictor variables and the outcome variable, as presented in Table 1, shows that self-efficacy and active procrastination were significantly correlated. These findings were in line with Chu and Choi's (2005) study which found significant positive relationship between self-efficacy and active procrastination. In addition, Cao (2012) found that active procrastination positively predicts educational psychology self-efficacy. However, Gendron's (2011) study found no significant relationship between self-efficacy for learning and performance and active procrastination. Furthermore, the results of this study indicate that the correlation between task value and active procrastination was found to be significant. This result contradicts the findings of Cao (2012) study that task value was not found to be related to active procrastination. While making comparison, active procrastinators reported a significantly lower level of task value than non-procrastinators; furthermore, Cao (2012) found no significant difference in task value between active and passive procrastinators. In contrast, the results of this study were in harmony with the findings of Anderson (2001), Sokolowska (2009), and Steel (2007) that task value is significantly related to academic procrastination; however, active procrastination was not found to be related to task value.

Moreover, self-regulation was found to be significantly correlated with active procrastination. This is in line with the observation of many studies that self-regulation is an important variable associated with academic procrastina-

tion (Klassen et al., 2008). Steel (2007) further described procrastination as a "quintessential self-regulation failure" (p.65). Again, the findings were in line with the claim that deficits in self-regulatory behaviours, such as cognitive strategy use and monitoring important aspects of learning, result in an avoidance of tasks (Wolters, 2003). Thus, students' motivation and the extent to which they engage in procrastination behaviour were also significantly related with their learning strategies (Pintrich, 2000; Zimmerman, 2008). However, Gendron's (2011) study did not find significant relationship between the global score of active procrastination and measures of self-regulated learning.

In addition, based on the self-regulated learning (SRL) perspective (Pintrich, 2000; Zimmerman, 2008), the hypothesized indirect relationships of the independent and dependent variables through self-regulation have been tested.The result revealed that self-regulation, as mediator, plays a significant role in the hypothesized indirect relationships between self-efficacy, task value and active procrastination. This also supported by the fact that the two predictor variables explained 42% of the variance in self-regulation, which in turn, explained 15% of the variance in active procrastination.Thus, the findings of this study lend some support to the Steel's (2007) assertion that procrastination is essentially a failure in self-regulation.

## CONCLUSION AND IMPLICATIONS

Based on the findings of the present study, the conclusion is that procrastination is essentially a failure in self-regulation (Steel, 2007); and that the results lend a strong support to the theory of self-regulated learning which assumed that "self-regulatory activities are mediators between personal and contextual characteristics and actual achievement or performance" (Pintrich, 2000, p. 453). As the findings established the mediating effect of self-regulation in the relationship between the independent variables and active procrastination, this underscores the importance of self-regulation in procrastination research. One significant theoretical implications of this study is the shift in the procrastination research focus by viewing procrastination as a failure in self-regulation which involves cognitive, affective and behavioural components. From practical point of view, if any intervention is to be conducted in order to improve students' active procrastination for better performance and achievement, self-regulation strategies should be given prior attention or to be included in the intervention. This is especially important for School Counsellors and Lecturers to pay more attention to students' effective use of self-regulation strategies in their academic engagements. In addition, as procrastination may continue to be prevalent among students, at least for now (Cao, 2012), any intervention should be geared towards making

students to be 'positive' procrastinators rather than just being procrastinators. Finally, to fully explore procrastination and its underpinnings future research that will include other aspects of it is needed.

## Conflict of Interests

The author has not declared any conflict of interest.

### REFERENCES

Anderson  EM (2001). The relationships among task characteristics, self-regulation and procrastination. *Unpublished doctoral dissertation*, Loyola University of Chicago, Illinois.
Bandura A(1997). *Self-efficacy: The exercise of control.* New York: W.H. Freeman and Company.
Bandura A(1986). *Social foundations of thought and action: A social cognitive theory.* Englewood Cliffs, NJ: Prentice-Hall.
Brownlow  S, Reasinger RD(2000). Putting off until tomorrow what is better done today: Academic procrastination as a function of motivation toward college work. *J. Soc. Behavior Personality, 15*, 15-34.
Byrne BM (2010). *Structural equation modeling with AMOS: Basic concepts, applications, and programming* (2nd Ed). New York: Routledge.
Cao L (2012). Examining 'active' procrastination from a self-regulated learning perspective.*Educational Psychology, 32* (4), 515-545.
Choi JN,Moran SV(2009). Why not procrastinate? Development and validation of a new active procrastination scale. *J. Soc. Psycho., 149,* 195-211.
Chu  AHC, Choi JN (2005). Rethinking procrastination: Positive effects of "active" procrastination behavior on attitudes and performance. *J. Soc. Psychol*, 145: 245–264.
Corkin DM, Yu SL, Lindt SF(2011). Comparing active delay and procrastination from a self-regulated learning perspective.*Learning and Individual Differences, 21*(5): 602-606.
Eccles JS, Wigfield A (2002).Motivational beliefs, values, and goals. *Annu. Rev. Psychol.* 53(1), 109-132.
Ferrari  JR (2001). Procrastination as self-regulation failure of performance: Effects of cognitive load, selfawareness, and time limits on "working best under pressure." *Euro. J. Personality, 15*, 391-406.
Ferrari JR(1993). Christmas and procrastination: Explaining lack of diligence at a "real-world" task deadline. *Personality and Individual Differences, 14,* 25–33.
Gendron  A L (2011). Active procrastination, self-regulated learning and academic achievement in university undergraduates.*Unpublished Master's Thesis*, University of Victoria.
Gropel ., Steel P (2008).A mega-trial investigation of goal setting, interest enhancement, and energy on procrastination.*Personality and Individual Differences*, 45, 406-411.
Hannok  W (2011). Procrastination and motivation beliefs of adolescents: A cross-cultural study. *Unpublished PhD Dissertation*, University of Alberta.
Hen M, Goroshit M (2014). Academic procrastination, emotional intelligence, academic self-efficacy, and GPA: A comparison between students with and without learning disabilities. *J. Learning Disabilities*, 47(2), 116-124.
Howell A., Watson DC (2007). Procrastination: Associations with achievement goal orientation and learning strategies. *Personality and Individual Differences*, 43, 167-178.
Klassen RM, Ang RP, Chong WH, Krawchuk LL, Huan VS, Wong  IYF, Yeo, LS. (2010). Academic procrastination in two settings: Motivation correlates, behavioural patterns, and negative impact of procrastination in Canada and Singapore. *Applied Psychology: An International Review*, 59(3): 361-679.
Klassen RM, Krawchuk LL, Rajani S (2008). Academic procrastination of undergraduates: Low self-efficacy to self-regulate predicts higher

levels of procrastination. *Contemporary Educational Psychology, 33:* 915-931.

Kline RB(2005). Principles and practice of structural equation modeling Guilford. *New York*, 366.

Klingsieck KB, Fries S, Horz C, Hofer M(2012). Procrastination in a distance university setting. *Distance Education*, *33*(3): 295-310.

Rakes GC, Dunn KE (2010).The impact of online graduate students' motivation and self-regulation on academic procrastination.*Journal of Interactive Online Learning*, 9(1): 78-93.

O'Brien WK (2002). *Applying the transtheoretical model to academic procrastination.*Unpublished doctoral dissertation, University of Houston.

Onwuegbuzie AJ(2000). Academic procrastinators and perfectionistic tendencies among graduate students. *J. Soc. Behavior Personality, 15:* 103-109.

Pintrich PR (2004). A conceptual framework for assessing motivation and self-regulated learning in college students. *Educ. Psychol. Rev.* 16(4): 385-407.

Pintrich PR (2000). Multiple goals, multiple pathways: The role of goal orientation in learning and achievement. *J. Educ. Psychol.* 92: 544-555.

Pintrich PR, Smith DAF, Garcia T, McKeachie WJ (1993). Reliability and predictive validity of the motivated strategies for learning questionnaire (MSLQ*). Educational and Psychological Measurement*, 53, 801–813.

Pintrich PR, Smith DAF, Garcia T, McKeachie WJ (1991). *A manual for the use of the motivated strategies for learning questionnaire (MSLQ).*The Regents, University of Michigan.

Seo EH (2013). A comparison of active and passive procrastination in relation to academic motivation.*Social Behavior and Personality*, 41(5): 777-786.

Shin EJ,Goh JK (2011).The relations between active-passive procrastination behaviour and self-regulated learning strategies.*Korean J. Educ. Sci.*, 42: 25-47.

Sokolowska J (2009). Behavioural, cognitive, affective, and motivational dimensions of academic procrastination among community college students: A Q methodology approach. *Unpublished PhD Dissertation*, Fordham University, N.Y.

Steel P (2007). The nature of procrastination: A meta-analytic and theoretical review of quintessential self-regulatory failure. *Psychological Bulletin*, 133: 65–94.

Van Eerde W (2003).A meta-analytically derived nomological network of procrastination. *Personality and Individual Differences, 35:* 1401–1418.

Wolters CA (2003). Understanding procrastination from a self-regulated learning perspective. *J. Educ. Psychol*, 95: 179–187.

Zimmerman BJ(2008). Investigating self-regulation and motivation: Historical background, methodological developments, and future prospects. *American Educ. Res. J.* 45(1): 166-183.

*Full Length Research Paper*

# Perceived psycho-social and school factors contributing to malpractices in internal examinations among secondary school students in Kakamega-Central Sub-county: Implications for counseling

**Patricia Naliaka[1]\*, Peter Odera[2], and Moses Poipoi[2]**

[1]Department of Agriculture, Sang'alo Institute of Science and Technology, P.O. Box 158-50200, Bungoma, Kenya.
[2]Department of Education Psychology, MasindeMuliro University of Science and Technology, P.O. Box 190-50100, Kakamega, Kenya.

Examination malpracticeis rated as one of the greatest problems that undermine the foundation of educational practicein Kenya today. The magnitude of the problem and the dangers posed bythe phenomenon have been identified by stakeholders as national malady that requires drastic solution. Thus, this study attempted to investigate the view of students about the psycho-social and school causes of and roles of guidance and counselling in addressing the malpractices in internal examination in Kakamega Central Sub-county. A total of three hundred and fifty nine students were randomly sampled from twelve schools selected at random for the study. Data were collected using researcher developed questionnaires. Four research questions were raised and answered using frequency counts, simple percentage and means scores. However, results indicated that poor study habits, laziness, lack of self confidence, family pressure to excel and host of others were considered by students as the major psycho-social causes ofexamination malpractice. Inadequate preparation for examination,poor teaching, overcrowded exam rooms and poor invigilation were considered by respondents as the causes of examination malpractice. On the roles of the school guidance and counselling units most of the respondents indicated that the G&C unit exists and talks to them about self esteem, peer pressue management, self confidence and that exam cheating is wrong. However, most of them did not agree that G&C can assist students involved in exam cheating to change. The psycho-social factors are the predisposing factors to exam malpractices while the school factors are the environmental causes. Most schools have active guidance and counselling units. However, these units do not seem to be effective in addressing the problems of malpractices in internal examinations in secondary schools. Based on these findings, it was recommended that students and teachers should be given enlightenment campaign that will highlight the consequences of examination malpractice. Also, government should sensitize all citizens to basic ethical values of selfworth, dignity of labour, integrity and personal responsibility. Professional guidance counselors should be employed and posted to secondary schools to help students in self understanding and self management as well as the development of effective study habits in relation to how they can utilize their assets and manage their abilities for optimal development. Further, all schools should be adequately equipped and staffed to address issues of overcrowding and poor invigilation.

**Key words:** Examination malpractice, secondary schools students, counselling.

## INTRODUCTION

Evaluation in the education process provides the means of finding out whether educational objectives are being attained (Wheeler, 1997). According to Nevo (1995) evaluation in education has also come to be viewed by different scholars as: providing information for decision makers; the systematic investigation of the worth or Merit of some object and an act of collecting systematic information regarding the nature and quality of educational objects. Evaluation should therefore be carefully designed and undertaken in a manner that it ensures fairness and objectivity on the outcome of the process. Examinations are a form of evaluation that would be internal or external. Internal examinations are set by teachers in form of tests, reports, and end term examinations. Public or external examinations on the other hand are conducted in public interest by Kenya National Examination Council (KNEC). The outcome of the examination is used as a basis for decision-making on the examinee's ability (Fasasi, 2006). The examinee is consequently promoted to another level or awarded a certificate which could qualify him for admission into a school, promotion into higher level of an institution or offered employment opportunities. However, many decisions, which emanate from examinations may not be valid due to involvement of examinees in malpractices (Oniye and Alawaye, 2008). Malpractice occurs in both internal and external assessment of educational outcome.

The World Bank Group (2002) defined malpractices in public examinations as a deliberate act of wrong doing contrary to official examination rules that are designed to place a candidate at an unfair advantage. It is a problem which has been afflicting the education system for many years (Oniye and Alawaye, 2008). It seems to have defied solutions, as all antidotes applied so far have been faulted by fraudsters.

It is evident that a lot has been documented in Kenya on examination malpractices especially in national examinations (KCPE and KCSE). However, there is very little documentary evidence on examination cheating in internal examinations at secondary school level. Further examination cheating is a learned behaviour and seeks a rewarding outcome. There is no evidence to show that guidance and counselling principles have been applied to address the problem.

School factors are those aspects associated with the learning environment that may lead to exam cheating. They may include the teacher, management and school facilities. Research has demonstrated that cheating behavior in examinations is influenced by students' actual academic performance (Onuka and Obialo, 2004). According to Singhal (1982), as much as 68% of students regarded the wish to get good grade points as the main reason for cheating. These findings were confirmed by Davis and Ludvigson (1995) who also pointed out that pressure for good grades in higher education, student stress, teachers' attitudes and an increase in lack of academic integrity are important determinants of cheating in examinations.

In a study carried out in North America it was observed that schools obsession with performance spurs cheating and that classrooms that emphasized on high grades and test scores may drive students to cheat (Anderman and Midgley, 2004). They also identified examination scheduling, poor supervision and a badly organized course as other causes of exam dishonesty. Fasasi (2006) revealed that cheating in examinations is motivated by; desperation to acquire certificate or get placed in a programme or be selected for a position, carelessness on the part of the teacher/examiners in safeguarding the examination paper before it is administered, emphasis on grades, poor arrangement, poor invigilation, and use of objective tests, among others.

Many psycho-social factors have been attributed to cause examination malpractices. Psycho-social as been defined as a study that examines the relationship between a person's fears and how he relates to others in a social setting (www.wikipedia.org/wiki/psychosocial). It has been noted that students who are encouraged to learn for the sake of learning and who exhibit higher intrinsic value of education are less likely to cheat than those who are encouraged primarily by grades and other extrinsic rewards (Bowers, 1964). Bowers found that some students may feel pressured to develop unorthodox means to get competitive and credentials. He also noted that fear of failure is the most important reason for students to cheat in examinations and that most students doubted their capability to pass in examinations. Psychologists note that all people tend to follow the norms of their peer group, which would include norms about academic dishonesty. In an environment where students experience their peers cheating and are not caught they too will develop an attitude of "everybody else does it."

This is supported by a study which observed that peer pressure is an important cause of academic dishonesty (Pope, 2007). Thus students who believe that their peers disapprove of cheating are less likely to cheat. Fear of failure, peer pressure and lack of confidence in their abilities has been cited by other researchers (Okoh, 1996;

*Corresponding author. E-mail: Patricia.naliaka@gmail.com.

Onuka and Obialo, 2004) Indeed when asked why they engage in examination malpractices, fear of failing examinations was listed as one of the top reasons for engaging in malpractice in the United States of America (Schab, 1991) and in Nigeria Fatai (2005) outlined the fear of failure, craze for certificate, desire of parents to have their children in choicy university and profession, pressure on students to pursue courses for which they have no aptitude, pressure on teachers who want to gain favour of student, inordinate ambition of some people to get rich quick, and overcrowded sitting arrangement as causes of examination malpractices.

This researcher is not aware of any study that has been conducted to quantify perceived school and psycho-social causes of malpractices in internal examination among secondary school students in Kenya. The study therefore investigated the students' perceived Psycho-social and school causes of examination malpractices in internal exams with a view of proffering effective guidance and counselling solutions to curb the menace among secondary school students in Kakamega Central Sub-County, Kenya.

## RESEARCH METHODOLOGY

The study was carried out in public secondary schools in Kakamega Central Sub-County, Kenya. The Sub-county is located in Kakamega County. It lies between longitude 34`34` East and 0`20` North. It borders Mumias Sub-county in the north, Kakamega South and Kakamega East Sub-counties in the east and Kakamega North Sub-county in the west. It consists of three divisions namely, Municipality, Shishiru and Nambacha. The three divisions are managed by area Education Officers. The Sub-county has 43 secondary schools out of which 39 are public and 4 private. Of the 39 public secondary schools, 6 are girls' only, 3 boys' only and 35 are co-educational (S.E.O'soffice, Kakamega Central Sub-County, 2011).

The research was conducted among 3590 secondary school students drawn from 43 secondary schools. Purposive and simple random sampling techniques were used to pick respondents. The study sample comprised 359 students from 2 girls only schools, 1 boys only school and 10 co-educational schools representing 30 percent of the population.

The self-administered questionnaires were completed by respondents themselves. Closed ended questionnaire were used to collect information on perceived Psycho-social and school causes of examination malpractices and their opinions on roles of guidance and counselling to address the malady (Appendix 1).

The respondents had to score items on Likert type scale by checking one of the five possible responses from each item. It was scored on five point grades as follows: Strongly Agree (SA) = 5 Points, Agree (A) = 4 Points, Undecided (UD) = 3 Points, Disagree (D) = 2 Points and Strongly Disagree (SD) = 1 Point. A score indicative of most favourable response was given 5 while the least favourable response was given 1. Scores eliciting Strongly Agree and Agree responses were collectively rated positive or favourable while scores eliciting Strongly Disagree and Disagree responses were collectively rated negative or unfavourable and finally Undecided was rated neutral. Pilot study was carried out before the main study. The research tool was administered on 10% of form three students in these schools. Content validity and reliability of the tools was ascertained using Pearson Product Moment Correlation. The schools used in the pilot study did not participate in the main study.

The reliability of the measurement of instrument was assessed using Cronbach's alpha reliability coefficient which is a test for internal consistency in items. Reliability analysis in the current study was conducted for the three scales measuring Psycho-social and school causes of examination malpractices and roles of guidance and counselling services.

Data collected were sorted out, edited, coded, classified and then tabulated and analyzed using SPSS version 17 software. Quantitative data were analyzed using descriptive and inferential statistics such as frequency counts, means and percentages. Inferential statistics such as Analysis of Variance was used to determine the impact of various demographic aspects. Besides any appropriate statistical procedures found valuable was used.

## DATA PRESENTATION, INTERPRETATION AND DISCUSSION

A total of 359 copies of questionnaires were distributed to respondents. Out of 350 copies of questionnaires distributed 297 copies of questionnaires were returned out of which 11copies were discarded for lack of response and some for incompleteness. This left a total of 286 copies of usable questionnaires amounting to 81.7 percent response rate. This response rate was deemed acceptable since according to Fowler (2002), there is no agreed-upon minimum response rate; the more the responses received the more likely it is that statistically significant conclusions about the target population will be drawn.

Question one: What are the perceived psycho-social causes of examination malpractices in examinations in secondary schools in Kakamega Central Sub-County?

In addressing question two, data on the psycho-social causes of examination malpractices as perceived by the students were collected from the responses to the questionnaire and analyzed using percentages. The findings are shown in Table 1. The opinions of the respondents varied on the psycho-social causes of examination malpractices in the Sub-county. Some of the major causes according to the survey included; poor study habits (89.9%), not reading well (88.6%), laziness (87%),lack of self confidence among the students (73.4%), family pressure to perform well (68%) and to please parents, peer pressure (66.8%).

This findings are in agreement with a study by Pope (2007) in which it was observed that peer pressure is an important cause of academic dishonesty. Thus students who believe that their peers disapprove of cheating are less likely to cheat. Fear of failure, peer pressure and lack of confidence in their abilities have been cited by other researchers (Okoh, 1996; Onuka, and Obialo, 2004) as causes of exam cheating. Indeed when asked why they engage in examination malpractices,fear of failing examinations was listed as one of the top reasons for engaging in malpractice in the United States of America (Schab, 1991) and in Nigeria (Onuka and Obialo, 2004). The research observed that all the respondents were admitted to secondary schools because they qualified and were therefore above average in intellectual ability. They therefore engage in exam cheating due to laziness and peer pressure.

The study further revealed that peer pressure, pressure from parents and the school management make students to resort to cheating. These findings are in agreement with observations by Davis et al. (1992) that pressure for good grades, stress and ineffective deterence were some of the determinants of cheating.

Question two: What are the perceived school causes of examination malpractices in examinations in secondary schools in Kakamega Central Sub-County?

As shown in Table 2 the opinions of the respondents varied on

**Table 1.** Perceived psycho-social causes of examination malpractices in secondary schools in Kakamega Central Sub-County.

| Perceptions | % Responses | | |
| --- | --- | --- | --- |
| | Agree | Undecided | Disagree |
| A student will be interested to buy the exam question paper before the examination | 144(45.6%) | 37(11.7%) | 135(31.6%) |
| Students cheat in examination due to lack of self confidence | 232(73.4%) | 15(4.7%) | 69(21.8%) |
| No matter how hard you read, if you don't cheat you will fail the exam. | 48(15.2%) | 17(5.4%) | 251(79.4%) |
| Students cheat in examination in order to please parents and friends. | 211(66.8%) | 12(3.8%) | 93(29.4%) |
| Students with good study habits can avoid cheating in exams | 284(89.9%) | 7(2.2%) | 25(7.9%) |
| I can allow my friend to copy from my paper during exams | 41(12.7%) | 17(5.4%) | 258(87.6%) |
| Involvement in extra-curricular activities makes students to cheat in exams | 97(25.6%) | 16(5.1%) | 219(69.3%) |
| Students who cheat in exams perform well | 102(32.3%) | 33(10.4%) | 181(57.3%) |
| Family pressure for high exam achievement contributes to cheating in exams | 215(68%) | 26(8.2%) | 75(23.8%) |
| Laziness among students causes them to cheat in exams | 275(87%) | 12(3.8%) | 29(9.1%) |
| Cheating is not necessary if one has read well before the examination | 280(88.6%) | 6(1.9%) | 30(9.5%) |

the perceived school causes of examination malpractices in the Sub-county. Some of the major causes of examination malpractices according to the survey include; poor preparation for examinations (86.4%), overcrowded examination rooms (78.2%), poor invigilation of examinations (71.9%), pressure to improve on the ranking of the school (52.6%) and poor teaching (51.6%).

A significant proportion of respondents (45.6%) agreed that they will be interested to buy an exam question paper if they were offered before the exam, while 11.7% were undecided. 232 (73.4%) respondents out 316 interviewed disagreed that students cheat because they are not aware of examination rules and regulations. Most (71.9%) of the respondents disagreed that cheating is encouraged since many people who cheat often escape punishment and 71.1% disagreed that it is difficult to stop cheating in examinations in our schools.51.6% of the respondents disagreed that one will not feel guilty to cheat if the teacher has not taught well, however 37.6% agreed with the assertion.

The aforementioned causes and others conform with the ones listed by Oniye and Alawaye (2008), Ogerinde (2000), Onugbu (2003), malpractice in Asa local government: implication for counseling; Oniye and Alawaye (2008) found societal preference for paper qualification; inadequate preparation by Fatai (2005) and Ibinaye (2006). For instance, on a study on female students' perceived causes of and solution to examination for examination, lack of self confidence, ill equipped schools, lack of good study habits and host of others were considered by female students as the causes of examination malpractice.

Teachers are employed to teach students and the quality of teaching should therefore aid retention ability of students. Students can only recall or reproduce what is retained through teaching. It has been observed that poor quality teaching aggravates the urge to cheat in the examination by students with low academic ability (Ewangle, 1997). In a similar study Gesinde (2002) noted that some teachers commence teaching a few days to exams, others concentrate on areas to be set in exams; some are not qualified to teach while others use wrong teaching methods.The same author further observed that teachers also serve as invigilators to watch over examinees. They are therefore expected to be vigilant to prevent cheating and to report any such cases. However, the author observed that most teachers spent their time either reading newspapers or discussing with their collegues instead of watching over the examinees. This encourages cheating and even very few bother to report cases of cheating.

In a related study on student factors influencing cheating in undergraduate examinations in universities in Kenya, Ruto et al.

(2011) observed that majority of the students ranked as first lack of preparedness for examination with mean of 2.99 on a 1-5 scale. This was followed by factors such as peer influence (2.93), poor attendance of lectures (2.58), lack of confidence (2.35) and pressure from parents to perform well (196).

The survey revealed occurrence of various causes of examination malpractices in secondary schools in the sub-county. Among prominent causes of cheating was lack of preparedness. Students may not adequately prepare for examination if they know from past experience that they can engage in various of cheating without being caught due to weak invigilation. This collaborates with the study by Davis and Ludvickson (1995) who established in a study that those who cheat in the university level studies cheated in earlier studies or examinations.

Question three: How effective does guidance and counselling programme address examination malpractices among secondary school students in Kakamega Central Sub-County?

In addressing question three, data on the effectiveness of guidance and counselling in addressing examination malpractices in secondary schools in Kakamega Central Sub-County, Kenya as perceived by the students were collected from the responses to the questionnaire and analyzed using percentages. The findings are shown in Table 3.

As shown in the table the opinions of the respondents varied on the effectiveness of guidance and counselling in addressing examination malpractices in the Sub-county. However, 94% of the respondents indicated that there were Guidance and Counselling Units in their schools. An overwhelming majority indicated that the Guidance and Counselling unit often talks to them about self-esteem, peer pressure management, good study habits and proper time management among other topics. Further, most of the respondents felt that from the guidance and counselling talks they know that exam cheating is wrong. 95% of the respondents were in agreement that guidance and counselling has taught them self-confidence to face the exams and 68.4% follow examination rules and regulations. 72.2% will feel guilty if they cheated in exams. However, 59.5% do not think guidance and counselling assist exam cheats.

Further analysis (Table 4) indicated a highly significant difference among schools in students' perception of the effectiveness of guidance and counselling in management of examination malpractice among students in secondary schools in Kakamega Central Sub-County.

**Table 2.** Perceived school causes of examination malpractices in secondary schools in Kakamega Central Sub-County.

| Perceptions | % Response | | |
|---|---|---|---|
| | Agree | Undecided | Disagree |
| Students cheat in examinations because their friends cheat. | 115(35.4%) | 27(8.5%) | 174(56.1%) |
| Students cheat to improve on ranking of their school | 166(52.6%) | 38(12.0%) | 112(35.4%) |
| It is difficult to stop cheating in examinations in our schools | 78(24.7%) | 14(4.4%) | 224(71.1%) |
| Cheating is encouraged since many people who cheat often escape punishment. | 71(22.5%) | 18(5.7%) | 227(71.9%) |
| Students cheat because they are not aware of exam rules and regulations | 74(22.4%) | 12(3.8%) | 232(73.4%) |
| Lack of proper invigilation by teachers encourages cheating in exams | 227(71.9%) | 24(7.6%) | 65(20.5%) |
| Overcrowded exam rooms encourage exam cheating | 247(78.2%) | 18(5.7%) | 51(16.1%) |
| One will not feel guilty to cheat in the examination if the teacher fails to teach well. | 163(51.6%) | 33(10.4%) | 119(37.6%) |
| Poor preparation makes students to cheat in examinations | 273(86.4%) | 13(4.1%) | 30(9.5%) |

**Table 3.** Students perceptions of effectiveness of guidance and counselling programme in secondary schools in Kakamega Central Sub-County.

| Perceptions | Respondents categories | | |
|---|---|---|---|
| | Agree | Undecided | Disagree |
| Our school has a guidance and counselling unit | 297(94%) | 5(1.6%) | 14(4.4%) |
| The guidance and counselling unit often talks to students | 263(83.3%) | 11(3.5%) | 42(13.3%) |
| Need for self-esteem, peer pressure management, good study habits and proper time management are some of the topics discussed in the meetings | 294(93.1%) | 6(1.9%) | 16(5.0%) |
| From the guidance and counselling discussions I know that exam cheating is wrong | 299(94.6%) | 5(1.6%) | 12(3.8%) |
| Guidance and counselling has taught students to have self-confidence to face the exam | 300(95%) | 4(1.3%) | 12(3.8%) |
| Students follow school rules and regulations in regard to examinations | 216(68.4%) | 22(7.0%) | 78(24.7%) |
| Cheating in examinations makes students feel guilty. | 228(72.2%) | 36(11.4%) | 52(16.5%) |
| Guidance and counselling can assist students involved in exam cheating | 125(39.6) | 3(0.9) | 188(59.5%) |

## CONCLUSION AND RECOMMENDATIONS

It was noted that malpractices are caused by numerous factors that could be categorized as either school factors or psycho-social factors. The most prominent school factors noted in the survey were poor preparation of students for exam, overcrowded exam rooms and poor invigilation. These factors are mainly centered around the teacher as he is the one responsible for preparation of students and provision of the right atmosphere for teaching and examination. The most prominent psycho-social causes of cheating in the survey were poor reading habits, laziness, lack of self confidence and peer pressure. Laxity in the school environment provides the right motivation for psycho-social factors that cause exam cheating.

Rampant examination malpractices are witnessed despite the overwhelming evidence of the existence and relatively active Guidance and Counselling units in most schools. School managers have used retribution, deterrence and societal protection methods to address the malpractices but this does not seem to effectively curb the menace. The Government has also enacted the revised KNEC Act (2012) that provides for stiffer penalties against the offenders. However, the legislation is targeted at offenders at national examination but not internal examinations. It therefore does not nib the menace in the bud but allows it to metamorphozise. The Act does not also provide for rehabilitative methodo-logies for offenders.

From the survey it may be concluded that the guidance and counselling methods chosen to address exam malpractices should be based on whether the cause is either school or Psycho-social. School causes should be addressed mainly administrative that is through proper teacher recruitment and management and provision of adequate teaching and learning facilities. Psycho-social causes may require appropriate guidance and counselling method to effectively address.

### Recommendations

Since the whole segments of the nation's life are unfortunately connected to the issues of examination malpractice, there is a need to sensitize all citizens on basic ethical values of self-worth, dignityof labour, integrityand personal responsibility.

Only teachers who are qualified, certificated, competent and of good moral standing need to be employed to

teach the students. They should be dedicated teachers who would serve as role models in matters of punctuality, self-discipline, accountability, integrity and sound leadership styles.

Furthermore, well-equipped functional libraries should be in place to promote good reading habits.Facilities, like laboratories, and amenities for basic needs should be available.

Continuous assessment procedure should be given to students to ignite the zeal to study and develop self-confidence with less emphasis  on certification.

Competent counselors should be employed and posted to secondary schools and other tertiary institutions. They should help students in self-understanding and self-management, in relation to how they can utilize their assets and manage their abilities, and capabilities for optimal development.

Further research should be carried out on the effectiveness of the schools Guidance and Counselling units to manage examination malpractices especially internal examination. Examination cheating is a learned habits and the rampant cheating in national examinations would have a linkage to the malpractices in internal examinations.

## Conflict of Interests

The author has not declared any conflict of interest.

## REFERENCES

Anderman E, Midgley C (2004). Changes in self-reported academic cheating across the transition from middle school to high school. *Contemplary Education Psychology,29,.*, 499–517.

Bowers JW (1964). *Student Dishonesty and its Control in Colleges*. *Bureau of Applied Social Research* (pp. 1–7).

Davis SF, Ludvigson HW (1995). Additional data on academic dishonesty and a proposal for remediation. *Teaching of Psychology, 22, 2, S. 119-121.*, *22*(2), 119–121.

Ewangle SMO (1997). Major reasons for examination malpractices among college students with particular references to College of Education, Gindiri Pacen. *J. Educ 1*: 115–119.

Fowler FJ (2002). *Survey research methods*. California: SAGE Publications Inc.

Fasasi YA (2006). Quality Asurance: A Practical Solution To Examination Malpractices In Nigerian Secondary Schools. *International Journal of African and African American Studies*, *5*(2): 15–21.

Gesinde MA (2002). Teachers involvement in the sustenance and promotion of examination malpractices in Nigerian schools. *Oyo COEASU J. Ft Prints*, *2*(1), 31–41.

Nevo, D. (1995). *School Based Evaluation: A Dialogue for Schools*. New York: Elsevier Science Inc.

Okoh N (1996). Psycho-social approaches to reducing malpractice in large-scale examinations. In G. A. Badmus & P. I. Odor (Ed.), *Challenges of managing educational assessment in Nigeria* (pp. 95–107). Kaduna, Nigeria: Atman Limited.

Oniye AO, Alawaye AS (2008). Female students perceived causes of and solution to examination malpractice in Asa local government: implication for counselling. *Sokoto Educational Review*, *10*(2), 1–16.

Onuka A, Obialo FO (2004). Causes of and solutions to examination malpractices in Nigeria: The perception of some stakeholders. In O. A. A. & J. G. Adewale (Ed.), *Issues in educational measurement and evaluation in Nigeria: In honor of Wole Falayajo* (pp. 469–482). Ibadan, Nigeria.

Pope J (2007, May). Higher Education Sees rise in students' dishonesty. *Associated Press*.

Schab F (1991). Schooling without learning: Thirty years of cheating in high school. *Adolescence*, *26:* 839–847.

Singhal AC (1982). Factors in Students dishonestyl. *Psychological Reports*, *51*, 775–780.

Wheeler DK (1997). *Curriculum Process*. London: Hodder and Stoughton.

World Bank. (2002). *Public Examination Systems.*

**International Journal of Psychology and Counselling**

*Full Length Research Paper*

# Dual relationships and boundary crossing: A critical issues in clinical psychology practice

### Olusegun Emmanuel Afolabi

Department of Educational Foundation, University of Botswana, Botswana.

The issue of boundary and dual relationship has been a major subject of concern in psychological practice. Ethics complaints on dual relationship and boundary crossing continue to rise both in nature and variety. This paper examined and shed light on the complexities surrounding dual relationship and boundary crossing in clinical psychology by explaining the pertinent moral and clinical worries that clinical psychologist's face daily in their practice. To achieve the objectives, the paper analysed underlying themes: 1) using empirical review of relevant literature to identify clinician's attitudes toward risky and useful dual relationship and boundary crossing in clinical practice, 2) to learn whether involving in dual relationships negatively or positively influences therapeutic outcome, 3) analyze the concept, challenges and differences associated with dual relationship in clinical practice using decision making model, and 4) come up with strategies that help clinical psychologists to make flawless ethical standards as well as offering of moral *guidance.* Finally, the study suggests that, though dual relationship sometimes enhances therapy, aids treatment strategy, and promotes positive relationship between clinician and client, it also weakens the treatment process, hampers the clinician-client cooperation, and brings instant or lasting damage to the service user.

**Key words:** Boundary crossing, dual relationship, ethical decision making.

## INTRODUCTION

The issue of boundary and dual relationship has been a major subject of concern in psychological practice in recent time. In fact, psychology and other mental health professionals have grown increasingconcerned about "dual relationship," in clinical practice including the boundary crossing and boundary violation. Of most concern is that, the issue has developed in the context of professionalization to say the least. No time in the history of psychology profession has the ethics of professional conduct being questioned or confronted with a wide range of contemporary ethical problems like it is today in our society. The profession has been besieged with clear

E-mail: afo13@yahoo.com.

messages about the immorality and negativity of dual relationship and boundary crossings, to the extent that the values and moral foundation of the psychology discipline was seriously challenged both by clients and consumers.

For instance, from the psychology course guidelines, to literatures on moral values, and clinical internships, it has been labelled as inappropriate, if not unprofessional for clinical psychologists to get involved in the following circumstances: unofficial work or private relationship with clients, taken gifts offer, engage in physical contact and last but not the least, socialize with clients in their practice. This position also received plaudit from large number of researchers, who one way or the other have made massive contributions in the area of study, particularly as regard to boundary crossing and dual relationships (Corey, 2009).

In fact, most evidence suggests that, in most cases, client's faces higher risk during treatment due to negativity of dual relationship. Professional training also highlighted that boundary crossing is likely toaffect clients 'right and also causes unjust sexual contacts. Though this is reported as immoral and often linked to abuse and harm, its continuous existence in clinical practice remains an issue of concern till date. Similarly, health professional associations obligated their members to respect and uphold ethical standards and codes of conduct that guides, regulates and protect clients from experiencing bad practices. Therefore, for a clinical psychologist, navigating through an ethical practice is a difficult mountain to climb.

Also, psychologist and clients are regularly hindered by uncontrollable circumstances that prompt porous boundary between therapeutic and social relationships.

Additionally, earlier reports gave special consideration to issues that are scientifically related to beliefs and behaviours about boundaries. Among the problems that emerged from these studies include: therapist sexual category, career (psychiatrist, psychologist, social worker), knowledge, marital status, practice situation (private or public), locality, client sexual category, (such as solo or group private practice and outpatient clinics), practice area (size of the community), and last but not the least, theoretical belief.

Surprisingly, the corollary assertion is the religious and communitybeliefs about the issue, particularlythe way they stuckwith the prospect of relationships concept in clinical practice (Catalano, 1997; Doyle, 1997; Sidell, 2007). Despite all the aforementioned challenges, it is important to state that research on boundary crossing continue to provide guidance to difficult issues that clinicians come acrossas they make judgement on certain ethical issues in clinical practice. The question is, how can we as psychologist blend our professional roles and personal needs without compromising our profes-sional responsibilities?

## Purpose

Clinicians often miss the mark or fail to understand the possibility for dual relationships, particularly, how to cope with relational dilemma in clinical practice. This problem remains an issue in clinical practice till date. This paper examines and sheds light on the complexities of dual relationship and boundary crossing in clinical psychology and explains the pertinent moral and clinical worries that clinicians faces in their practice. The paper also looked at how dual relationship influences decision making process in clinical practice. To achieve this, the paper focuses on five underlying themes: 1) makes a distinction between the following factors: risky boundary violations, useful boundary crossings and inevitable or caring dual relation-ships, 2) used an empirical review of relevant literature to identify clinician's attitudes toward risky and useful dual relationship and boundary crossing, 3) observed whether involving in dual relationships during clinical practice has any negative or positive influence on therapeutic outcome, 4) used the decision making model to address the concept, challenges and variances associated with dual relationship in clinical psychology and 5) come up with strategies that help psychologists to make flawless ethical standards and offer moral guidance regarding dual relationships.

## LITERATURE REVIEW

### Dual relationship and boundaries in clinical practice

As we all know, psychology profession strives to promote the emotional well-being and social welfare of others. However, events in recent time continue to point towards its utmostscrutiny. Clinical psychologist faces daily challenges by handling the issue of dual relationships and boundary crossing without compromising their pro-fessional conduct and practice. In facts, earlier research, particularly in the 80s and 90s demonstrated how hypothetical orientation, community size, psychoanalyst sexual characteristics, client sexual category, occupation, and other issues impact psychology profession, particularly on the issue of nature and suitability of borderline crossings in clinical practice. Besides, the period between the 1980s and 1990s also witnessed a practical outburst of healthy argument and considerable works on dual relationships, bartering, companionable touch, out of office consultation and other nonsexual boundary matters to mention a few in clinical practices.

Also, thought-provoking and considerable literature on dual relationship in clinical psychology observed a constructive and undesirable aspect of boundaries and

boundary crossings. A typical example of this is the article published by American Psychologist in 1992 requesting for drastic changes in the ethics code of the profession. This publication further showed lack of clarity and awareness on when and how clinicians should engage with clients. To buttress this position, the Committee on Ethics of the American Psychological Association in their report suggested that around 40 to 50%of the complaints receivedduring the period of 1990 to 1992 are on dual relationship. Also, Sonne (1994) reported that, of all the problems facing APA members, the issue of dual relationship was the most common reason for their membership termination. Unfortunately, as a result of the ambiguity attracted, the concept continues to face serious litigation and disciplinary cases, such as ethics committee hearings, and complaints to professional boards of licensure. Research sees boundary crossings as a well-fashioned treatment strategy that increasesthe therapeutic success (Lazarus and Zur, 2002). For instance, the recent APACode of Ethics of 2002 offered a new insight into the issue of boundary crossing by stating that, "Psychologists ordinarily refrain from bartering", that was in the 1992 code,and incorporate a new sentence, "Multiple relation-ships that would not rationally be expected to cause impairment, risk exploitation or harm are not unethical" (APA, 2002, section 3.05), to the multiple relationships unit.

In addition, the dual relationship also focused on role theory. That is, the issue of social roles that covers innate anticipations about how somebody in a specific role should conduct himself or herself, along with the rights and responsibilities that go along with the functions needed to be addressed. Psychology profession uses ethical principles to advance moral code and moderate professional behaviour of their members (Beauchamp and Childress, 1994). To buttress this assertion, the code of conduct of the American Psychological Association, ethical principles (APA, 1992) recognized "multiple dealings". According to the code of conduct, it is not being possible or sensible in particular circumstances, "for psychologists to evade other non-professional interaction with their clients" (p. 1601). However, going into such interactions might prejudice the psychologist's fairness; hinder their professional practice or abuse the other party" (p. 1601).

Moreover, other health professionals also incorporated in their ethical guidelines, principles and practice that regulated and contained dual relationships in clinical practice. Yet, conflicts arise when the beliefs and expectations linked to one role call for the conduct that is unsuited of the other role (Kitchener, 1988). Dual role relationship happens when a particular person or an individual concurrently or successively partakes in double role (Kitchener, 1986). This definition is supported by

Carroll et al. (1985), where they established that in addition to the professional rapport, the clinician created some other rapports with the person: colleague, relative, student or business partner. Despite all these challenges, further research and literatures on boundary and dual relationship are needed to aid and change our thoughts and knowledge about boundary crossing in clinical psychology. Therefore, the question is: what and what should be prohibited or condoned when working with clients? Which of the boundary crossings were therapeutically helpful and harmful? And what therapeutic methods are acceptable or not acceptable for certain culture or communities?

## Boundary crossing and violations in clinical practice

Logically and practically, not all boundary crossings were harmful to clinical work. Studies in Europe and the US demonstrated that dual role relationships can be neither harmful nor helpful to clients and therapist (Edwards, 2007; Kitson and Sperlinger, 2007; Lazarus et al., 2004; Pugh, 2007). Research also maintained a distinction between boundary crossing and violations in clinical prac-tice (Remley and Herlihy, 2009). Literature on ethical issue in clinical practice found that boundary violations are more injurious to clients, whereas, some boundary crossing is beneficial (Knapp and Slattery, 2004). As a consequence, professionals must endeavor to always differentiate between conducts that are boundary cross and those that are boundary violations. Also, the APA Code of Ethics of 2002 made some clarification that prevents authorities, courts and ethics committees from employing the logical or community yardstick to evaluate non-logically oriented psychologist, who embraced boundary crossing interventions in a society where dual relationship and boundary crossing are inevitable. On the other hand, some school of thought, such as the behavioural, and humanistic, sees supportive boundary crossing that is client's focused oriented (Lazarus, 1994; Williams, 1997) as predicting positive therapeutic out-comes. In addition, a body of psychology literature (Roth and Fonagy, 1996, Hubble et al., 1999) also suggested positive therapeutic outcome as a correlation of clinician–client relationship. For example, Roth and Fonagy (1996) and Hubble et al. (1999) also found that client variables and extra-therapeutic elements are responsible for the 40 percent of progress made in therapy, while 30 percent are accounted for the therapeutic relationship.

Consequently, a dual relationship happens when there were multiple roles or external relationship between a clinician and a client (Bleiberg and Skufca, 2005; Moleski and Kiselica, 2005; Ringstad, 2008). This include: busi-ness, social, communal, familial, sexual, and professional oriented to mention a few (Nigro, 2004). A dual role

relationship is also classified into two types: sexual and non-sexual (Corey et al., 2007). Corey et al. (2007) linked sexual dual-role relationships with negative outcomes. They found that such relationship is the probable cause of harm to client's emotional and social wellbeing. These interactions are categorized as harmful and can lead to bigger potential for negative outcomes (Bleiberg and Baron, 2005; Kolbert et al., 2002; Reamer, 2003). Though this is not made equal, they are structured this way in this paper in order to distinguish the degree of harm they bring to clients.

Similarly, research on dual relationship emphasized more on sexual misconducts between client-therapist (Gutheil, 1989, Corey et al., 2007) and less on other complex boundary crossings that are less noticeable but pose difficulties for clinicians. Empirical evidence on dual relationship found that boundary violations often go along with or lead to sexual misconduct (Corey et al., 2007; Gutheil and Gabbard, 1998), It was also established that abuses themselves do not constantly institute misconduct or misdemeanours or even bad method. While most psychologists believethey have a better understanding of boundary issues, using it when working with clients remains difficult. It was even worse when we look at the difficultyposed by the legal system, particularly, the complainants' lawyers, who see any act of boundary crossing as immoral, flawed, and injurious to their clients. This upshot is considered to be inherently harmful and consistently inhibit and undermine clinical practice (Epstein and Simon, 1990; Simon, 1992). Therefore, dual relationships are intrinsically dangerous and clinicians must endeavour to prevent it during practice.

In addition, many definitions were used to explain dual relationship in clinical practice. Some of these definitions are recognized by functions (Doyle, 1997; Edwards, 2007; Kitson, 2007; Nigro, 2003), while some by inter-personal closeness (Pugh, 2007). Functional interactions are defined as a situation where clients have an outside contact with a clinician in shared or professional means like community or business affiliation. In this circum-stance, dual relational role happens when service users and clinicians developed external relationships or connection that was outside professional practices. The former can happen without the service users and clinicians' knowledge; while the latter grows with the understanding of the clinician (Borys and Pope, 1989). This, according to the American Associate for Marriage and Family Therapy (2001), builds and promotes abuse. Therefore, clinicians must look-for a way out by taking safety measures when working with clients. In addition, psychoanalytic theory highlights the significance of boundaries and the unbiasedposition of the clinician.

According to the theory, active and proper manage-ment of transference and other therapeutic process need a flawless and reliable boundary that allows the clinicians to sustain the analyticsetting of therapy (Langs, 1988). Like many other ideas in clinical practice, i.e., "therapy," "transference," and "association," thisconcept is closely linked when observed.

Of most importance is that, clinical psychologists must strive to understand and take into cognisance the three values that govern the relationship between boundaries, boundary violations, boundary crossings, and sexual misconduct. To start with, sexual misconduct starts with slight boundary violations. This showed an upsurge incursion into the patient's space and culminates to sexual contact. Gabbard (1989) and Simon (1989) found that the act of engaging in sexual misconduct takes the following sequence: moving from calling each other the last-name to the first-name; engaging in the personal or private discussion that hampers professional duty, involving in body contact i.e., pats on the shoulder, massages, and hugging each other; outdoor outing; sessions at lunch; having dinner together, going for movies and any other social event together; and last but not the least engaging in sexual intercourse. However, not all the act of boundary crossings or violations promotes or signifies sexual misconduct. An act of boundary violation of one professional ideology may be a normal professional practice for another. For instance, a "Christian psychiatry movement" might encourage clinicians to attend church service with one or more clients, while some permit an inherent boundary violation that supports employing clients in therapy by using them for experiment treatment setting. Though, negative training, messy practice, lapses of judgment, unconven-tional treatment ideas, and social-cultural condition are all revealed as promoting boundary violation in clinical practice, they arenot necessarily predictors of sexual misconduct or action that pushes professional away from the principle and standard of care. Despite all this, the fact still remains that professional ethics committee, criminal juries, regulating boards, to mention a few, still seeboundary violations or crossings as aprobable evidence of sexual misconduct.

Lastly, from historical perspectives, some psychology school of thought favoured an inflexibleboundary crossing or violation. For instance, studies found that some professional therapeutic leaning permitted inflexible boundaries using Freud as an example. This school of thought illustrated how Freud himself occasionally sent cards to his clients, borrowed them books, gave out gifts, discussed his personal life with clients, ate with them while on vacation, carried out outdoor analysis and last but not the least, analysed his own biological daughter. This, according to Guthiel and Gabbard, formed the basis for emerging research on "explorations," and develop-mental framework on boundary crossings and violations, and echoed its authentication in clinical practice. Guthiel and Gabbard (1993) found that judgments must be based

on the following situation and specifics: If exploration is to be beneficial, professionals should accept the resolution that "boundary crossing" is a descriptive word, neither admiring nor disapproving.

Therefore, judges should determine the effect of a boundary crossing on individual basis with emphasis on context and situational-facts like probableharmfulness of the violation to the client. A violation, then, represents a harmful crossing, a transgression, of a boundary (p. 190). Gutheil and Gabbard (1993) also looked at boundary crossing and violations from the context of role, time, place and space, money, gifts, services, clothing, language, self-disclosure, and physical contact to mention a few. Though they underlined the fact that border crossing sometimes is salutary, neutral, and harmful", they also concluded that the nature, clinical effectiveness, and influence of a particular crossing "can be measured through systematic consideration of the clinical environment" (pp. 188-189). This argument confirms that psychology profession is still confronted with how to handle and resolve boundary crossing and dual relationship in clinical setting. It also takes into consideration, both the theoretical orientation and contextual situation of both the client and the clinician. Although this issue was later addressed some years later by Gutheil and Gabbard (1998) in their article titled "Misuses and misunderstandings of boundary theory in clinical and regulatory settings"

## Boundary decisions in context

Although boundary decision is a weird and forbidding part of clinical practice, it requires a specific guideline and decision that is different from the general code of conduct of clinical profession. The theoretical momentous recorded in the literature provided a basis for clinical psychologists to decide whether or not it is appropriate for themto cross a particular boundary with client at a particular time and for a specific purpose. This can be achieved when we carefully observe and analyze the following factors: the therapeutic context, the clinician, and lastly the client to mention a few. But then, the decision taken should be based on a holistic approach to ethics. This sound very difficult, if we consider factors, such as the intense focus, the historical arguments, and the doubt and worry that follows the boundaries decision. Although boundary decision is a weird and forbidding part of clinical practice, it requires a specific guideline and decision that is different from the general code of conduct of clinical profession. Therefore, approach to boundaries as professionals should base on our attitude to ethical decision-making. Moreover, research shows that people, sometime, do not perceive their actions as having negative implication on others (Rest, 1983). Thus, this paper

revised the following basic assumptions about the ethical awareness and decision-making from ethics literature (Koocher et al., 2008; Pope and Vasquez, 2007).

1.     As a clinician, ethical consciousness is a constant process that contains constant probing and individual obligation. For instance, conflicts with managed care companies, the intensity of clients' needs, the likelihood of formal criticisms of clients or condemnation by professional co-workers about boundary decision taken, mind-deadening procedures undertaken in the course of our duties, exhaustion, just to mention a few, can have adverse effect on our individual awareness and cloud our sense of personal obligation. These factors, if not properly considered, can overpower, drain, divert and lure professionals into ethical slumber. It also makes professionals more vulnerable to the extent that people around us will start questioning our ability and decision making.

2.     Consciousness of professional codes and ethics is a vital feature of critical thinking and ethical decisions. Our professional codes and values enlighten rather than control our ethical judgments. As psychologists, we cannot substitute this for our emotion and thinking when we face ethical challenges. At the same time, they cannot defend us from ethical tussles and doubt that confront us daily as professionals. Besides, we should understand and appreciate individual uniqueness, particularly among clients and therapist, irrespective of their similarities. We should also appreciate the fact that every situation is unique and constantly evolves; In addition, we should understand that our professional inclination coupled with contextual factors such as community belief, client's orientation, and culture influences our perception of ethical decision.

3.     The knowledge about the emerging profession and scientific theory and research is another vital feature of ethical competence. Therefore the assertions and conclusions from research should not be inactively acknowledged or automatically applied irrespective of their popularity and acceptability. We must receive published statements and recommendation with active and complete enquiring.

4.     Though majority of psychologist and counsellors are reliable, devoted, thoughtful individuals, and dedicated to high ethical standards, none is infallible. As humans, we are all prone to mistakes in our professional duties. We sometimes overlook things that are important, make wrong choices, work from limited viewpoint, make a wrong conclusion, and have a strong view about things that are unwise. To address these problems, professsionals should endeavour to always examine and assess their judgement, i.e., "What if I'm wrong about this? Is there something I'm not seeing? Is there any other way to approach this situation? Is there any other effective or

creative way to answer?"

5.        As psychologists, we often find it easier to query the ethics of others -- particularly in a tough and contentious area like boundaries, while placing our own opinions, expectations, and actions out of bounds.  For us to query the other colleague's ethical decision, we must also question our own decision and conduct and be ready for others to question us.  That is, we must take it as duties to challenge and question our self, as we engage in pointing out weaknesses, flaws, mistakes  and ethical  blindness  observed  in  other  colleagues. This action will help us to be productive and awake to the new challenges and possibilities in our profession.

6.        Also, as psychologists, we tend to question our ability in areas where we are unclear, while, we find it harder to query our self about what we are more certain of or beyond questioning. It will be more productive and beneficial for us as professionals to ask questions about what we know and follow it to the conclusion. While this might take us to a new challenge, it will also make people around us to see our action as "psychologically improper" (Pope et al., 2006).

7.        As psychologists, we frequently bump into ethical problems devoured of clear and easy answers. This mostly  happens  in  boundary  issues  than  any  other matter. We might be threatened with vast needs that are unsurpassed by adequate resources, conflicting duties that appear difficult to resolve, and other uncountable problems that we face in our day to day actions as clinicians who offer support for those who are desperate and in need of care. Also, we make unnervingly difficult decisions about boundaries "on the spot" due to clients and colleague's unforeseen statement or actions. As a result, we cannot run away from ethical challenges, as they are part of our professional call.

8.        Last  but  not  the  least,  as  psychologists, consultation is crucial and paramount in our day-to-day dealing  with  clients.  We  sometimes  cover  our  own personal issues. So, turning to other trusted colleagues, particularly those who are not involved in our situation helps in building ourethical decision-making.  Similarly, valuable ideas that are not well-thought-out, particularly unknown biases can be pointed out by colleagues. Furthermore, as we take hard decisions under pressure, we  may  inadvertently  but  reasonably  become  more worried about how the action might affect our duties. For instance, as professionals, we tend to contemplate whether our action can cause us a misconduct suit or accrediting  complaint,  or  estrange  us  with  our  depen- dable referral sources. We also think that our action can cause  us  to  lose  our  clients  or  client's  provider. Therefore, engaging in consultation helps us to reflecton our decision's outcomes consequences for those who are affected.

## A decision-making model

For us as psychologists to continueto emphasize the significant implication of dual relationship and boundary crossing in clinical practice, a variety of ethical issues must be considered if professional standard is to be maintained. Simon and Shuman (2007) in their contribu- tion to ethical decision making, found that a psychologist should always form the habit of upholding applicable boundaries even in the face of working with tough clients and boundary-testing. They argued that in a therapeutic practice, there are neither faultless therapists nor perfect treatment.  This  statement  alone  ought  to  inspire psychologists to be acquainted with their boundaries. It also makes their work easier. This paper used a decision making model to analyze potential dual relationships and the boundary issue in clinical psychology. The model has three advantages that make it appropriate for analysing ethical issues in clinical practice. Firstly, it is specifically designed  to  address  potential  dual  relationship  and ethical  problems  confronting  professionals  in  clinical practice.  Secondly,  the  model  is  too  broad,  i.e.,  it provides  limited  direction  for  professional  and  narrow, i.e., explained how clinician should behave. Lastly, the model contains all possible dual relationship issues that might happen, irrespective of the situational context.

## Assumptions

The decision making model is purposely designed to help professional  colleagues  to  manage  their  relationships effectively and efficiently, if they realised that they cannot avoid it. The model uses seven assumptions to analyse relationship and boundaries in clinical psychology. As a model  that  focuses  on  ethical  decision  making,  it embraces all professional relationships that we undertake in  clinical  practice.  The  model  is  not  only  limited  to interactions with service users, learners, or supervises, it also  applicable  to  anyone  who  uses  psychological services, irrespective of the kind of support provided. The model  believes  that  as  professionals,  our  social  role should  be  professionally  oriented,  irrespective  of  our situation and relationship with clients. The model also assumes that, our aspiration should be on how to avoid any  act  of  dual  relationships  inall  our  dealings  (APA, 1990). This remains impossible in most situations, as we are  all  confronted  with  multifaceted  problems  and challenges. Similarly, Kieth-Spiegel and Koocher (1985) and Haas and Malouf (1989) supported this assertion by reporting that such interactions are not totally avoidable. This  supposition  is  also  related  to  the  APA  Ethical Principles (APA, 1992) and the concept of overlapping interactions presented by the Feminist Therapy Institute's Code of Ethics (1987).

**Table 1.** Dimensions for ethical decision-making.

| Low power | Mid-range power | High power |
|---|---|---|
| Little or no personal relationship or persons consider each other peers (may include elements of influence). | Clear power differential present, but the relationship is circumscribed. | Clear power differential with profound personal influence. |
| **Brief Duration** | **Intermediate Duration** | **Long Duration** |
| Single or few contacts over short period of time. | Regular contact over a limited period of time. | Continuous or episodic contact over a long period of time. |
| **Specific Termination** | **Uncertain Termination** | **Indefinite Termination** |
| Relationship is limited by time externally imposed or by prior agreement of parties who are unlikely to see each other again. | Professional function is completed but further contact is not ruled out. | No agreement regarding when or if termination is to take place. |

Thirdly the model assumes that, because of the high inherent risk that clinical psychologists experience daily with clients, any interactions with service users must beassessed critically in order to evaluate possible harm. The model assumes that all dual relationships are oppressive and that engaging in dual relationships come with little or no risk and sometime helpful. However, the act must always be circumvented, if we realise it can lead to harm. Fifthly, the model also educates professionals on how to manage pertinent issues, and make recommendations for action. The model assumes that professional's problem arises when psychologists anticipate adding additional relationship to the current one. However, the model is not planned forlesser relationships. Lastly, the model proposes that in clinical practice, the dimension of any relationship must be measured from thepoint of view of theservice user, and, not that of professionals. While we do not have access to the client's feelings in most circumstances, our decisions must be conservatively done in order to ensure that clients' welfare are protected.

**The model**

The decision model is based on three dimensions (Gottlieb, 1986). These dimensions are vital to the ethical decision-making process in clinical practice. The first dimension observed in this paper is power. This is explained as the amount of power that psychologists weld in their relationship with their clients. Although this is widely varied, psychologists who give a talk during community practice have relatively little control over those in the gathering, compared to those that work with clients over a long-term period. Secondly, the time of the relationship, coupled with the aspect of power is relevant in decision making. That is in therapist-client relationship, power rises over time. This means that, the intensity of

power is limited in a brief relationship, such as a single assessment session for referral, and increases as the interactions progress, i.e., student and teacher. Thirdly, the clarity of termination means that the client and the clinician might engage in a further professional contact. For instance, a psychological assessment with a job seeker involves clear-cut termination, with little or no additional contact. Conversely, a clinical psychologist working with family, sometime believes he has a long-term obligation to his client. The question is, how can we terminate a professional relation in clinical practice? This model indicates that, a professional relationship with clients continues until the client thinks otherwise, irrespective of the time or contact in the interim. As soon as the psychologist realises he/she does not understand how the client feels, the ethical choice is to accept that the client has the right to recommence the professional connection in the future (Table 1).

**Application ofdecision-making model**

Decision making model can be applied in clinical practice, particularly, when a psychologist is consideringhaving an additional relationship. This can be achieved through the following process:

Firstly, psychologists need to appraise theirpresent relationship with clientsby using the following dimensions: from the client's angle, where do the relationship lies on each? How pronounced is the power difference, for how long is the relationship, and is it evidently over? If the relationship takes the right side on two or three of the scopes (i.e., upper power, lengthier period and no end), the probability of danger is higher; therefore, the clinician must avoid creating any other relationship apart from the existing one. However, for family, group or individual therapist, the circumstances are clear. For them, the

power differential is boundless. This means that the therapy session can be extensive; therefore, ending such session is not explicit. Besides, the clients might believe it is their right to come back for treatment any time they want in the future. Also, some families may perceive a psychologist the way they see a family physician by thinking that he/she will always be accessible anytime they need a service. In such circumstances, the general belief that a professional-client relationship does not end is correct. On the other hand, if the relationship lies on the left flank of the three dimensions (i.e., less power, fewer periods, and clearly ended), one can shiftor move down to the subsequent level. But, in a situation where a relationshiplies inthe middle of the three dimensions, some kinds of extra relationships are allowed, so, the psychologist can possibly move down to the subsequent level.

Secondly, psychologists must observe the anticipated relationship based on the three dimensions analysed in the present interaction with clients. If the expected relationship cascades to the right side of the scopes (i.e., leading to long and indeterminate end), then such relationship must not be jettisoned, particularly, in a situation where the present relationship also cascades to the right. On the other hand, if the projected relationship falls in between the middle and the left side of the scopes, the rapport can be allowed and the psychologist can proceed to step three.For instance, a psychologist might ponder about going into a relationship with a family 'client she has worked with before thatneeds no further engagement. In this situation, the clinician has enormous power that isshort-lived and last for a definite period, and thus makes closing the professional rapport more explicit. The new rapport, though, having unstated and unclear length and termination, comprises little or no power difference. In contrast, if the first relationship falls to the left part of the dimensions, and the anticipated relationship falls to the right side, the relationship can be promoted and allowed, i.e.,  a psychologist could ponder about assessing a child that he or she has previously engaged with the parents.

Thirdly, psychologists must look at the relationship for anyrole incongruity and see if they fall in-between the middle or the left side of the dimensions. According to Kitchener (1988), role incongruity rises as a result of the following factors: higher differences in anticipations of the two roles, greater divergence of the duties of the two roles, and last but not the least an upsurge in the power disparity. Whenever the two diverse roles look highly unsuited, the clinician should endeavour to reject or abandon the expected relationship. For instance, a clinician must not take member of staff as a transitory psychotherapy client.  But, if the relationship falls in the middle, or left side of the sizes, and the level of unsuitability is small, the clinician  can  continue  with the

relationship. For example, a psychologist might consider one of his employees as a participant in an assessment process he or she is supervising. A psychologist, who worked with a drug addicted man before, might consider working again with him and his spouse for conjugal problems.

Fourthly, clinical psychologists must be ready to engage other professional colleagues in consultation. In line with the seventh assumption, the new relationship must be measured from clients' viewpoint, and judgements must be done in a conservative manner. Meeting with a professional colleague must be seen as normal, when making judgements. A colleague who is used to such situations, i.e., the service user, and the decision-maker is the perfect choice for professional consultation. For instance, an associate might view it ill-advised that a recently divorced, troubled, male medical training supervisor agreesfor a date from one of his female interns.

Lastly, it is also imperative for psychologist to always engage clients in decision making, if he or she decided to continue with the extra relationship. The psychologist must assess the following factors, such as the impo-rtance of the decision-making model, its justification, the relevant ethical questions, obtainable options, and lastly, likely adverse implications as an element of informed consent. If the client is capable, and decides to involve in an additional relationship, the clinician can continue, once the service user is given ample time to think about the other options. If the service user/client fails to be aware of the quandary or is reluctant to ruminate on the matters before making a choice, he or she is seen as at risk, and the anticipated relationship should be forbidden.

**METHODOLOGY**

This paper analysed and reviewed empirical literature in order to investigate and check new empirical studies that highlight the complexities of dual relationship and boundary crossing in clinical psychology. The study collated and reviewed relevant articles, books, journals, and meta-analysis on dual relationship, boundary crossing and ethical decision making. Both the ERIC and PSYCHLIT databases were searched using the following key words: ethical decision making, boundary crossing, dual relation-ship and clinical psychology. This procedure initially reported about 1298 articles, journals, technical reports, paper presentation and book chapters covering more than 23 year period. Based on the abstracts retrieved from this initial 1298 plus articles and publications, the search was lessened to a relatively few hundred of studies that are pertinent and relevant to the theme of this paper. The contents of the remaining several hundred of articles cum journals were further scrutinised and only those that reported empirical findings were kept aside and used in this review, while others were left out for further consideration. This process shows that only a few studies documented empirical findings on boundary crossing and dual relationship in clinical psychology practice. To verify references, manual searches of relevant journals and articles related to the paper are performed.

## Case Study 1

Dr Badmus is a clinical psychologist working in a private psychotherapy clinic. A young lady in her middle twenty was referred to her for relationship issues. After working with her for 3 months, the client thinks that her problems are over and after discussing with the psychologist, they both agreed to end the therapy. Three years later the client and the psychologist, coincidentally, met again at a get together party. They both had a lengthy discussion and at the end of the day, they exchanged address and the client asked the psychologist if they can meet again. The clinician responded and quickly pointed out that he would have loved to take her out, but due to their past professional contact, he would not be able to do so. To buttress his point, he told her that such relationship would affect any future professional consultation she might need from him. She agreed with him, and suggested that if there is any need for future consultation, she would not mind him referring her to a professional colleague. Though they went out together for quite some time, the relationship did not last long. Two years after ending their social relationship, she called the psychologist and requested for service. The clinician declined the consultation by mentioning their last discussion at the party and offered to refer her to a professional colleague. She immediately gets annoyed with the suggestion and bangs the phone. Since then, there has been no contact between them.

### Case analysis

Many people would contend that Dr. Badmus took a good decision the way he handled the situation. He was conscious of the danger that may follow his friendship with a former client. Besides, he was even aware of the informed consent processes in the hub of a social event. But, if all his action is right, then, what is the problem? By using the model to analysis the scenario, it shows that Dr. Badmus had a rapport with high power of intermediate period and a seemingly exact termination. The model also discloses the effect of great role unsuitability when counsellors get involved in a social relationship with former clients. Moreover, Dr. Badmus should have considered the client's need in these circumstances. Though agreed with her, the clinician failed to observe and analyse the intended relationship from the client's perspective. Additionally, the model recommends a waiting period and discussion with a professional colleague. Supposing Dr. Badmus, followed the principle of the model to the end; he might have re-evaluated the situation.

### Case Study 2

Dr. Titus is a private clinical psychologist practitioner; one day he was having a psychotherapy session with a young lady who was having a relationship problem. During the therapy session, the young lady told the clinician about her problem in keeping a long term relationship with the opposite sex. She told the psychologist that since the death of her husband, she has not been able to hold a relationship for a long period. Some weeks later the client called Dr. Titus and reminded him of their conversation and asked if he can recommend somebody for her. As a result of their conversation, Dr Titus decided to consult a trusted professional colleague for advice. After his consultation with a professional colleague, Dr Titus called the client and declined further consultation with her.

### Analysis

In analysing this scenario, some might think Dr. Titus action is conservative. The client is a mature lady who has a right to make a decision. The model demonstrates that the power differential was in the middle, of unknown closure and perhaps of long period. Dr. Titus recognized that as long as the power differential is sustained, the inharmoniousness in the role would continue. The discussion had shown additional information critical to his decision. Dr Titus understood that if he went ahead and introduce someone to the client and they start a relationship, she might feel indebted to him and susceptible to potential manipulation. Had the relationship failed, the client might displace or have hostile feelings towards him, and this may have an impact on their future professional conduct together. Moreover, Dr Titus followed the model recommendation for a waiting period and discussion with a professional colleague and this went a long way to help him make a positive decision, which was eventually useful in his decision making.

## DISCUSSION AND CONCLUSION

Though the American Psychological Association (APA) came out with elaborate ethical values and principles that guide the professional conduct of its members, there is still lackof comprehensive, systematically gathered data about the degree to which members believe in or comply with these guidelines. Research has long identified lack of broad and scientifically generated data on psychologists' beliefs and compliance with ethical principles as the bane of the profession. As important as they are, such information, as important are not available to guide individual clinical psychologistsin their decision making or the APA in their efforts to review, improve, and spreadthe code of practice. For instance, evidence till date, still shows that little is known about the valuable experience needed in regulating appropriate conduct in clinical practice. As mentioned in most of the ethical literature, the practicability of boundary issues remains unsolved in clinical practice. Although the ethical principle offers common guidelines for clinical psychologist, little or no guideline is offered when it comes to decision making. Nonetheless, there are a number of reasons why ethical conducts continue to influence decision making process in clinical practice. This paper describes the relevant steps that psychologists must followin the course of making a professional decision , and defines a decision-making model that helps psychologists make professional judgement. Though the model is relevant to psychologists, thereare still some issues that need to be solved if professionalism is to be sustained.

Also, the study demonstrated that power differential remained even when it is evidently clear that a service has ended. For instance, some clients strongly believe that they can come back for further service despite the fact that the session has ended. The question is, should we engage former psychotherapy clients in social relationship even withclear evidence to show that the service has ended? If this arises, does making relationship with such client untenable and unwise? This

question continues to influence decision making in clinical practice, thus hampers the success of the therapy. Also psychologists face similar nettlesome conditions when they had middle to long-term personal contact with clients and interns. For instance, in the beginning of the treatment, the power differential was pronounced, and contacts may go on for ages, and then developed into peer, friendly, companion-able or passionate ones. In this case, it is advisable that psychologists take into consideration the issue illustrated earlier, thatstate that the scopes of the relationship must be viewed from the client's perspectives. So, it is not sufficient to conclude that the approved professional rapport is reaching termination. Finally, as good as a decision making model is to clinical practice, it still lacked empirical validation. Hence, for it to be properly applied in clinical practice, it requires a subtle professional judgement as well as careful and thorough reflection from a clinical psychologist. Finally, it is worth mentioning that consultation is an important ingredient in the decision-making process. There is still no alternative to professional consultation of trusted colleagues.

## RECOMMENDATION

As the decisions whether or not to cross a borderline threaten us every day, they are often subtle and influence the progress recorded in the therapy. Although dual relationships sometimes enhance therapy, aid the treatment strategy, and promote the clinician-client working relationship, they also weaken the treatment process, hamper the clinician-client cooperation, and bring instant or lasting damage to the service user. At the individual level, psychologists should take cognisance of their individual and professional needs and be self-care. They should endeavour to achieve those needs without allowing them having any bearing on their relationships with clients. Based on these analyses, this paper recommends that: 1) professionals should position themselves and make sound choices by coming up with a strategyon boundary crossings that focus on their general attitude to ethics. 2) Efforts must be directed toward staying up-to-date with the evolving law, ethical values, research, concept, and practice procedures. 3) Before taking any decision, a psychologist must take into consideration the situational context of each client.4) Clinical psychologist must involve incritical thinking devoid of common cognitiveblunders that can affect clinical duties. 5) Efforts should be directed toward avoiding personal responsibility for our decisions and we should justify our choices and conduct. When we realise our mistake or notice that our boundary choices have led to woe, we should apply accessiblemeans to come up with the best solution to solve the problem.

## REFERENCES

American Association for Marriage and Family Therapy (2001). *AAMFT code of ethics.* Alexandria, VA: Author.

American Psychological Association (APA).(1992). Ethical Principles of Psychologists and Code of Conduct.Amer. Psychol. 47, 1597-1611.

American Psychological Association.(1990). Ethical principles of psychologists.Amer. Psychol.45, 390-395.

American Psychological Association (APA) (2002). Ethical Principles of Psychologists and Code of Conduct.Amer. Psychol. 57, 1060-1073.

Beauchamp TL, Childress JF (1994). *Principles of biomedical ethics*(4th ed.). New York: Oxford University Press.

Bleiberg RJ, Baron J (2005). Entanglements in dual relationships in a university counseling center. Edu. Administrat. Abstracts, 40(2), 21-34.

Bleiberg RJ, Skufca L (2005). Clergy dual relationships, boundaries, and attachment. Pastoral Psychol. 54(1), 3-22.

Borys D, Pope K (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. *Professional Psychology:* Res. Practice, 20, 283-293.

Carroll MA, Schneider HG, Wesley GR (1985). *Ethics in the practice of psychology.*Englewood Cliffs, NJ: Prentice-Hall.

Catalano S (1997). The challenges of clinical practice in small or rural communities: Case studies in managing dual relationships in and outside of therapy. J. Contemporary Psychotherapy, 27: 23-35

Corey G (2009). Theory and Practice of Counseling and Psychotherapy, (8th ed.). Belmont, CA: Brook/Cole.

Corey G, Corey MS, Callanan P (2007).Issues and Ethics in the Helping Professions.(7th Ed.). Belmont: Thompson Brooks/Cole.

Doyle K (1997). Substance abuse counselors in recovery: Implications for the ethical issue of dualrelationships. J. Counsel. Develop.75:428-432.

Edwards J (2007). Speaking the unspeakable: The ethics of dual relationships in counseling and psychotherapy. Hove: Routledge. ISBN 1-58391-985-6. Counsel. Psychothera.Res.7, 128-131.

Epstein RS, Simon RI (1990), The Exploitation Index: an early warning indicator of Boundary violations in psychotherapy. Bull Menninger Clinic 54(4):450-465.

Feminist Therapy Institute (1987). *Feminist therapy code of ethics.* Denver: Author.

Gabbard GO (1989).Sexual Exploitation in Professional Relationships. Washington, DC, American Psychiatric Press,

Gottlieb MC (1986). *Dual relationships: Is it ever all right? In* R. M. Dawes (Chair), "Dual relations: therapist and ex-patient." Symposium conducted at the annual Annual meeting of the American Psychological Association, Washington, DC.

Gutheil TG (1989). Borderline personality disorder, boundary violations and patient-therapists ex: medicolegal pitfalls. Am. J. Psychiatry 146, 597-602.

Gutheil TG, Gabbard GO (1993). The concept of boundaries in clinical practice: theoretical and risk management dimensions. Am. J. Psychiatry 150: 188-196.

Gutheil TG, Gabbard G.O (1998), Misuses and misunderstandings of boundary theory in clinical and regulatory settings. Am. J. Psychiatry 155: 409-414.

Hubble MA, Duncan BL,Miller SD (1999) *The Heart and Soul of Change: What Works in Therapy*. Washington, DC: American Psychological Association.

Kitchener KS (1986, August). *Dual role relationships: Can and ought psychologists avoid them?* Paper presented at the 94th Annual Convention of the American Psychological Association, Washington, DC.

Kitchener KS (1988). Dual role relationships: What makes them so problematic? J. Counsel. Develop. 67: 217-221.

Kitson C, Sperlinger D (2007). Dual relationships between clinical psychologists and their clients: A survey of UK clinical psychologists' attitudes. Psychol.Psychothera.80, 279-295.

Knapp S, Slattery JM (2004). Professional boundaries in non-traditional

settings. *Professional Psychology:* Res. Practice, 35:553–558.

Kolbert J, Morgan B, Brendel J (2002). Faculty and student perceptions of dual relationships within counselor education: A qualitative analysis. *Counselor Education and Supervision,* 41(3): 193-206. Retrieved from PsycINFO database

Koocher GP, Keith-Spiegel P (2008). *Ethics in psychology and the mental health professions*. New York: Oxford University Press.

Langs R (1988). *A primer of psychotherapy*. New York: Gardner Press.

Lazarus AA (1994). How certain boundaries and ethics diminish therapeutic effectiveness. *Ethics, Behavior,* 4: 253-261.

Lazarus AA, Zur O (2002). *Dual Relationships and Psychotherapy*. New York: Springer.

Lazarus AA, Zur O, Doverspike WF (2004). Dual relationships and psychotherapy. Contemporary Psychotherapy, 49: 209-211.

Moleski SM, Kisicela MS (2005). Dual relationships: A continuum ranging from the destructive to the therapeutic. J. Counsel. Develop. 83(1): 3-12.

Nigro T (2004). Counselor's experiences with problematic dual relationships. Ethics, Behav. 14(1), 51-64.

Pope KS, Sonne JL, Greene BG (2006). *What therapists don't talk about and why: Taboos that hurt us and our clients*. Washington, DC: American Psychological Association

Pugh R (2007). Personal and professional boundaries in rural social work. Br. J. Social Work, 37(8), 1405-1423.

Rest JR (1983). Morality.*In* J. Flavell, E. Markman (Eds.), *Cognitive development*. New York: John Wiley.

Sidell N (2007). An exploration of nonsexual dual relationships in rural public child welfare settings .J. Pub. Child Welfare, 1: 91-104.

Simon RI (1989). Sexual exploitation of patients: how it begins before it happens. Psychiatric Annals; 19:104-122.

Simon R, Shuman D (2007). Clinical Manual of Psychiatry & Law. Arlington, VA: American Psychiatric Publishing, Inc.

Sonne JL (1994). Multiple relationships: Does the new ethics code answer the right questions? *Professional Psychology:* Res. Practice, 25: 336-343.

Remley TP, Herlihy B (2009). Ethical, legal, and professional issues in counseling. Boston, MA.

Ringstad R (2008). The ethics of dual relationships: Beliefs and behaviors of clinical practitioners. *Families in Society:* J. Contemporary Human Services, 89(1): 69-78.

Roth A, Fonagy P (1996) *What Works for Whom: A Critical Review ofPsychotherapy Research*. London: Guilford Press.

Williams MH (1997). Boundary violations: Do some contended standards ofcare fail to encompass common place procedures of humanistic, behavioral, and eclectic psychotherapies? *Psychotherapy,* 34: 238-249.

*Full Length Research Paper*

# "They will not even give me a cup of water": Stress and coping among women living with HIV in Southern India

## Meghan Hunter, Rachel Gray*, Courtney Welton-Mitchell and N.M. Samuel

University of Denver, United States.

Limited research has examined the mental health of women living with HIV and AIDS in low and middle income countries such as India. This exploratory study examined distress and coping among twenty HIV positive women in rural southern India. Focus groups were conducted in Tamil, and coded for thematic content. Women were asked about hardships, support from the community, and preferred forms of coping. Several themes emerged including: *social and familial rejection; difficulty meeting basic needs; concerns for the future of children; and interest in helping others in similar circumstances.* Participants highlighted the importance of medication adherence and social support in maintaining physical and mental wellbeing. Future research should investigate these themes in a larger sample of HIV positive women in the region using mixed methods. Intervention strategies should also be explored to reduce HIV stigma, and increase community acceptance and social support for individuals struggling with HIV-related social exclusion.

**Key words:** HIV and AIDS, India, mental health, women, stigma, coping.

## INTRODUCTION

Despite continued efforts to control the epidemic, rates of infection with human immunodeficiency virus(HIV) and acquired immune deficiency syndrome (AIDS) remain high, especially among women and children in low and middle income countries (UNAIDS, 2012). Countries such as India are struggling to control the epidemic, particularly among the most vulnerable groups (NACO, 2013). According to the World Bank (2012), an estimated 2.4 million persons in India are HIV positive. Women comprise thirty-nine percent of those in India living with HIV, with children under the age of fifteen representing another almost four percent (World Bank, 2012). Infection rates are highest in the southern and western parts of the country, particularly among rural populations. The southern states of Andhra Pradesh, Maharashtra, Karnataka, and Tamil Nadu have some of the highest rates in the nation, with actual infection assumed to be substantially higher than what is reported (World Bank, 2012). A generation of women in India is struggling with the physical and mental health implications of being HIV positive. These stressors may be compounded by high rates of exposure to interpersonal violence among women in India (Simister and Mehta, 2010), and often limited social supportfrom family and community members for persons living with HIV (Sivaram et al., 2009).

Rising HIV infection rates among vulnerable populat-

*Corresponding author. E-mail: racheletepfer@gmail.com

ions in India have been linked, in part, to the status of women and children (Claeson and Alexander, 2008). Traditional family systems and associated sex-role expectations mean that women have limited power or control, often resulting in an inability to protect themselves from infection (World Bank, 2012). Intimate partner violence (IPV), specifically sexual violence, has also been linked to the spread of HIV (Karamagi et al., 2006). Lifetime partner violence, including emotional, physical, and/or sexual abuse is estimated to be nearly forty percent among married women in India (Silverman et al., 2008), with some recent research suggesting that rates of IPV have further increased in recent years (Simister and Mehta, 2010). Another survey of three-hundred ninety-seven rural southern Indian women found that thirty-four percent had been hit and/or forced in other ways to have sex with their husbands (Coast, 2013). Exposure to this type of interpersonal violence has been associated with negative mental health consequences including depression, social isolation, and hopelessness (Silverman et al., 2008).

Research indicates that social support can prevent or mitigate mental health and other consequences of exposure to potentially traumatic stressors, including interpersonal violence and life-threatening health conditions such as HIV and AIDS. For example, in one study of sixty-five men and women living with HIV and AIDS, higher rates of satisfaction with social networks and social support were associated with fewer HIV and AIDS symptoms (Ashton et al., 2005). Results from another study indicate that social support is associated with medication adherence for persons with HIV (Gonzalez et al., 2004). Social support has also been linked to decreased risk of adverse mental health consequences in persons with a history of exposure to stressful life events (Ozbay et al., 2007) The association between social support and health-related outcomes highlights the importance of access to support for those living with HIV (Ashton et al., 2005).It is noteworthy however, that most studies of social support and HIV have been conducted in the U.S. and Western Europe, with limited research having been done in settings such as Southern India.

Some research does exist however, on the social experiences of persons living with HIV in India, suggesting that social support can play a critical role in wellbeing. For example, people living with HIV in Chennaihave been found to have relatively low levels of social support, higher feelings of isolation, and a sense of loss of control compared to those without HIV (Sivaram et al., 2009). It is not uncommon for persons living with HIV to report loss of social support from family and friends, the larger community, and even health workers following disclosure of status. Research indicates that some doctors in Southern India have even refused to see or touch an HIV positive patient and have been known to wear masks, mistakenly assuming that they can contract HIV through

airborne transmission (Thomas et al., 2009). This type of social rejection, along with other forms of prejudice and discrimination typically associated with HIV- related stigma, has been linked to increased risk of depression and anxiety among HIV positive persons in India (Nyamathi et al., 2013b).

Being HIV positive has been associated with a varietyof stressors as outlined here. As such, it is not surprising that living with HIV can tax coping abilities, potentially having a significant impact on mental health outcomes (Varni et al., 2012). Research suggests that some HIV positive individuals, perhaps due to fear of being socially ostracized, engage in avoidant coping (e.g. attempting to pass as a member of the uninfected majority, hiding medications, or avoiding healthcare facilities). Such avoidant coping, in conjunction with limited social support, can lead to negative health outcomes, reduced quality of life, and psychological distress (Nyamathiet al., 2013a). Some stigma-reduction interventions have shown promise in reducing avoidant coping among HIV positive women in rural India (Nyamathi et al., 2013a).

In addition to mental health symptoms such as depression, anxiety, and low self-esteem, culturally-specific expressions of distress can be a useful means of understanding the experience of HIV positive women in rural India. Somatic complaints including headaches, back pain, gastric problems, painful urination, visual disturbances, palpitations, high blood pressure, and fainting attacks have been reported among South Asian populations with a history of exposure to potentially traumatic stressors (Kohrt and Hruschka, 2010; Pereira et al., 2007). While it is important to rule out other health problems, such complaints may be indicative of psychological distress. Physical complaints are often viewed as more acceptable to report than overt mental health concerns. Little is known about the mental health consequences of living with the various physical and psychological stressors that can accompany HIV, especially in communities where persons may be socially ostracized because of their status. The primary aimof this exploratory study is to address gaps in the literature, increasing understanding of the experience of HIV posi-tive women in rural Southern India. Specific objectives of this study include obtaining a better understanding of the psychological difficulties such women encounter, including treatment by family and community members, and preferred forms of coping with HIV-associated stressors. All of the women in this study were receiving supportive services through a local organization known for assisting HIV positive women with a history of interpersonal violence exposure. As we conducted open-ended focus groups and examined thematic content, many of the struggles, concerns, and coping strategies of the women became clear. This exploratory qualitative study makes a significant contribution to the literature by emphasizing the voices of typically marginalized HIV positive women in Southern India.

## METHODS

### Participants

Twenty women receiving services from a local non-governmental organization (NGO) participated in two focus groups over the course of two weeks. The specific service provider was selected based on a prior relationship with members of the research team, and because it is one of the only agencies in the area providing services for women living with HIV.

In an effort to encourage open discussion, demographic data was not collected for focus group participants. This decision was made based on concerns from the research team and NGO staff that collecting demographic data may discourage some women from participating, or may result in unrealistic expectations of some additional benefit from participating. However, demographic data for a random sample of women also utilizing services through this same NGO was collected for a related study (author, *in preparation*). Although the demographics from this randomly selected group may not reflect the specific composition of the focus groups, this information is reported below as a point of reference.

Demographics for random sample of women engaged with the service provider: average age $M$ = 42.5 years; $SD$=7.10; range=28-55 years; 85% Hindu, 10% Christian; 100% reported being married, although only 15% were living with their spouse - 25% reported being separated and 60% were widowed; 95% of participants indicated they have children; 75% of women had no more than fifth standard year of education; 75% were employed - although 90% reported having "less" or "much less" money than other members of the community. Rates of exposure to traumatic stressors were high: 80% of women surveyed reported a history of interpersonal violence, primarily in the form of abuse by close family members (e.g., husband, mother-in-law).

### Procedure

Women were approached by NGO staff at regular social gatherings held at the center as well as contacted by phone and invited to participate in focus groups. Both means of contact were utilized in order to minimize the potential for recruitment biasassociated with only reaching out to women who utilize social services provided by the NGO. They were told they would be asked to discuss topics related to their HIV status. Participants were offered compensation in the form of bus fare to cover transport to and from the center on the day of the focus group. Snacks, coffee, and tea were also provided. In accordance with local standards consent was verbally discussed with each participant. Ethical concerns were minimized by emphasizing the voluntary nature of the focus group in the consent form, emphasizing an 'opt-in' procedure for participation; thus making it easy for women to choose to not participate, and explaining that no identifying demographic data would be collected. Confirmation of consent was obtained by either a signature or thumbprint for those who could not write. Study procedures were approved by a university institutional review board at a US-based university and an equivalent in New Delhi before data collection began.

### Focus groups

Two focus groups, comprising nine and eleven members, were conducted two weeks apart. At the start of each group, the interpreter reviewed informed consent, emphasized the importance of confidentiality, and requested permission to audio record the session.

Focus groups lasted between 30-60 min. One NGO staff member facilitated the discussion while two to three researchers observed.It is the belief of the research team that the NGO staff facilitator was a trusted familiar face to many of the women, increasing the possibility that women would feel comfortable providing honest responses. Both focus groups were conducted in the local language of Tamil, audio recorded, and later transcribed.

### Measures

Open-ended questions were used to guide focus group discussion. Questions were developed by researchers with the intention of eliciting responses related to distress, social support, and coping. Questions were developed in collaboration with staff and previous volunteers working at the NGO, based on anecdotal reports of common issues brought up by women utilizing the center. Specifically, the following questions were asked (back-translated English version provided): 1) "What type of physical and mental difficulties do women in your situation typically experience?", 2) "Does your community or family treat you differently because of your health status?", 3) "In difficult times, what do you do to overcome the situation?", 4) "What gives your life meaning?", 5) "How do you keep others close to you?" (maintain social ties), 6) "What advice would you give to other women with the same HIV status?", 7) "Is there anything else you think is important for us to know about women in your situation?"

### Translation

Responses were transcribed from Tamil to English, and then back translated from English into Tamil. The NGO-provided interpreter worked closely with other members of the research team throughout this process in an attempt to maintain equivalence of constructs between Tamil and English.

### Qualitative data analysis

Two researchers independently coded the back translated English data from the focus groups in order to derive themes based on grounded theory and the constant comparative method (Glaser, 1965; Lincoln and Guba 1985). This has been recognized as a useful approach to coding qualitative data (Maxwell 1996; Maycut and Morehouse 1994; Powell 1997; Westbrook 1994). Coders first independently generated themes based on frequency of responses, resulting in over forty categories. Next, categories were consolidated based on consensus, collapsing overlapping categories into broader themes. This resulted in between three and five categories for each of the seven questions. For example, in response to the focus group question "What type of physical and mental difficulties do women in your situation typically experience?"The following categories emerged: *physicalreactions; psychological reactions; rejection by family members; rejection by community; difficulties with employment.*

## RESULTS

Common themes emerging from focus groups with detailed examples are provided in Table 1 and elaborated here.

In response to the question "What type of physical and mental difficulties do women in your situation typically experience?" respondents provided descriptions of physical reactions, psychological reactions, examples of rejection by family members and community, and stories about difficulty finding and maintaining employment.

**Table 1.** Focus group responses to coping with HIV (N = 20).

| Inquiry (back translated) | Common themes | Examples |
|---|---|---|
| 1. "What type of physical and mental difficulties do women in your situation typically experience?" | Physical Reactions; Psychological Reactions; Rejection by family members; Rejection by community; Difficulties with employment | *weight loss; hair loss; fatigue; vision problems; pain; skin rashes; worry about oneself; family/children; fear; feelings of isolation; desire for company/affection; doesn't get invited to events; blamed for HIV status; can't get a job because of HIV status* |
| 2. "Does your community or family treat you differently because of your health status?" | Rejection by family members; Rejection by community; Community is supportive | *they will not talk to me; they will not even give me a cup of water neglected by others; people talk negatively behind my back in the last few years the community is more accepting due to education; people have been supportive; no difference* |
| 3. "In difficult times, what do you do to overcome the situation?" (how do you cope) | Turn to religion; Work; Socialize; Care for others | *pray; go to job; keep status a secret to maintain job; go to local organizations that help people with HIV; talk with others; take care of children* |
| 4. "What gives your life meaning?" | Family members; Children; Desire to prove others wrong | *my husband consoles me; need to care for other family members; I want to see my children do well in life; living for my children; to live as an example and show others they are wrong* |
| 5. "How do you keep others close to you?" (what do you do that others value?) (social support) | Be affectionate towards others; Spend time with family; Earn money; Not possible, rejected by community; Can't tell others about status or they will not want to be near me | *be loveable, act and speak with affection towards others; take care of uncle; because I earn money mother and brothers visit; people won't speak to us; others see HIV as a punishment for sins; others will blame me; seen as a disease of women* |
| 6. "What advice would you give to other women with the same status?" | Promote wellness; Help them physically; Promote being positive; Be an advocate | *take medication; eat well; educate about services; discourage suicide; take to hospital; help when sick; introduce to local organizations; be happy for others; share my knowledge* |
| 7. Other comments from women in the focus groups | *the community needs to be educated about HIV; helping others with HIV makes me worry less about myself; my husband drinks because he is worried about my HIV status; it is important not to spread to others; others must be advised about HIV* | |

Physical difficulties included: *weight loss; hair loss; fatigue; vision problems; pain; and skin rashes.* Psychological reactions included: *worry about oneself; worry about family/children; fear; feelings of isolation; desire for company/affection: not being invited to community events; being blamed for HIV status; and an inability to get a job because of HIV status.*

When asked specifically about how they are treated by family and community members, most women were quick to explain that many people reject them. Examples of rejection included: *they will not talk to me; and they will not even give me a cup of water.* One woman stated that even her own mother will not give her water; another explained that cups used by HIV positive persons are often thrown away. Some women went on to explain, *my children aren't allowed to play with others; (I'm) neglected by others; people talk negatively behind my back;* and stated, *the community blames women for HIV.* Some went on to explain that fear of rejection is why they have not shared their status with others. A few women however, provided examples of community support and explained, *in the last few years the community is more accepting due to education.*

Given the challenges associated with being HIV

positive, we were interested in understanding how the women cope. Specifically we asked, "In difficult times, what do you do to overcome (cope with) the situation?" Common themes included turning to religion – praying often, working to take one's mind off the situation, socializing with supportive family and community members, participating in HIV positive support groups provided by a local organization, and caring for others, including children and other HIV positive women.

In order to better understand how some women are able to maintain an optimistic outlook despite the challenges associated with being HIV positive, we asked, "What gives your life meaning?" Several women indicated that supportive family members(*my husband consoles me*) and the desire to ensure their children's wellbeing (*I want to see my children do well in life*), give their lives purpose and meaning. Interestingly, some women indicated that a desire to prove others wrong, to show the community that HIV positive persons can make valuable contributions, enables them to get out of bed each day.

Many of the women mentioned the importance of family and community, so we asked a follow up question about how they have been able to find and maintain social support. Some women indicated that they did *not* have social support because of their HIV positive status (*others see HIV as a punishment for sins*). Other suggested however, that they had been able to find and maintain social ties by being especially loving/loveable in the eyes of others (*act and speak with affection towards others*) and providing material support to others (*I take care of my uncle; I earn money so my mother and brothers visit*).

Finally, we wanted to know what advice these women would give to other HIV positive women. Women spoke at length about the importance of being an advocate for others with HIV, encouraging healthy behaviors such as taking medication and eating well, and the importance of access to material assistance and emotional support. Some mentioned that it is important to learn about what resources exist locally, others stated that HIV positive women should not consider suicide an option. The issue of suicide came up several times, with a few women providing examples of how to take one's mind off suicide – e.g. *I think about my daughter, I live for her.*

When provided an opportunity to share additional comments, several women emphasized the importance of HIV positive women such as themselves advocating for others and educating the community about HIV. Other women emphasized that helping others can be therapeutic - *helping other with HIV makes me worry less about myself.* Some also shared examples about difficulties family members face in coping with a loved one who is HIV positive (*my husband drinks because he is worried about my HIV status*).

## DISCUSSION

This study involved a unique sample of HIV positive women in rural Southern India.  Through focus groups, researchers were able to collect data about various challenges and hopes, as women shared experiences of familial rejections, changes in social status, concerns about their children's future, and a strong desire for social support. Women offered rich examples of what they can and want to do for themselves and others.  The results of this exploratory study contribute to our understanding of the psychological difficulties women living with HIV in Southern India encounter, including treatment by family and community members, and preferred forms of coping with HIV-associated stressors.

The results of this study are also consistent with previous research in Southeast Asia, highlighting somatic complaints among those experiencing both acute and chronic stressors (Kohrt and Hruschka, 2010). Many of the women in this study reported weight loss, physical pain, vision problems, and hair loss in response to questions about distress associated with their HIV status. While some of these physical symptoms may be a direct result of their illness, women repeatedly emphasized these complaints when asked about mental health concerns. Another theme that emerged from focus groups was feeling ostracized, specifically, social isolation, and overt rejection by family members and concerns about employment related to their HIV status. Many women reported a change in familial and other social ties following community awareness of their HIV status. Participants indicated that this social rejection has implications for access to healthcare, social support, general wellbeing, and hampers daily functioning. This is consistent with previous research indicating that such forms of social rejection can have negative effects on mental health (Sivaram et al., 2009).

Although women did not speak openly about interpersonal violence in focus groups, research indicates that women who experience physical abuse by their partners are more likely to contract HIV (Dunkle et al., 2004). In fact, there is a growing body of research on the bidirectional nature of domestic violence and HIV *in India*, with women victims of violence at greater risk for contracting HIV, and HIV positive women more vulnerable to various types of interpersonal abuse (Desai, 2005; Go et al., 2003; Blanchard et al., 2005) This, along with the high rates of interpersonal violence (80%) reported by a random sample of women utilizing the same service provider, suggests that the women in this study are likely coping with multiple stressors, including exposure to interpersonal violence.

Women also expressed substantial worry about the future. Women repeatedly expressed concerns for their children's wellbeing including worry over what will happen in the event of their death, how to financially support their children considering their deteriorating health and limited income earning potential, and/or the social implications for the children (e.g. social rejection) as a result of their HIV status.

Participants reported that focusing on children, religion (e.g. praying), and the potential to prove others wrong (e.g. stabilizing medically, maintaining employment, or being active socially) were things that give their life meaning. Participants also indicated a desire to remain active in their children's lives and to continue to act as caregivers for their children. Participants identified religion as a comfort in that it provided opportunities for social support through conversations with others about spirituality and spiritual connection through prayer.

Participants emphasized that pursuing education about HIV, engaging in advocacy about HIV, and taking advantage of social support opportunities such as gathering at the local NGO, are important elements of coping with HIV. Many of the women were eager to share this advice with other HIV positive women and expressed a desire to act as role models for others. Several women indicated that community education and raising aware-ness is critical for addressing stigma surrounding HIV. Several participants explained that there are many reasons to live, highlighting the importance of medication adherence and social support in maintaining physical and mental wellbeing.

### Future research

Future research should investigate the themes arising in this exploratory study in a larger sample of HIV positive women in South Asia using mixed methods. Intervention research should also be conducted to determine the potential for HIV stigma reduction strategies to prevent interpersonal violence, increase community acceptance and enhance social support for individuals struggling with the effects of HIV. Specifically, public service announce-ments emphasizing safe sex practices, means of HIV transmission, dispelling myths, and highlighting the experience of those living with HIV and AIDS should be investigated to determine if these approaches might address some aspects of prevention and treatment. Finally, future research should further examine the inter-section between HIV status and interpersonal violence with an eye towards violence mitigation.

### Conclusion

This research examined the experience of rural Indian women living with HIV and AIDS. Specifically we consi-dered the psychosocial impact of the epidemic on 20 women engaged with a local service provider. All women expressed some feelings of despair relating to their HIV status, including concerns about the implications of disclosure. Common HIV-related physical and mental health difficulties included feelings of sadness, shame, body aches, and fatigue. Most women provided examples of being socially ostracized by family and other community members: "they will not even give me a drink

of water." However, a few noted that attitudes about HIV positive persons appear to be changing. Popular adaptive coping strategies used to mitigate ongoing stressors included use of religion, engagement with children, accessing social support, and other services through a local NGO. Results suggest service providers should employ strategies designed to enhance effective coping and mitigate distress, especially the distress associated with community rejection.

### Conflict of Interests

The author has not declared any conflict of interest.

### ACKNOWLEDGEMENTS

### REFERENCES

Ashton E, Vosvick M, Chesney M, Gore-Felton C, Koopman C, O'Shea K, Maldonado J (2005).Social support and maladaptive coping as predictors of the change in physical health symptoms among persons living with hiv/aids.*Mary Ann Libert Publishers*, *19*(9):587-598.doi: 10.1089/apc.2005.19.587.

Blanchard JF, O'Neil J, Ramesh BM, Bhattacharjee P, Orchard T, Moses S (2005). Understanding the social and cultural contexts of female sex workers in Karnataka, India: implications for prevention of HIV infection.*J. Infectious Diseases.191(1)*:139-46. Retrieved from http://jid.oxfordjournals.org/content/191/Supplement_1/S139.full.pdf+html

Claeson M, Alexander A (2008). Tackling hiv in india: Evidence-based priority setting and programming. *Health Affairs*, *27*(4):1091-1102.doi: 10.1377/hlthaff.27.4.1091

Coast E (2013, 01 23). [Web log message]. Retrieved from http://blogs.lse.ac.uk/indiaatlse/2013/01/23/gender-based-violence-in-india/

Desai S (2005) HIV and Domestic Violence: Intersections in the Lives of Married Women in India. *Health and Human Rights.8(2):*140-168. Retrieved from http://www.hsph.harvard.edu/fxbcenter/v8n2.htm

Dunkle KL, Rackel KJ, Brown HC, Gray GE, McIntryre JA, Harlow SD (2004). Genderbased violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa.*The Lancet*, 363(9419):1415-1421.doi:10.1016/S0140-6736(04)16098

Glaser BG (1965). The constant comparative method of qualitative analysis.*Social Problems. 12*:436–445.

Go VF, Sethulakshmi CJ, Bentley ME, Sivaram S, Srikrishnan AK, Solomon S, Celentano DD (2003). When HIV-prevention messages and gender norms clash: the impact of domestic violence on women's HIV risk in slums of Chennai, India.*AIDS Behaviour, 7(3),* 263-72. Retrieved from http://saathii.pantoto.org/p/UpLoad/idb/librarian/f/vgo2003pdf.pdf

Gonzalez JS, Schneiderman N, Penedo FJ, Antoni MH, Duran RE, McPherson-Baker S, Ironson G, Isabel Fernandez M, Klimas NG,

Fletcher MA (2004). Social support, positive states of mind, and hiv treatment adherence in men and women living with hiv/aids. Division Health Psychol. 23(4):413 - 418.doi: 10.1037/0278-6133.19. 2.124

Karamagi CA, Tumwine JK, Tylleskar T, Heggenhougen K (2006). Intimate partner violence against women in eastern uganda:implications for hiv prevention. BMC Public Health. 6(284). doi: 10.1186/1471-2458-6-284

Kohrt BA, Hruschka DJ (2010). Nepali concepts of psychological trauma: the role of idioms of distress, ethnopsychology and ethnophysiology in alleviating suffering and preventing stigma. Culture Medicine Psychiatry. 34(2):322-352.doi: 10.1007/s11013-010-9170-2

Lincoln YS, Guba EG (1985). Naturalistic Inquiry. Sage Publications Inc., Newbury Park, London, New Delhi.

Maxwell JA (1996). Qualitative research design: An interactive approach. Thousand Oaks, CA: Sage.

Maycut P, Morehouse R (1994) Beginning Qualitative Research: A Philosophic And Practical Guide (London, Falmer Press).

National AIDS Control Organization (NACO, 2013). *Annual Report 2012-2013*.Department of AIDS Control, Ministry of Health and Family Welfare, Government of India. Retrieved from:http://www.naco.gov.in/upload/Publication/Annual%20Report/Annual%20report%202012-13_English.pdf

Nyamathi A, Ekstrand M, Salem BE, Sinha S, Ganguly KK, Leake B (2013a). Impact of Asha Intervention on Stigma Among Rural Indian Women With AIDS. Western J. Nursing. Res. doi: 10.1177/0193945913482050

Nyamathi A, Ekstrand M, Zolt-Gilburne J, Ganguly K, Sinha S, Ramakrishnan P, Leake B (2013b). Correlates of stigma among rural Indian women living with HIV/AIDS. AIDS Behavior. 17(1):329-339. doi: 10.1007/s10461-011-0041-9

Ozbay F, Johnson D, Dimoulas E, Morgan C, Charney RD, Southwich S (2007) Social Support and Resilience to Stress. Psychiatry 4(5):35–40. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2921311/

Pereira B, Andrew G, Pednekar S, Pai R, Pelto P, Patel V (2007). The explanatory models of depression in low income countries: Listening to women in India. J. Affective Disorders. 102(1):209-218.doi:10.1016/j.jad.2006.09.025

Powell Ronald R (1997). Basic Research Methods for Librarians. 3rd ed. London,England: JAI Press.

Silverman J, Decker M, Saggurti N, Balaiah D, Raj A (2008). Intimate Partner Violence and HIV Infection Among Married Indian Women. JAMA. 300(6):703-710. doi: 10.1001/jama.300.6.703

Sivaram S, Zelaya C, Srikrishnan AK, Latkin C, Go VF, Solomon S, Celentano D (2009). Associations between social capital and HIV stigma in Chennai, India: considerations for prevention intervention design. AIDS Educ. Prevention. 21(3):233-250. doi: 10.1521/aeap.2009.21.3.233

Simister J, Mehta P (2010). Gender-based violence in India: Long-term trends. J. Interpersonal Violence. 25(9):1594-1611. doi: 10.1177/0886260509354577

The World Bank, (2012).Hiv/aids in India. Retrieved from Feature Story website: http://www.worldbank.org/en/news/feature/2012/07/10/hiv-aids-india

Thomas B, Nyamathi A, Swaminathan S (2009). Impact of HIV/AIDS on mothers in Southern India: a qualitative study. AIDS Behavior, 13(5):989-996. doi: 10.1111/j.1745-7599.2007.00221.x.

UNAIDS (2012). Global Report: UNAIDS Report on the Global AIDS Epidemic 2012. Retrieved from http://www.avert.org/worldwide-hiv-aids-statistics.htm#sthash.LepKEcX5.dpuf

Varni SE, Miller CT, McCuin T, Solomon SE (2012). Disengagement and engagement coping with HIV/AIDS stigma and psychological well-being of people with HIV/AIDS. J. social clinical psychol. 31(2):123. doi: 10.1521/jscp.2012.31.2.123

Westbrook L (1994). Qualitative research methods: A review of major strategies, data analysis techniques and quality controls. Library Inform. Sci. Res. 16:241-254.

# International Journal of
# Psychology and
# Counseling

## Related Journals Published by Academic Journals

- Journal of Media and Communication Studies
- International Journal of English and Literature
- Philosophical Papers and Reviews
- Educational Research and Reviews
- Journal of African Studies and Development
- Philosophical Papers and Reviews