

# THEOLOGY IN THE HIV&AIDS ERA SERIES



## MODULE 9

HIV&AIDS PASTORAL CARE  
AND COUNSELLING

BY  
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THE HIV&AIDS CURRICULUM FOR TEE  
PROGRAMMES AND INSTITUTIONS IN AFRICA

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## A NOTE TO LEARNERS, USERS AND READERS

The overall goal of this module is to contribute towards building HIV&AIDS competent churches and theological institutions. This module is part of a series of ten modules entitled, *Theology in the HIV&AIDS Era* which were developed for distance learners. The modules accompany the HIV&AIDS Curriculum for TEE Programmes and Institutions in Africa.

The process of production began with an all Africa training of trainers' workshop on mainstreaming HIV&AIDS in Theological Education by Extension (TEE), held in Limuru Kenya, July 1-7, 2004. The workshop called for the production of a distance learning curriculum and accompanying ten modules to enable the mainstreaming of HIV&AIDS in TEE programs.

Writers were thus identified, trained in writing for distance learners and given their writing assignments. In July 2-13, 2005, twelve writers gathered at the Centre for Continuing Education at the University of Botswana with their first drafts for a peer review and a quality control workshop. The result of the process is this series on *Theology in the HIV&AIDS Era* and the accompanying curriculum for TEE. The whole process was kindly sponsored by the Ecumenical Initiative for HIV&AIDS in Africa (EHAIA).

Although the target audience for these modules is the distance learning community, it is hoped that the series will also stimulate new programmes, such as diplomas, degrees, masters and doctoral studies in HIV&AIDS theological research and thinking in residential theological institutions. It is also hoped that the series will contribute towards breaking the silence and the stigma by stimulating HIV&AIDS theological reflections and discussions in various circumstances, such as in Sunday schools, women's meetings, youth and men's fellowships, workshops, conferences and among teachers and preachers of religious faith.

Musa W. Dube  
Gaborone, Botswana  
July 28, 2006

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# MODULE 9

## MODULE OVERVIEW

Welcome to module 9 of the HIV&AIDS curriculum for Theological Education by Extension (TEE). This module will expose you to the theory and practice of counselling in the context of HIV&AIDS. The module is broken into ten units that discuss in detail the different aspects of counselling in general, and HIV&AIDS counselling in particular. It further discusses the pastoral, cultural, legal, ethical and policy dimensions of HIV&AIDS counselling. Unit 1 defines the problem of HIV&AIDS and the challenges it poses for counselling. Unit 2 to 3 covers the definition and aims of counselling; the basic skills and qualities for being an effective counsellor as well as the theories and stages of counselling. Unit 4 to 7 concentrates on HIV&AIDS counselling as applicable in different contexts. Unit 8 looks at the legal, ethical and policy dimensions of HIV&AIDS. Unit 9 to 10 deals with the role of the church in the context of HIV&AIDS.

It is hoped that after going through this module you will be able to appreciate the theory and practice of counselling in general, and that of HIV&AIDS in particular. The information in this module has been presented in a very concise and simplified manner to enable you to read and translate what you have learned.

## MODULE OBJECTIVES

At the end of this module, you should be able to:

- ✂ Analyse the problems around HIV&AIDS, and review challenges they pose for counselling.
- ✂ Describe counselling theories and skills.
- ✂ Practice counselling skills in different situations.
- ✂ Define HIV&AIDS counselling and apply it in HIV&AIDS situations.
- ✂ Practice the process of HIV&AIDS counselling in different settings
- ✂ Critically analyse the mission of the church in general and its role in HIV&AIDS situations in particular.

## ACTIVITIES

This module consists of text activities, self-assessment exercises and further reading. The text questions are meant to engage you as you read through the module. At the end of every unit there is a self-assessment exercise. This exercise is meant to test your understanding of the main sections of the unit. It also prepares you for the later assessments in the form of assignments, tests and examinations. Further reading provides you with additional material that could be helpful for the understanding of individual sections of the unit. Apart from the written material, people are also another useful source you can learn from.

## ASSESSMENT

The module assessment consists of two (2) assignments, one (1) test and a final examination. The first assignment is based on the first six units (units 1-6) and the second assignment is based on the last four units (units 7-10). After reading through the first six units please do the first assignment. After reading through units 7-10, please do the second assignment. The test and the examination cover almost the entire module. After you complete the whole module, please re-read the whole module more carefully for the second time and then write your test and examination.

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# UNIT 1

## DEFINING THE PROBLEM OF HIV&AIDS

### OVERVIEW

Welcome to unit 1. Unit 1 introduces you to the problem that HIV&AIDS creates for all members of society—but especially for women and girls. We will look at how the different areas of society such as health, education and food production are affected by the epidemic. We will also look at how individuals within communities such as PLWHA, the affected and caregivers, are affected by HIV&AIDS. HIV&AIDS related stigma and discrimination are also discussed. Stigma and discrimination constitute a problem for HIV&AIDS prevention, treatment and care, and a challenge to counselling.

### OBJECTIVES

At the end of this unit you should be able to:

- ⌘ Explain the problem around HIV&AIDS.
- ⌘ Analyse the impact of HIV&AIDS on the different sectors of our society.
- ⌘ Discuss how individuals within communities are affected by HIV&AIDS.
- ⌘ Explain HIV&AIDS related stigma and discrimination and its impact on prevention, treatment and care.
- ⌘ Identify the challenges HIV&AIDS pose for the counselling profession.

## TOPICS

### ⌘ The Problem of HIV&AIDS

- Statistics
- Women and Girls

### ⌘ Structural Dimension

### ⌘ Health Sector

- Education Sector
- Food Production Sector

### ⌘ Community Dimension

- PLWHA
- The Affected
- The Caregivers

### ⌘ HIV&AIDS and Stigma

- Types of Stigma
- HIV&AIDS Related Stigma
- Expressions of HIV&AIDS Related Stigma
- Effects of HIV&AIDS Related Stigma

### ⌘ HIV&AIDS and Discrimination

### ⌘ Challenges for Counselling

Summary, Self-Assessment, Further Reading, Glossary

## THE PROBLEM OF HIV&AIDS

In 2001 the *United Nations Special Session on HIV&AIDS* released a report that painted an alarming picture. Since it was first identified 20 years ago, HIV&AIDS has spread to every corner of the world and it continues to grow at an alarming rate. And as it does, it affects everything and everybody. It affects the social, economic, cultural and religious spheres of our lives. It infects and affects all people irrespective of status, sex or race. Let us start by looking at the statistics.

### The Statistics

The total number of people living with HIV has been rising in every region. Our African continent, too, has felt the devastating effects of the epidemic. While some parts of Africa show some significant declines in HIV prevalence—especially among pregnant women— sub-Saharan Africa remains by far the hardest hit region. At the end of 2004, it is reported that there were 25.4 million people living with HIV&AIDS (PLWHA) in Sub-Saharan Africa, with no indications of declining figures. Sub-Saharan Africa, therefore, accounts for one-third of all AIDS deaths globally (UNAIDS 2004:30). These sobering statistics affect the institutions and the people through two main pathways; namely, morbidity (illness) and mortality (death).

### ACTIVITY 1

1. *Find out and write down the number of people in your country who are living with HIV&AIDS.*
2. *Write down the number of people in your village who are living with HIV&AIDS.*
3. *List the number of people in your church who are living openly with HIV&AIDS.*

### Women And Girls

One very notable feature of the HIV&AIDS epidemic is its impact on women and girls. Women and girls make up almost 57 per cent of all people infected with HIV in sub-Saharan Africa, where a striking 76 per cent of young people (aged 15-24) living

with HIV, are female. This indicates that women and girls are most vulnerable to HIV&AIDS than their male counterparts (UNAIDS 2004: 38).

## ACTIVITY 2

- 1. Find out the number of women and girls living with HIV&AIDS in your country.*
- 2. List the things that make women and girls more vulnerable to HIV&AIDS than their male counterparts. Take into consideration, biological make up, culture and religion.*

In the following sections we will discuss how HIV&AIDS impacts on the structural (institutional) and community dimensions of society.

### THE STRUCTURAL DIMENSION

What do we mean when we say ‘structural dimension’? By structural dimension we mean the different institutions of society, such as family, health, educational and food production. HIV&AIDS permeates all the above listed structures of society and renders them dysfunctional. It also works through them to hinder prevention, treatment and care, and consequently fuels the spread of HIV&AIDS. Let us see how HIV&AIDS affects these different structures of society and renders them dysfunctional.

#### Health Sector

In the health sector, health services are overburdened. A lot of health facilities are not able to deal with increasing numbers of people who need treatment and care. As a result, demand for care and treatment exceeds the personnel and structural resources. In Burkina Faso and Ghana, for example, the ratio is one doctor to 29000 people. In Liberia there are only 40 doctors in the entire country. With the onset of HIV&AIDS, health services are overstretched and the staff is overworked. This is bound to affect the quality of services.

## ACTIVITY 3

1. *Does most of the population in your country live in rural areas or urban areas?*
2. *Name areas that have the high concentration of health services.*
3. *In terms of population, what could be the number of people serviced by the nearest hospital?*
4. *List the number of health professionals (doctors, nurses, counsellors) that work in that hospital.*

### Education Sector

The education sector is equally affected. A significant number of teachers and education officials are infected (supply). As a result of this, the quality of education is negatively affected and the reduced number of teachers, due to illness or death, are not able to meet the demand for education especially of the vulnerable children and orphans.

## ACTIVITY 4

*Find out the number of teachers and students that have been lost due to HIV&AIDS related illness or death in schools around your area. Discuss how this affects supply and demand of teachers and students.*

### Food Production Sector

Illness and death resulting from HIV&AIDS affects demand and supply in the food production sector. How? HIV&AIDS increases the demand for food because PLWHA and the affected are not able to provide for themselves. We also know that people living with HIV&AIDS have specific nutrition needs. This means that increased capacity for more production of food is needed to meet the increasing demand for food. Yet ironically, the HIV&AIDS epidemic reduces people's capacity to produce food.

## ACTIVITY 5

*Poverty influences choices people make. In your experience, in what way does poverty make people vulnerable to HIV&AIDS?*

### THE COMMUNITY DIMENSION

In the preceding section we have seen how different institutions or structures in society are affected by HIV&AIDS in terms of demand and supply. We have seen that HIV&AIDS affects these structures in two ways: illness (morbidity) and death (mortality). In this section we are going to investigate ways in which individuals in communities are infected and affected by the HIV&AIDS epidemic.

#### PlwHa

The psychosocial experiences of people living with HIV&AIDS are unique. This is because, as W.J. Smith puts it, in the natural history of medicine, the HIV&AIDS epidemic is without parallel (1988:17). We, therefore, need to understand the plight and the unique situation of PLWHA.

PLWHA have unique fears. They fear the gradual loss of their bodily integrity; their beauty and sexual relationships. They also fear the loss of self-worth and self esteem. They have seen their loved ones and their friends, stigmatised, discriminated against and rejected and they are afraid of having these experiences turned against them.

PLWHA may be afraid of death and fear the unknown. The feelings of guilt, anger and anxiety that they experience may be so overwhelming that they lead to suicidal behaviours. They may fear losing their job. PLWHA may worry about the plight of their partner and their children, who after their death would have to manage without a bread-winner. Another worry for PLWHAs is coping with the financial demands of having to pay for the antiretroviral (ARV) therapy. All of these issues are sources of pressure and frustration.

## ACTIVITY 6

*Stop reading for a moment, recall and write a paragraph on:*

*The experiences of the PLWHA closest to you (at work or at home).*

### The Affected

Partners, children, relatives and friends of PLWHA are all affected by the plight of their loved one. They have their own fears, frustrations and anxieties to deal with as result of their loved one's infection or illness. They more or less experience the same psychosocial feelings as do their loved ones. They are constantly living with the fear of being infected (real or imaginary). They are sometimes angry at the infected person for bringing 'this shame' upon them. The partner, in particular, has to bear the brand of harassment for having infected the other party. The wives are the ones who normally suffer more than their male counterparts because of their subjugated status and lack of negotiating power (power leverage) in most of our African societies. Women and girls are at the end, the ones who bear the burden of care. This makes them more vulnerable to stigma and discrimination for being associated with PLWHA.

## ACTIVITY 7

*Pause and write a paragraph about:*

*'How HIV&AIDS has affected you, your family or your church.'*

### Care givers

We have seen above that a lot of hospitals and health facilities are not able to cope with the growing numbers of people who need treatment and care. Because of this individual family members are forced to take care of their own sick members. This means that there are new demands on the part of children and relatives placed by the sick member of the family. Untrained and with no material resources, the caregivers become helpless and acquire feelings of incompetence, which sometimes lead to abandonment of the sick person.

The majority of PLWHA are usually young people in the reproductive stage. This means that they have to be taken care of by parents and grandparents, who also have to take care of the children of PLWHA. In cases where the parents and the grandparents have all died, the children have to head the households. This is a huge responsibility placed on such young people with no life skills.

Dealing with the issues of the magnitude of HIV&AIDS is very stressful—and both emotionally and physically demanding. Caregivers have to take care of themselves and because of the demands of what they have to deal with, they need care and support from others as well.

## ACTIVITY 8

1. *Discuss the psychosocial problems that confront the HIV&AIDS infected and affected people.*
2. *List ways in which caregivers are cared for in your own country.*
3. *In community home-based care, which group is more active? Males or females. Give reasons why this is the case.*

## HIV&AIDS AND STIGMA

In this section we are going to look at HIV&AIDS related stigma. It is an ‘epidemic’ that not only affects people living with HIV&AIDS, but also the affected people. It expresses itself in various forms and has proved to be the number one enemy in effectively fighting the HIV&AIDS epidemic.

Let us now define stigma. The term *stigma* derives from Greek culture. In Hellenistic Greek the word *stigma* means a scar, mark or a brand indicating ownership. In the Graeco-Roman world stigma could be used of cattle and people. For people, it meant an actual physical mark, cut or burned into a person’s skin designating a person’s particular defect. This was a distinguishing sign so that the rest of society could recognise the marked person as disgraced and could avoid contact with him/her. The reality represented by the term stigma is however not restricted to the Greek context. It is found and expressed in different ways in our societies. In Sesotho (language of



Lesotho), we have words such as *senyama*, *sesila*, *sekhobo*. A person who has all these is marked off from others. S/he is to be dreaded or avoided. There are also groups of people that are stigmatised. Terms such as *sehole*, *sebupuo* refer to someone who is physically or psychologically challenged.

We have similar cases of stigma and stigmatisation in the Hebrew Bible. The lepers, for example, were isolated. They were expected to dress in such a way that they would be easily distinguishable so that they could be avoided (Leviticus 13:1-2; 45-46).

How would we define stigmatisation then? According to the Synergy Project, 'Stigma and HIV/AIDS: A Pervasive Issue' (2004:1), *stigmatisation* refers to a social phenomenon or process that results in a powerful and discrediting social label that affects the way individuals view themselves and are viewed by others. There are certain qualities or attributes in our own cultural settings that are seen by others as unworthy and therefore discreditable. A person with a stigma has either marked himself/herself or has been marked as being unacceptable as a result of his/her behaviour (being a criminal) or as a result of the attribute or attributes s/he possesses which are defined by others as discreditable (being blind).

## ACTIVITY 9

*We all experience stigma in one form or another in our lives. Have you ever experienced stigmatisation? In a paragraph, describe your feelings when you experienced stigmatisation.*

### Types Of Stigma

Stigma can be internal or external. *Internal stigma* is experienced internally. It is a felt shame associated with a certain condition, and the fear of being discriminated on account of that condition. Certain conditions or attributes are categorised by society as shameful. The knowledge of such categories by society makes the person feel internally stigmatised. *External stigma*, on the other hand, refers to the actual experiences of discrimination. It refers to the treatment that people receive as a result of their condition. Now that we have defined stigma and stigmatisation in general

terms, let us talk about HIV&AIDS related stigma. These two types of stigma are often intertwined. They feed each other.

## ACTIVITY 10

1. *List things that are categorised by your culture as shameful.*
2. *Share an experience where you actually discriminated against a person as a result of a stigma you associate him/her with*

### Hiv&Aids Related Stigma

HIV&AIDS related stigma is an attribute used to set affected people aside from normalised social order. They are, as a result of their infection and illness branded as deviants. HIV&AIDS related stigma is a social construct whose specific causes include: pack thinking; ignorance about HIV&AIDS transmission; treatment and prevention; traditional and religious beliefs about sickness and death; judgemental attitudes about the lifestyles of those who are affected by HIV&AIDS; and fear of those infected. For example, HIV&AIDS is associated with stigmatised behaviours such as those of homosexuals, sex workers and drug users.

This perception has triggered by people who would like to believe that they are immune from HIV&AIDS infection and would like to believe that PLWHA are receiving punishment for their immoral behaviour. Some images created of HIV&AIDS resemble a horror show. These stereotypes not only demonise PLWHA and the affected people, they also create the impression that there are individuals and groups that are destined to be infected.

### How is HIV&AIDS Related Stigma Expressed?

HIV&AIDS stigma can be expressed in different ways:

- Through laws and policies by governments and non-governmental organisations.
- Through language and media.
- Through people's attitude and stereotypes seen in the family, workplace, health service centres, and in faith organisations and insurance companies.

Let us pick a few examples to show how HIV&AIDS related stigma finds expression in policies, laws, language and people's attitudes. Some countries have adopted policies and laws that restrict PLWHA free movement into their countries. In South Africa, the AIDS Law Project has documented discriminatory policies and laws around HIV&AIDS especially in the workplace. People are required to do HIV screening and to disclose their HIV status to be employed. Those who are employed loose their jobs if found to be HIV+. Children living with HIV&AIDS are denied educational opportunities in day care centres and schools. Nkosi Johnson who died at the age of twelve was not admitted to school for fear that he might infect other children. In a case of Hoffmann vs South African Airways (SAA), the court declared that pre-employment HIV testing was a violation of a worker's rights to dignity and equality (AIDS LAW Project 2004: 11).

### What are the Effects of HIV&AIDS Related Stigma?

The effects of HIV&AIDS related stigma are very devastating. They affect, adversely, all efforts aimed at preventive measures in general; mother-to-child transmission; antiretroviral treatment; and care and support for the patient and the family, including children. On a personal level, stigma means loneliness, abandonment, ostracism, violence, anger, secrecy, starvation and death.

The impact of stigma is felt more among socially, culturally and economically disadvantaged groups and individuals. Homosexuals, sex workers, injecting drug users and women are but some of the marginalised groups that are affected by stigma. In a tragic example of stigma, Gugu Dlamini, health worker and AIDS activist, was stoned to death by neighbours for speaking openly about her HIV status. She but one example of acts of violence and murder carried out against PLWHA.

## ACTIVITY 11

- 1. In half a page discuss perceptions in your community about homosexuals.*
- 2. Discuss how HIV&AIDS related stigma affects relationships between peoples.*

## HIV&AIDS AND DISCRIMINATION

We have often seen stigma and discrimination used together and sometimes interchangeably. Though closely related, their meaning is not the same. We have seen above that stigma is an attribute or quality. Discrimination, on the other hand, is a behaviour. Let us now define discrimination. *Discrimination* is defined by Manser and Thomson (1999) in *Combined Dictionary Thesaurus*, as the unjustifiable different treatment given to different people or groups.

### Hiv&Aids Related Discrimination

HIV&AIDS related discrimination is much more than the anxiety and the concern that results from how people might react and what they would say. It is the actual experience of being treated differently as a result of HIV&AIDS status. When a child is denied educational opportunities as a result of his/her HIV status, this is discrimination. When Gugu Dlamini was stoned and beaten to death, she was being discriminated against because people branded her with a mark of shame and danger (stigma).

## ACTIVITY 12

- 1. Do people living with HIV&AIDS face discrimination in your community or church?*
- 2. In a paragraph, describe the cases of discrimination that you are aware of or have experienced in your community or church.*

## CHALLENGES FOR COUNSELLING

The massive impact of HIV&AIDS on livelihoods constitutes a challenge to the counselling profession in general and pastoral counselling in particular. Below are some of the challenges that HIV&AIDS poses for the counselling profession:

- HIV&AIDS is a life-threatening illness and confronts both PLWHA and the affected with the prospect of imminent death.
- The impact of HIV&AIDS permeates all structures of society. Advocacy is an essential component for transforming disabling structures and healing the wounds of PLWHA and the affected. Counselling plays an integral role in this healing.
- HIV&AIDS raises emotional and religious issues. It involves restoring hope in the face of hopelessness.

- Counselling PLWHA and the affected involves confronting head-on HIV&AIDS related stigma and discrimination.
- Counselling in HIV&AIDS situations means increasing our capacity to manage stress and burnout that results from having to deal with an incurable disease that causes so much suffering and uncertainty.

## SUMMARY

Let us now summarise what we have learned in this unit. You are all aware that the main focus of this unit was to define the problem of HIV&AIDS. We set out to achieve this by showing that:

- The statistics show that HIV&AIDS prevalence is on the increase.
- HIV&AIDS permeates the structure of our societies.
- HIV&AIDS related stigma and discrimination are rife, and discourage all efforts at prevention, care and counselling of PLWHA and the affected.
- Women and girls, though very vital in care and treatment of PLWHA and the affected, are unfortunately victims of social deprivation and disparate social opportunities, and the most vulnerable to HIV&AIDS infection.
- These issues pose massive challenges for the counselling profession.

## SELF-ASSESSMENT ACTIVITY

### **Answer All Questions**

1. Name the three most serious issues resulting from the HIV&AIDS epidemic.
2. Identify some psychosocial problems faced by PLWHA and the affected.
3. In your own words, explain HIV&AIDS related stigma.
4. How is HIV&AIDS related stigma expressed in your country, church or community.
5. Name some of the effects of HIV&AIDS related stigma and discrimination.
6. How do you distinguish between stigma and discrimination?
7. What factors in your culture contribute to marginalisation and promote the vulnerability of women and girls to HIV&AIDS?
8. Show how the psychosocial conditions of PLWHA and the affected pose a challenge to counselling.



## FURTHER READING

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## GLOSSARY

<b>AIDS:</b>	Acquired Immune Deficiency Syndrome.
<b>Affected:</b>	A term used for the family, friends, neighbours, workmates, church mates and other persons closely associated with someone living with HIV&AIDS.
<b>Care givers:</b>	A term used for people who look after those who are terminally ill. Care givers may also look after children orphaned as a result of HIV&AIDS.
<b>Discrimination:</b>	Unjustifiable treatment of people or groups.
<b>Discriminatory policies:</b>	Policies that sanction, directly or indirectly unjustifiable treatment given to different people or groups.
<b>Epidemic:</b>	The widespread outbreak of an infectious disease in which many people are infected. An epidemic covers a wide geographical area. HIV&AIDS is an epidemic in that it has global impact.
<b>External stigma:</b>	Refers to the treatment that people receive as a result of their condition.
<b>HIV:</b>	The human immunodeficiency virus.
<b>Infected:</b>	The term used for a person who has the HI virus within his or her body
<b>Internal stigma:</b>	The shame a person feels that is associated with a certain condition and the fear of being discriminated on account of that condition.
<b>Morbidity:</b>	The number of illnesses in a given period.
<b>Mortality:</b>	The number of deaths in a given period.
<b>PLWHA:</b>	People living with HIV&AIDS.
<b>Stigma:</b>	A powerful and discrediting social label that affects the way individuals view themselves and are viewed by others.
<b>Stigmatisation:</b>	A phenomenon or process that results in a powerful and discrediting social label that affects the way individuals view themselves and are viewed by others.

# UNIT 2

## BASIC COUNSELLING SKILLS

### OVERVIEW

Welcome to unit 2. In this unit you will be introduced to the concept of counselling. The general components of counselling will be covered. In the same unit, you will learn about the qualities of an effective counsellor. Counselling is a skill oriented profession. Hence, there is a section that deals with different skills that are at the disposal of a counsellor. These skills are divided into micro and explorative skills. Through examples and illustrations you will be taken through the practice of different counselling skills.

### OBJECTIVES

At the end of this unit you should be able to:

- ✂ Define counselling.
- ✂ Discuss the aims of counselling.
- ✂ Identify the qualities that makes one an effective counsellor.
- ✂ Identify the basic skills that one needs to be an effective counsellor.

### TOPICS

- ✂ What is Counselling?
- ✂ Aims of Counselling
- ✂ The Effective Counsellor
- ✂ Basic Counselling Skills
  - Microskills
  - Explorative Skills
    - Listening Skills
    - Reflective Skills
    - Probing Skills

Summary, Self-assessment, Further reading, Glossary



## ACTIVITY 1

1. Write down your own definition of counselling.
2. Give examples of some professional counsellors in your community.
3. List some of the things done by the counsellors in your community.
4. State the differences between counselling done by ministers of religion and that done by other counsellors.

### WHAT IS COUNSELLING?

Let us start our discussion by looking at what counselling is. Counselling as a profession is a relatively new art although it occurs in many of our every day interactions, with family members, friends and acquaintances. Many of these interactions may be referred to as informal counselling. In this unit we are going to focus on counselling as a more professional, structured and formal skill. Counselling has been defined by a number of people. Each of the following people put emphasis on different aspects of counselling:

- Lawrence Brammer (1979) and G. Egan (2002) put more emphasis on the counsellor and the role s/he plays.
- T. Bond and S. Culley (2004) put emphasis on the process itself which entails the skills and the techniques.
- Richard Nelson-Jones (2002) put more emphasis on the client and his/her needs.

Let us now look into a definition that attempts to balance the different emphases we have seen above:

*Counselling is a structured conversation within a relationship of trust, between a counsellor and a counselee aimed at enabling the counselee or client to utilise the resources s/he has for solving or coping better with their problems.*

This definition acknowledges the importance of the role of the counsellor and the client. The definition also acknowledges the importance of the skills that have to be developed for effective counselling to take place.

We will now analyse the above definition by indicating its important components.

*Counselling as a relationship*

The definition tells us that counselling is first and foremost a relationship. A relationship by definition implies two people or more, for instance, the counsellor and the client(s). These two people or more are normally brought together by the need or problem, usually, brought by the client. The problem or the need gives direction to the conversation that follows between the two.

*Counselling as a structured conversation within a relationship of trust*

The counsellor as the more skilled party structures the conversation and gives it direction. It is in this sense that we call this conversation structured, disciplined, focused and goal oriented. The relationship between the counsellor and the client must be that of mutual trust. This helps in shaping and determining the success or failure of the counselling process.

*Counselling helps the client to make use of his/her resources.*

Clients often come to counsellors because they are not happy with one or more dimensions of their lives. They go to the counsellor because they have been advised by a friend to do so. Sometimes they volunteer to see the counsellor. Whatever the reasons are for these different clients, at the end of the day, their expectation and their wish is that counselling should help them to cope better with their problems.

## ACTIVITY 2

1. *Recall some informal counselling sessions you have had. What pattern or structure did they have?*

### AIMS OF COUNSELLING

The definition of counselling given above tells us what counselling involves. For example, we saw that counselling involves a conversation between two parties—the counsellor and the client. In this section we shall be looking at the aims of counselling. We need to ask ourselves what counselling seeks to achieve. This helps in determining whether the aims of counselling have been achieved or not. We will

first outline the basic aims of counselling and discuss them. There are four basic aims of counselling, given as follows:

- To enable the client to identify and cope with the impact of his/her problem.
- To facilitate problem solving through understanding of the problem.
- To enable the client to use coping abilities to solve problems.
- To empower the client to become more effective at self-help in the future.

What follows now is a discussion on the aims of counselling. Our understanding of counselling is that it is a joint venture involving both the counsellor and the client. Both the counsellor and the client each have a role to play. Let us look at the first basic aim of counselling.

To enable the client to identify and cope with the impact of his/her problem.

#### *The role of the counsellor*

The role of the counsellor in any given counselling transaction is to assist, help or enable a client. The first aim suggests that one of the roles of a counsellor is to enable, assist or help the counsellor to identify the problem. When clients decide to consult a counsellor it is, in most cases, because they have tried to resolve their problems and have not succeeded. Sometimes clients are so immersed in their problems that they cannot even say where the real problem lie. Enabling means collaborating with a client in exploring and eventually identifying the problem and the impact this problem has had on the client. The counsellor's role is to facilitate disclosure. Disclosure will in turn make it easier for both the counsellor and the client to understand the problem.

#### *The role of the client*

It would seem from the above aim that the counsellor is the one running the show. S/he is assisting, helping and enabling. On the contrary, the client is not a passive beneficiary of the service offered by the counsellor. He has to actively participate in the process of identifying the problem by relating the story and confirming with the counsellor the nature and seriousness of the problem. Because the management of specific problems and daily coping belongs to the client, it is important that s/he take ownership of the problems. The second basic aim of counselling is:

To facilitate problem solving through understanding of the problem.

#### *The role of the counsellor*

When the problem has been identified and understood by both the counsellor and the client, the solution to the problem is within reach. The counsellor's role consists mainly of assisting the client to see alternatives to the problem.

#### *Role of the client*

The client's role is to explore options for solving the problem. If the client has understood the problem well, s/he should be able to work out these possibilities and alternatives with the help of the counsellor.

The third aim of counselling is:

To increase the client's coping mechanisms.

Every individual has coping abilities. These refer to the power that allows a person to cope with problems as they occur. These abilities are enhanced by internal or external resources. External coping resources refer to the family members, friends, colleagues and religious resources. Sometimes the problems are so intense that a person is not able to cope. In this case s/he can resort to the external resources. Sometimes even the external resources are non-existent or not within immediate reach.

#### *Role of the counsellor*

The role of a counsellor is to help to determine the coping levels of the client. A skilled counsellor should be able to do that. For example, if the client is sobbing incessantly and is not able to come to terms with whatever has occurred, this could be a sign that his/her coping abilities are low. Again, a person may feel that s/he cannot trust anybody. To a skilled counsellor these are indications of the coping levels of the client. These levels will determine the type of help the counsellor should recommend.

#### *The role of the client*

The client's ability to talk will assist the counsellor in measuring their coping levels. The counsellor's efforts to boost the client's coping abilities cannot be done without

the direct involvement of the client. His/her active participation in this process is a step in the direction of resolving the problem.

### ACTIVITY 3

*Pause for a moment and recall some problems you have encountered in one way or another in your life. In a few lines describe how you dealt with those problems. Did you resolve them on your own or with the assistance of another person? In what ways did the other person assist you?*

Let us continue with the last aim of counselling. The last aim is:

To empower the client to become more effective self-helpers in the future.

#### *Client's role*

R. Nelson-Jones in his book, *Essential Counselling and Therapy Skills*, asks the following question: "If we can have skilled counsellors, therapists and helpers, why can't we have skilled clients too?" (2000: xii) In fact, Nelson-Jones is convinced that clients are not passive recipients of the counselling service. Their active participation, so much emphasised in resolving their own problems, ensures that they are empowered. When clients are empowered, their ability to think, communicate, and act on their own, is improved. This active involvement is empowerment and it ensures self-help. This means that at the end, the client should be able to say, 'I discovered what my problems were and what caused them. I have identified the best way of dealing with my problems. I am responsible for managing these problems now and in the future.'

#### *The counsellor's role*

Frequently, clients confront us with the question: 'what must I do?' The most tempting response for any counsellor is to give advice. J. Moore argues that giving advice is very unhelpful in a number of ways. First, it cuts short the process of talking about the confusion the client has. Second, it robs the client of the choice to own up to his/her decisions. Third, by giving advice you are taking responsibility for a choice that is not properly yours. When you give an advice which is supposed to be a solution and it does not work, who is to blame? (1992:8).

## ACTIVITY 4

*A woman by the name of 'Mathabo comes to you with some marital problems. She admitted being undecided about separating from her husband. This is her second marriage and she is very much concerned about failing for the second time. She is tied financially to her husband by the joint ownership of the house as well as paying of the tuition to a special school for her two sons. The love between them has died. Moreover, the husband is involved with another woman for over two years now. She has come to you for counselling. In not less than 400 words write down the kind of advice you would give her.*

### EFFECTIVE COUNSELLOR

Let us now turn to the qualities expected from an effective counsellor. We have to admit that there is no blueprint (meaning that there is no standard guideline) for an effective counsellor. In other words, there is no fixed pattern that is universally applicable for effective counselling. However, there are certain qualities that every counsellor needs in order to be effective. An effective counsellor is the one who through informed and skilled interventions, enables a client to grow toward wholeness. Wholeness involves growing in ways that enliven (meaning that which enhances the ability to function as it should) the mind, revitalise the body, renew and enrich relationships, revitalize our relationship with nature and deepen our relationship with God. Qualities that are required of a counsellor include but are not limited to the following:

- Self awareness and understanding
- Competence
- Warmth and Caring
- Empathy
- Openness
- Trustworthiness

**Self awareness and understanding:** There is strong belief that effectiveness in counselling begins with the self. Counsellors as helpers have to be aware of who they are in terms of their personalities, values, experiences (positive and negative) and convictions—be they social, political or religious. However, these personal values and

convictions should not necessarily be used as a yardstick for measuring the behaviours and choices of other people. For example, if I conclude on the basis of two instances that a client is very undependable, the question is, 'How much of this judgement is descriptive of that person and how much of myself and my values and norms am I reading into that description? Again if I have had a rough experience in dealing with people of a certain gender or ethnic background, that should not influence my future dealings with individuals from that same gender or ethnic group. A counsellor who is genuine and honest about himself/herself knows that s/he is not 'a know it all'. S/he has to be realistic about their personal strengths and limitations.

## ACTIVITY 5

*Write some of the strong values and convictions you have on sexuality, gender and religion. Explain how far these values and convictions should affect your judgement as a counsellor.*

*Competence* refers to the ability to deal professionally with people and to conduct sessions with the necessary information, knowledge and skills. A professional counsellor is supposed to be someone trained in the skills of counselling. Normally such person is issued with a certificate as a proof of the training they have gone through, and the knowledge and skills they have acquired. The expectation is that the counsellor should discharge their duties in keeping with the knowledge and skills they have acquired.

T. Bond, in his *Standards and Ethics for Counselling in Action*, states that, it is part of the counsellors' responsibility to ensure that they monitor their level of competence and be willing to be accountable to clients and other counsellors for their practice on a daily basis (2000: 126). The minimum standard of competence that you as counsellor should aspire for are to:

- Know why you are doing or saying something to your client
- Be sure you are saying or doing what you intend
- Know the likely effects of what you say
- Adjust your interventions according to the client's actual needs
- Review your counselling practice regularly to remain up-to-date and informed.

- Assess whether your level of skill is the same or better than that of other counsellors offering counselling on similar terms.

The above principles can act as the foundation of competent counselling practice.

## ACTIVITY 6

*You or the person you know might have been subjected to incompetence. In a paragraph, explain the side effects of incompetent counselling.*

*Warmth and caring:* Warmth is an emotional quality of friendliness reflected in the facial expressions, non-verbal attending behaviours. Showing concern and interest are indicators that a person is respected and valued. Caring, though related to warmth, is regarded as showing deep and genuine concern about the welfare of the other person. The modalities of showing this warmth and caring concern have to take into consideration the cultural differences.

*Openness:* One of the principal roles of the counsellor is that of facilitating disclosure (meaning sharing of information) and ventilation (meaning release of painful feelings) from the side of the client. When the client shares information and is able to ventilate,

## ACTIVITY 7

1. *List things that evoke trust in the other person.*
2. *Write down things that are positive and negative about your personality and your dealings with other people. Confirm these with a person who can be honest with you.*
3. *List ways in which warmth and care can be shown to different categories of people in your culture.*

this is a sign that the counsellor has invited openness from the side of the client. How does the counsellor invite openness? The way a counsellor attends to the client communicates a regard for the client. Counsellors invite openness in their clients when their facial expressions are congruent with what they are saying.



*Trustworthiness:* A counsellor is given the benefit of knowing what is supposed to be confidential information about the client. Their professionalism should remind them of the reliability that goes with the task. The counsellor must be dependable and honest.

We now turn to the basic counselling skills that any counsellor ought to possess. When used well, these skills can enhance the counselling profession and make it an enjoyable and rewarding experience.

## BASIC COUNSELLING SKILLS

These skills are basic in that they form the basis of more complex skills that could be used in other cases of a more complex nature. Neither the disposition of a counsellor nor the content can alone achieve effective counselling. They have to be used in combination with skills. *Disposition* refers to the qualities discussed above that an effective counsellor should possess. *Content* is what both the counsellor and the client bring to the interaction—their thoughts, feelings, behaviours and experiences. S. Culley and T. Bond, in *Integrative Counselling Skills in Action*, define content as “the *what*. Skills refer to the *how*” (2004: 14).

What, therefore, are counselling skills? *Counselling skills refer to the basic tools which you develop in order to effectively conduct a counselling session.* We will see in the next section that there are different stages of a counselling process. Counselling skills help to fulfil the aims of each stage of the counselling process. We are going to group the counselling skills into two main categories namely; microskills or attending skills and explorative skills.

*Microskills/attending Skills:* Attending skills refer to the art of ‘being with’ the client. Attending skills are those skills that help the counsellor to attend fully to the client and to build a good working relationship. They help the counsellor to be present with the client both physically and psychologically. They are a means by which you communicate ‘non-verbally’ with clients so that you are: with them, interested in them, alert to what they want to share with you.

Egan, in *The Skilled Helper*, calls these, skills of visibly tuning in to clients and summarises them under the acronym SOLER (2002: 68). We prefer to call them *microskills*. These *microskills* being a collection of body language skills a counsellor adopts during a counselling session. These microskills are as follows:

**S= Squarely:** A posture adopted that implies involvement. It should be a posture that allows both the counsellor and the client to read messages that are communicated through bodily movements and gestures.

**O=Open:** As a counsellor you have to adopt an open posture that communicates non-defensiveness and availability to the client.

**L=Lean:** Leaning towards the client shows some kind of involvement and interest in what s/he is saying.

**E=Eye contact:** Maintenance of good eye contact conveys the message that you are with the client, you are interested and you want to hear what s/he has to say. Eye contact is important because it allows you to read your client's body language and to be guided by it. Maintaining eye contact is not staring. Staring is regarded in many cultures as rude and is a sign of confrontation. **A=aim** has been proposed for blind and visually impaired clients. So instead of E=Eye contact there is A=aim. Aiming your head and body in the direction of the blind and visually impaired client is extremely important.

**R=Relaxed:** It refers to being natural with the client. Nervousness and distraction are signs of discomfort. It is seen in the manner in which you use your body as a vehicle of personal contact and expression.

These attending skills are not necessarily applicable to the first stage of the counselling transaction (stages are discussed in the next unit), they (attending skills) cut across the entire counselling process.

In adopting the above attending skills, we should be mindful of the cultural differences. In certain cultures, the age and gender of the counsellor count for much of how these attending skills should be employed. How a man should act towards a woman, and how adults and children should behave towards each other for example, determines the way in which the attending skills should be employed.

## ACTIVITY 8

*Write a paragraph on how relevant the micro or attending skills are in your own cultural context. Consider how gender, age and status might interfere.*

**Explorative Skills:** These are the skills that help the counsellor and client explore and understand the problem from the client's point of view. Explorative skills can further be divided into listening skills, reflective skills and probing skills. Before discussing these individual skills we will first look at basic empathy as it accompanies the whole process of problem exploration and beyond.

**Empathy:** Empathy means seeing the world the way the client sees it, that is, from their perspective. Put in another way, it is the capacity to participate in another person's feelings or ideas without, however, losing one's identity or objectivity. It means that the counsellor is involved with the client but at the same time the counsellor is able to maintain 'otherness' (the state of being different). **Empathy** presupposes listening carefully to the client and then communicating back to the client his/her feelings. Let us look at the following example to illustrate empathy:

**Client:** I don't know what to do now that my girlfriend is HIV positive. My mother wants me to leave her and my father wants me to marry her.... I am not sure what to do.

**Counsellor:** You feel confused and pressurised because your mother and father have each their ideas about whether or not to marry your HIV positive girlfriend and you are not sure what to do.

The words of a counsellor above are an example of basic empathy. The counsellor has picked up the feelings of the client and communicated them back to the client. Having discussed this very important skill, we can now move on to the discussion of exploratory skills (i.e. listening skills).

**Listening Skills:** These skills refer to receiving the messages that clients are sending both through what they say and by what they do. Clients also send messages by what

they should be saying and they are not saying (omissions), and by what they should be doing and they are not doing (gaps). We normally talk of verbal and non-verbal messages. *Verbal messages* are those messages communicated through a word of mouth. *Non-verbal messages* are communicated through bodily behaviour (posture, body movement and gestures), facial expressions (smiles, frowns, raised eyebrows, twisted lips), voice-related behaviour (tone, pitch, voice level, intensity), and observable psychological responses (quicken breathing, blushing and paleness).

All these messages verbal or non-verbal have to be captured and interpreted by the counsellor. They have to be captured because they contain the grain of the truth that the client intends to share. Listening goes beyond paying attention to verbal and non-verbal messages. It also mean listening to the whole person in the context of his/her social settings. Effective listening brings you in touch with the feelings of a client. In counselling, feelings speak volumes. Indeed the whole point of counselling is to know what the person is feeling and to communicate this with the client.

## ACTIVITY 9

*List ways in which people communicate effectively. Give examples from your own cultural context.*

Reflective Skills are the skills that enable you to communicate your understanding of the client's perspective or frame of reference. The reflective skills are closely related to the listening skills. Reflecting follows upon what has been shared by the client consciously or subconsciously and has been understood by the counsellor. The counsellor listens, understands, and mirrors their understanding back to the client. Normally, the counsellor mirrors back this understanding in three ways: restating, paraphrasing and summarising. These three ways we call the reflective skills. Let us now turn to a detailed discussion of these three reflective skills. We start with restating.

Restating means repeating back to clients in a single word or short phrase which they have used. Restating helps to prompt further discussion. Look at the following example:

*Client:* I felt so humiliated.

*Counsellor:* Humiliated! (**Restating**)

*Client:* Yes, I felt really down. I thought I deserved a better treatment than that. The second reflective skill is paraphrasing. *Paraphrasing* means rephrasing what you have understood to be the substance or the core of the client's message. Rephrasing ensures that the counsellor and the client are on the same wavelength. It also ensures that both the counsellor and the client agree on the emerging issues or problems.

Look at the following example:

*Client:* I have always been a failure. I have not been as successful as my brother and sister in terms of education and work. Everything they have done has turned out so well. What is worse is that now I am HIV positive.

*Counsellor:* You are comparing your achievements with your brother's and your sister's and are telling yourself that you are a failure—especially now that you are HIV positive (paraphrasing).

*Client:* Yes! Sort of, not quite, you know.

The third reflective skill is summarising. *Summarising* refers to longer paraphrasing that enables you to bring together important aspects of the session in an organised way. Summarising normally focuses on what the client has said. It achieves the following:

- It clarifies content and feelings
- It reviews the work done so far
- It ends a session
- It begins the next session

Consider the following example:

*Counsellor:* From what you have said so far, you seem very unhappy about what you have achieved, especially in the light of your being HIV positive. You also compare yourself unfavourably with your brother and sister and see your achievements as inferior to theirs.

## ACTIVITY 10

*Discuss ways in which the above passage of the conversation between counsellor and client is an example of paraphrasing.*

**Probing Skills:** These are skills that enables a client to explore more deeply any issue that is, in the judgement of the counsellor, relevant to the issues alluded to by the client. Here the counsellor becomes more directive in their manner. Though important, these skills should be employed with care, as they may lead into areas which client may have deliberately avoided. Probing may take the form of statements, questions or requests. *Statements* are used to probe and it is up to the discretion of the counsellor to decide what questions might be too inquisitorial. For example, ‘I wonder what your parents would say about this’ might be better than ‘What would your parents think about this?’

## ACTIVITY 11

*Imagine yourself counselling another person in a specific setting.*

- 1. What is the client saying to you?*
- 2. What are you saying?*
- 3. What are you doing?*
- 4. How do you respond to feelings shared by the client?*

## SUMMARY

Remember, in this unit, we have defined counselling as a structured conversation within a relationship of trust. Counselling is aimed at utilising resources for solving problems. We have also outlined aims of counselling. The unit has explored the basic qualities required of an effective counsellor. These qualities are self-awareness, understanding of self, competence, empathy, warmth, openness and trustworthiness. These qualities when accompanied by the development of good counselling skills can ensure that helping service is given to those who need it. These counselling skills include attending skills and explorative skills. Explorative skills can be further divided into listening skills, reflective skills and probing skills.

## SELF-ASSESSMENT ACTIVITY

### Answer All Questions

1. Define counselling in your own words?
2. Discuss the following statement, “The relationship of mutual trust between counsellor and client determines the success of a counselling process”.
3. A counsellor is more of a facilitator than an advisor. Discuss this statement?
4. What does empathy mean?
5. Explain the importance of empathy as a quality for a counsellor.
6. Identify ways in which the attending skills (microskills) discussed above are applicable or not applicable in your own cultural context.
7. Explain the difference between verbal and non-verbal messages.
8. Choose a partner. Play the role of a counsellor and ask questions (probe) to seek clarity and concreteness from the client. Observe how the client responds to the questions. Discuss together how those questions were asked and what impact they had and whether or not they achieved their intended purpose.



### FURTHER READING

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## GLOSSARY

<b>Client:</b>	A person who is looking for counselling or who is referred to counselling services.
<b>Counselling transaction:</b>	It refers to a counselling encounter between a counsellor and a client.
<b>Counsellor:</b>	A person trained to provide counselling services. The term can be used interchangeably with therapist and helper.
<b>Disclosure:</b>	The act of relating one's story in a counselling transaction.
<b>Empathy:</b>	It is a conscious attitude of the counsellor by which they attempts to perceive events from the perspective of the client.
<b>Marital problems:</b>	These are problems associated with a marriage relationship.
<b>Non-verbal message:</b>	Message communicated through means other than the word, such as bodily behaviour, facial expressions, observable psychological responses.
<b>Professional counsellor:</b>	Someone who does counselling as a profession and who receives payment for their services.
<b>Self-help:</b>	It refers to the ability of the clients to live skilfully on their own. The main purpose of counselling is to enable clients to help themselves.
<b>Verbal message:</b>	Message communicated through a word.
<b>Ventilation:</b>	It refers to the expression of emotions or feelings.
<b>Restating:</b>	It is a reflective skill that involves repeating back to the client, a word or a phrase which s/he has used.
<b>Paraphrasing:</b>	It is a reflective skill of rephrasing what you perceive to be the core message of the client's communication.
<b>Summarising:</b>	It is a reflective skill of bringing together in a brief way, the salient aspects of the message communicated.



# UNIT 3

## COUNSELLING THEORIES AND PROCESSES

### OVERVIEW

Welcome to unit 3. This unit serves to introduce you to the theories of counselling. Counselling emerged from a specific cultural perspective. Logically, theories developed by counsellors and psychologists bear the cultural brand of their authors. These theories have something that can be applicable across cultures, but they also have cultural connotations. It is for this reason that we also discuss counselling in the African context to show that the African problems and world views are different, and need to be taken into consideration if proper healing is to be given to Africans. The unit also discusses the three stages of the counselling process. It also explores the pastoral dimension of counselling.

### OBJECTIVES

When you have completed this unit, you should be able to:

- ✎ Describe theory and its function in counselling.
- ✎ Critically discuss the role of culture in counselling.
- ✎ Explain various stages of a counselling process.
- ✎ Discuss the pastoral dimension of counselling.

## TOPICS

- ⌘ Theories of Counselling
- ⌘ Counselling in the African Context
- ⌘ Stages of a Counselling Process
  - Current Scenario
  - Preferred Scenario
  - Strategy
- ⌘ Pastoral Dimension

Summary, Self-assessment, Further reading, Glossary

## THEORIES OF COUNSELLING

I am sure you have come across the term theory. You have also probably used the term. The term theory is often used as an opposite of practice. Practice refers to something that has to do with action and so theory has to do with a thought, or a certain way of thinking. It is in this sense that L.M. Heyns and H.J.C. Piertese in their *Primer in Practical Theology* define theory as a discussion, consideration and planning pertaining to praxis (action) (1990: 24). According to this understanding, every action has to be preceded by some kind of thinking and planning. For example, what is actually carved on wood was first planned in the mind (theory).

But this is not the only definition of theory. Theory can also refer to *an explanation of a phenomenon*. An attempt to understand a phenomenon brings about a theory. For example, HIV&AIDS is a phenomenon. There are different theories that account for the origin of this phenomenon. For some, the HI virus is a punishment from God. For others, it is the wrath of ancestors for abandoning cultural traditions. Yet for others, the virus crossed the species barrier, from primates to humans. It changed its genetic character and invaded humans.

## ACTIVITY 1

1. *List some of the theories about the origin of the HI virus that causes AIDS that are common in your own culture.*
2. *How do these theories contribute in the prevention or spread of HIV&AIDS?*

As counsellors dealing with clients they will begin to arrive at certain conclusions that will account for the behaviour of these clients. They also make choices about how to think about the clients' behaviour, and how they can be treated during counselling sessions. These conclusions or explanations that account for the behaviour of the clients and plans for how they can be treated can be referred to as counselling theories.

The function of theories of counselling is to provide counsellors with concepts and frameworks which allows them to think systematically about human development and the practice of counselling. Over the years, many theories of counselling have been developed. This was in attempt to understand the problems of clients better and to offer appropriate help. Among these theories, we can mention for example, the psychoanalytic theory, the rational-emotive theory, the Rogerian theory and the eclectic approach. We will briefly look at what these theories represent.

**Psychoanalytic Theory:** This theory was founded by Sigmund Freud. This theory contends that early childhood memories shape our personalities in a particular way. Understanding these memories helps us to freely choose our future.

**Rational-emotive theory:** This theory was founded by Albert Ellis. Ellis contends that all humans have three fundamental goals, namely: to survive, to be relatively free from pain, and to be reasonably content. How we think, feel and behave can either contribute to or hinder the attainment of these goals. Ellis is known for his ABC theory of personality.

A= Activating events

B= Beliefs, rational and irrational

C= Consequences—both emotional and behavioural

According to this theory, it is our beliefs that determine how we behave and not a specific event. For example, a person who is infected with HI virus may be depressed. This depression, which is a consequence, might be a result of his belief that infection with HI virus means death. So the behaviour (C) is determined by belief (B) and not by the event (A).

Rogsonian Theory: This theory was founded by Carl Rogers. He believes that clients have the potential to resolve their problems without being given directives. His approach is non-directive, client-centred and person-centred.

Eclectic approach: This approach draws from all theories and combines them to come up with appropriate help in a particular situation. These theories were developed as a response to problems of people within a Euro-American context. They represent a different world view and they are responding to questions that are not necessarily African questions. It is for this reason that we have a section on counselling in an African context to raise issues that challenge counselling to be contextual.

## ACTIVITY 2

1. *Write down some of the theories in your culture that explain the cause of sickness or disease.*
2. *In what ways do these theories correspond to your world view?*

## COUNSELLING IN AN AFRICAN CONTEXT

It should be clear to you by now that counselling is a service intended for human beings alone. It aims at helping individuals to resolve their own problems. But every human person is a combination of both universal and individual traits. As humans for example, we enjoy, universally, the same gift of intelligence and free will (universal traits). But the exercise of these gifts is determined and limited by socio-cultural factors as well as the way an individual responds to this environment. As individuals, we are unique and distinct and yet we are part of a clan, ethnic group, village, culture and nation.

According to WCC's document *A Guide to HIV&AIDS Pastoral Counselling*, every culture has its own values, traditions and taboos about life, health, sickness, sex and death (1990:18). A good counsellor would do well to take these issues into consideration in offering counselling to the clients. J. Beuster says, in addition, that to ignore a client's cultural background not only leads to misunderstanding, it can also be anti-therapeutic and harmful (1997:5).

Before the advent of missionaries and colonisers, Africans have always had their way of helping individuals with their problems; healing the sick and caring for the old, terminally ill and orphans. There were family councils which were largely made up of members (male and female) from the extended family. In some cultures this role was vested upon the elders of the family. Their role was to give advice and to mediate conflicts in the family and to oversee things pertaining to that family or clan. They also ensured that cultural beliefs were transmitted from one generation to the next and were being properly observed.

Sickness for Africans was not only an individual experience and causes were varied. It was a communal experience including both the living and the living dead. According to Beuster (1997: 6), traditional Africans define abnormal behaviour in terms of disharmony in social relationships. This disharmony is not only recognised between the living but also between the living and the ancestors. The sickness of one member affected all other members of the family, including the living and the living dead.

### ACTIVITY 3

1. *In half a page explain the concept of sickness from your own cultural context.*
2. *Analyse ways in which you deal with sickness in your cultural context.*

Healing, therefore, involves more than just recovery from bodily symptoms. It extends to social and psychological reintegration of patient and community. It is normally done through the intervention of indigenous healers, diviners (*Mundo mugo, Inyangas, Ingangas, Lingaka*). Their job was to diagnose, heal people and account for the causes of illness. They also prescribed to people what to do to be spared or restored to good health. Because of their ability to converse with the Ancestors or

Spirits they facilitate harmony between the living and the living dead. When that harmony is restored, the patient is healed together with the whole family, clan or community; as there can be no individual healing outside the context of the family, clan or community.

We acknowledge the theories of Freud, Rogers and others. They have indeed made a lot of discoveries in the field of psychology. Their theories emerged from a certain world-view which served as a basis for their discoveries. We should, however, point out that they are experienced within specific cultural contexts. These theories, for example, place more emphasis on the individual client and how s/he responds. This need not be the case in counselling in an African context. For an African, the individual is not identifiable outside family, clan or community. The family, clan or community on the other hand is identifiable through its own Ancestors. This is because the person's being makes sense only within the framework of Ancestor-living relationship.

In Africa, there is no single word for counselling, instead there are different manifestations or expressions of counselling. In Sesotho (language of Basotho) there is *ho eletsa* (to advise); *ho tselisa* (to console); *ho tsehetsa* (to support); *ho tataisa* (to guide); *ho laola* (to divine). All these refer to different ways of doing counselling. And if one were to define counselling, we would define it as: to advise, to console, to support, to guide and to divine. And each of these activities is a response to a specific situation. Even as we do counselling, we should be mindful of the fact that cultural considerations are important in each of these various stages. You may have noticed that we have made a lot of generalisations when we talk about Africa. While to a certain extent this is possible, we need to remember that Africa is a big continent with a lot of differences in terms of cultures and cultural expressions.

## ACTIVITY 4

*List values, traditions and taboos about life, health, sickness, sex and death that can contribute either to the spread of HIV&AIDS or to its prevention.*

## STAGES OF THE COUNSELLING PROCESS

Counselling is a process or a journey that is taken by a counsellor and a client. Culley and Bond (2004:14) in their book, *Integrative Counselling Skills in Action*, say that the term ‘process’ refers to the dynamics of a counselling relationship or the *how*; how you and your clients are working together and what is happening between you. To say that counselling is a process implies that it has a beginning, middle and an end. The beginning, middle and end of the counselling process are referred to from now on in this text as ‘stages’ of the counselling process. The stages of a counselling process help the counsellor to know where they are with the client in any given counselling transaction.

In this module we have adopted the “Three Stage Model” of Gerald Egan. Egan, describes the three stages of a helping process; namely, the current scenario, the preferred scenario, and the strategy (2002:26-27). We will now look at the content of each of these three stages individually.

### Stage One: Current Scenario

Current scenario refers to the present state of affairs of the client as it stands currently. The client has been motivated to consult the counsellor because s/he has a problem. This problem may be seen clearly, obscurely or in a confused manner by the client. The role of the counsellor is to help the client to see the problem for what it is. The counsellor works to discover and deal with blind spots—that is underlying emotions, distortions and inadequately perceived processes. This stage is sometimes called a problem identifying stage.

The aims of this stage are the following:

- To establish a relationship between a counsellor and a client
- To listen to the client as they tell their stories.
- To help the client identify and understand the problem.

It is important that the counsellor and the client develop a working relationship that is based on genuineness, respect and trust. This atmosphere of trust and respect depends, for the most part, on how the counsellor uses the attending and skills that we talked about in unit 2. If they are well rendered, the client would be able to tell his/her story and the counsellor would be able to see the problem from the point of view of the client.

## ACTIVITY 5

*A couple have been married for over 10 years and they still cannot have a child. They have gone to a physician for help. He does the fertility test and further recommends that they do an HIV test. The results are that they are both productive problems and he will simply give them medication to sort out their problem. They are also both HIV positive.*

*Imagine and list some of the problems or anxieties that the couple may face.*

### Stage Two: Preferred Scenario

When the problem has been identified then solutions to the problem are within reach. The preferred scenario refers to the improved state of affairs or new situation that the client wishes to see himself or herself in. The leading question here is: what do I need or want (preferred scenario) in place of what I have (current scenario).

The aims of this stage are the following:

- To help the client to manage the problem by setting goals.
- To help the client develop a range of options for an improved future.
- To help the client to choose realistic options and turn them into viable goals
- To help the client to commit themselves to a programme of constructive change

Basing himself/herself on how the problem was presented and understood, the counsellor in this stage focuses on helping the client to formulate goals that would ensure that the preferred scenario is attained. We should remember that clients do not always see their problems as clearly as possible. If this is the case, it is the counsellor's responsibility to help clients see their problem clearly and for what it is. This s/he can achieve by employing some of the reflective and probing skills that we discussed in unit 2. The counsellor has to help the client to decide on the goals.

The counsellor should ensure that the goals are:

- Clear and specific
- Measurable and verifiable
- Realistic
- In keeping with the client's values
- Set within a reasonable time frame.



## Stage Three: Strategy

When the problem has been identified and the goals agreed upon, then the programme to achieve the client's goal has to be developed. This is where the strategy comes in.

### ACTIVITY 6

*You have managed to help the couple (see case immediately above) identify the problem or problems they may be facing. Encourage them to tell you what they want. List some of the possible goals that the couple may formulate in order to solve the problem or problems identified above.*

Strategy in this context simply means a procedure or a way of achieving a goal. Strategy is a response to the question: How do I get what I want? This stage serves as kind of bridge that unites the current scenario and the preferred scenario. This stage, in the counselling process, seeks to identify ways and means in which the set goals can be achieved.

The aims of this stage are the following:

- To help the client identify a range of strategies for achieving goals.
- To help the client choose strategies that are realistic.
- To help client set an implementation plan with set priorities of what activities need to come before all others.

Once the implementation plan has been finalised, the plan is then implemented. The role of the counsellor at this stage is to encourage, support and guide. The counsellor should also be prepared to help the client to monitor his/her progress with a view to review or improve their strategies.

### ACTIVITY 7

*You have helped the couple formulate goals toward the solution of their problem or problems. You now want to help the couple identify a range of strategies aimed at achieving the goals listed in the preceding stage. List a strategy or strategies for every goal listed.*

## PASTORAL DIMENSION

The term pastoral derives from the term pastor. This word comes from a Latin verb *pascere*, which means to feed. From the point of view of the bible, the term is used interchangeably with the term shepherd. God is the shepherd of his people Israel (Psalm 23). In the New Testament, Jesus calls himself the Good Shepherd (John 10:11). When he commanded Peter to feed his sheep, Jesus was entrusting to Peter, and possibly other disciples, the feeding and the tending of his flock (John 21:15f).

Traditionally, the term pastor was reserved especially for church ministers. It was, therefore, easier for people to relate pastoral counselling with counselling that is offered by pastors and priests to their congregations alone. D.W. Waruta in *Pastoral Care in African Christianity: Challenging Essays in Pastoral Theology*, rightly points out that a pastoral counsellor does not have to be a church minister (2000:7). That role, they assert, can be fulfilled by any person within the church who is engaged in the task of restoring fellow human beings to physical, emotional and spiritual wholeness. But the church's mission is not only to those who are inside the church, but also to those who are outside. In the context of HIV&AIDS, the church through its members, lay people and clergy, is called to offer counselling to PLWHA and those affected by the epidemic.

### ACTIVITY 8

1. Discuss the advantages and disadvantages of having pastoral counselling done by the whole church, clergy and the laity, especially in the context of HIV&AIDS.
2. Explain how it can be maintained that the church's mission is to those both inside and outside the church.

When the church, through its members, counsels people and restores them to well-being it is doing pastoral counselling. This is the pastoral dimension of counselling. This is not to say that a pastor or a lay member of the church cannot specialise in any other type of counselling. This is to say that *pastoral counselling is a specialised approach within general counselling which, over and above purely psychological problems, also helps people to grapple with the spiritual and religious dimensions of their problems.*

WCC document, *A Guide to HIV&AIDS Pastoral Counselling*, agrees that people living and dying of AIDS have—over and above emotional and medical needs—spiritual needs. They ask questions related to God, the soul, life and death, condemnation and forgiveness, eternity and transcendence, forgiveness and salvation (1990:5). As they do that, they are seeking this specialised type of counselling. Good counsellors will not overlook this important dimension of the client’s problems. If they cannot help in responding to such questions they should refer such client’s to pastoral counsellors.

## ACTIVITY 9

- 1. Write down your own definition of pastoral counselling.*
- 2. Give examples of some pastoral counsellors in your community and the kind of help that they offer.*

### SUMMARY

In this unit, we have looked at the theories on which counselling as a practice is founded. The development of these theories is a result of the desire on the side of the counsellors psychologists and communities to understand the problems of the clients better. We have also looked at the implications that culture may have on effective counselling. Every client and her/his problems are a product of an environment that encompasses beliefs, values, (religious or social) and world-view. By definition, counselling is a process and as such it ought to have stages. These stages help the counsellor know where s/he is with the client in any given counselling transaction. The pastoral dimension in counselling is also discussed.

## SELF-ASSESSMENT ACTIVITY

### Answer All Questions

1. Define theory in your own words.
2. Give examples of theories of counselling from your own culture and relate them to the definition given above.
3. Discuss the importance of culture for effective counselling.
4. Counselling is a process. Explain this statement.
5. In what way can the last stage of the counselling process be called a bridge between the current scenario and preferred scenario?
6. Discuss the following statement, 'every human being is a combination of universal and individual traits'.
7. Explain why it is the mission of the church to do pastoral counselling?
8. Discuss some of the skills that can be employed in the second stage of the counselling process.



### FURTHER READING

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## GLOSSARY

<b>Theory:</b>	Is an explanation of a specific phenomenon.
<b>Current scenario:</b>	Refers to the present state of affairs.
<b>Preferred scenario:</b>	Refers to the preferred improved state of affairs as compared to the current.
<b>Strategy:</b>	A procedure or a way of achieving a goal.

# UNIT 4

## HIV&AIDS COUNSELLING

### OVERVIEW

Welcome to unit 4. This unit deals with HIV&AIDS counselling as a specialised type of counselling. We will look at the definition and aims of HIV&AIDS counselling. Prevention of transmission and psychosocial support, as well as reducing stigma and aims of HIV&AIDS counselling will be explored. This unit further discusses the qualities of an effective HIV&AIDS counsellor. Voluntary Counselling and Testing (VCT) and Counselling Testing and Care (CTC) which are the essential components of HIV&AIDS counselling are also discussed.

### OBJECTIVES

At the end of this unit you should be able to:

- ✎ Define HIV&AIDS counselling.
- ✎ Outline and discuss the aims of HIV&AIDS counselling.
- ✎ Compare VCT and CTC as intervention strategies.
- ✎ Outline the qualities of an effective counsellor.

## TOPICS

- ⌘ What is HIV&AIDS Counselling?
- ⌘ Aims of HIV&AIDS Counselling
  - Prevention of Transmission
  - Psychosocial Support to PLWHA and the Affected
  - Who Needs HIV&AIDS Counselling?
- ⌘ Being an Effective HIV&AIDS Counsellor
  - Role of an HIV&AIDS Counsellor
- ⌘ VCT and CTC
  - What is VCT?
    - Goals of VCT
  - What is CTC?
    - Goals of CTC
    - Components of CTC

Summary, Self-Assessment Activity, Further Reading, Glossary

## WHAT IS HIV&AIDS COUNSELLING?

We have defined the term HIV&AIDS in unit 1. We have also discussed counselling, its aims and the skills required of a good counsellor in unit 2, as well as the counselling theories and processes. We now turn to the discussion of HIV&AIDS counselling. Some of the principles and skills of counselling discussed in the first three units will be recalled. *HIV&AIDS counselling* is as old as the HIV&AIDS epidemic. It evolved with the emergence of the HIV&AIDS epidemic.

It is true that most general counselling principles and skills can also be used in HIV&AIDS situations. However, problems associated with HIV&AIDS are such that they require a specialised types of counselling.

The World Health Organisation (WHO) defines HIV&AIDS counselling as *an ongoing dialogue and relationship between client and counsellor the aim of which is to prevent the transmission of HIV infection and to provide psychosocial support to those already infected* (WHO 1990:10).

What we learned from the definition of counselling in unit 2 is relevant in understanding the above definition. Normally the dialogue and relationship in the context of HIV&AIDS focuses more on HIV&AIDS and psychosocial issues that go with it. This dialogue and relationship can be between a counsellor and a PLWHA or an affected person. We are aware that the impact of HIV&AIDS is not only felt by those who are infected but also by those who are affected, family members, friends, neighbours, workmates as well as the caregivers.

HIV&AIDS is a very sensitive issue and counselling people in such a context requires more than is required in other types of counselling. It involves dealing with the medical, psychological (thoughts and feelings), behavioural, and relational (spouse, family, friends and community) aspects of a client's life. It also involves dealing with the spiritual and religious aspects (guilt, forgiveness and condemnation) of a client's journey. Hence there is a need for counsellors to be informed about such issues. Or they should at the very least be ready to refer such cases to people who are better equipped. This presupposes awareness of HIV&AIDS counselling-related services.

## ACTIVITY 1

*List some psychosocial concerns which you think are presented by PLWHA to counsellors.*

### AIMS OF HIV&AIDS COUNSELLING

We now move on to the discussion of the aims of HIV&AIDS counselling. According to the definition given above, HIV&AIDS counselling has two main aims, 1) to prevent the transmission of HIV infection and 2) to provide psychosocial support to PLWHA and the affected. We wish to add to this a third and fourth aim: 3) to reduce stigma, both internal and external. This aim will not be discussed here as it is discussed in units 1, 6, 7, 8, 9, and 10 of this module. Let us now move on to discuss the individual aims of counselling.



## Prevention of Transmission

The dictionary defines prevention as the act of stopping or securing the non-occurrence of something. In the context of HIV&AIDS what is being prevented is the transmission of the HIV infection from one person to the other. Prevention in HIV&AIDS counselling involves assessing risk of infection, creating insight among those at risk of infection and encouraging appropriate behaviour change and sustenance. Normally prevention of transmission divides into primary and secondary prevention.

**Primary prevention:** In primary prevention, counselling focuses on preventing infection among those who are not infected. Included here are people who are at risk of infection (knowingly or unknowingly). Counselling is aimed at 1) discussing behaviours that put people at risk of HIV infection and 2) reviewing ways of managing individual change (WHO 1990:10). This type of counselling can take place in classrooms, youth clubs, sports organisations, church groups and informal gatherings (F. Mc Donnell 2004:4).

### ACTIVITY 2

*Before we proceed with secondary prevention let us do the following exercise:*

- 1. Outline the two aims of HIV&AIDS counselling.*
- 2. Mention the two types of prevention of transmission.*
- 3. Discuss the focus of counselling in primary prevention.*

**Secondary prevention:** In secondary prevention, counselling is concerned with people who are known or considered likely to be HIV positive. The focus of counselling is 1) on the implications of being HIV positive and 2) on ways of avoiding further transmission of HIV. A. Nwoye sums up the content of secondary prevention thus:

- Getting infected with HIV does not automatically mean that one has AIDS.
- One can be infected without developing symptoms, and can still pass on the virus to others.
- People who are able to get nourishing diets can stay in good physical shape, especially where a healthy lifestyle is supported with conscientious in-take of

fresh air, going to bed early at nights and daily participation in some kind of non-strenuous physical exercise (1994:13).

### ACTIVITY 3

*Theresa has just discovered that she is living with the HI virus. She is thinking about what is going to happen to her little son Joe and her job once she gets seriously ill.*

*Do these questions have to do with primary or secondary prevention? Explain.*

#### Providing Psychosocial Support to PLWHA and the Affected

Because of the psychosocial problems experienced by PLWHA, they require both emotional and material support. HIV infection and AIDS are different from all other life-threatening medical conditions. They evoke severe emotional reactions from both PLWHA and the affected.

The words of a PLWH is quoted in Watts' article 'Breaking the AIDS taboo': 'AIDS is the stuff of all our nightmares, triggering many of our deepest fears' (1988:28). This quote explains the psychosocial situation of PLWHA and the affected.

It needs to be said that each person reacts differently to an HIV positive result. However, for many clients, a positive HIV test result come as a great shock which is followed by some of the following reactions: fear of rejection and abandonment by family and friends, denial, anxiety, depression, stress and suicidal feelings. Stigma and discrimination experienced by both PLWHA and the affected makes it difficult for them to come to terms with the fact of living with HIV or having to care for someone who living with HIV. (unit 1 gives a detailed treatment of the plight of both PLWHA and the affected). Because of their unique situation they require a lot of care and support.

## ACTIVITY 4

*Let us say, you have gone for an HIV antibody test. The result has come out positive.*

- 1. How do you feel?*
- 2. What are your worst fears?*

### Who Needs HIV&AIDS Counselling?

A response to this question requires that we talk about HIV testing first, as HIV&AIDS counselling is done in view of testing. There are a number of reasons why people go for an HIV&AIDS test. But everybody who goes for an HIV test is encouraged to do pre-test and post-test counselling (pre-test counselling is counselling done before HIV testing and post-test counselling is counselling done after HIV testing and these are discussed in more details in unit 5). So, everybody who goes for an HIV test, mandatory or willingly, needs HIV&AIDS counselling. Let us see the reasons why people go for an HIV test. It can be for:

- Insurance purposes
- Because of exposure to risky practices or activities (behavioural or not)
- People who have unfounded phobias of having HIV&AIDS
- Clients who are infected with HIV or other HIV related ailments
- Marriage plans
- To know your status so that you avoid self-exposure

Whatever the reason for the HIV test may be, any of the above persons qualifies you for HIV&AIDS counselling. HIV&AIDS counselling may also be offered to people who, though not infected, are family members of a PLWHA.

Read the following story and answer the questions that follow.

## ACTIVITY 5

*John was in taxi with a well known HIV activist. He came home in a panic because one person—had sneezed in the taxi and therefore infected everybody.*

- 1. Is John's fear founded?*
- 2. Write how you would help John with his fears.*

## BEING AN EFFECTIVE HIV&AIDS COUNSELLOR

HIV&AIDS Counselling is a specialised type of counselling. It requires special training and preparation. A good professional counsellor is, therefore, not necessarily a good HIV&AIDS counsellor. Over and above, the qualities and skills that an effective HIV&AIDS counsellor needs to have:

- Basic knowledge of facts around HIV&AIDS: origin, myths, modes of transmission, symptoms and associated diseases, diagnosis of HIV infection and AIDS, management of HIV infection, and care and support services.
- Right attitude: An HIV&AIDS counsellor must be impartial and non-judgemental, genuine, open minded, and have the ability to maintain confidentiality, empathy, awareness of strengths and limitations and the right motivation for helping others.
- The desire to learn by doing more: Like any other type of counselling, HIV&AIDS counselling is best acquired through practice. Though every individual who comes for HIV&AIDS counselling is unique, every encounter provides an opportunity for learning more about the skills of counselling.

### ACTIVITY 6

*With a partner who knows you well, ask them to analyse your attitudes and ability to be open-minded. Discuss with them your ability to maintain confidentiality, your motivation for helping for helping others and how you are in respect to being judgemental.*

### Role of the HIV&AIDS Counsellor

In any HIV&AIDS counselling transaction the role of the counsellor is to:

- Create a non-judgemental atmosphere of trust and confidentiality
- Listen fully and actively
- Provide accurate and consistent information in clear and simple terms
- Clarify misconceptions
- Provide options and leave choices open to client

- Explore and identify together with the client barriers to using risk reduction behaviour
- Develop together with a client a plan to connect with needed resources.

## ACTIVITY 7

1. List some of the common misconceptions regarding the origin, transmission and cure of HIV&AIDS in your context.
2. Critically analyse the reliability of these misconceptions.

### VCT AND CTC

VCT is a common abbreviation in HIV&AIDS counselling. It stands for Voluntary Counselling and Testing. It combines two important activities, namely counselling and testing. We know from the preceding units what counselling is. Testing refers to an accurate scientific test done on a person's blood, to see if a person has been infected with HIV.

It is clear from the preceding units that counselling is an important element in the response to the HIV&AIDS epidemic. Through counselling, PLWHA and those affected by HIV are given information, advice and support for coping with their situation. Testing as a process requires counselling, as people need to be prepared emotionally for the outcome.

These two activities are qualified by the term voluntary. *Voluntary* means that a person decides on their own whether or not to have a test. VCT can, therefore, be defined as *an intervention initiated and entered into freely by the client with a view to explore and understand his/her HIV risks and to learn about his/her HIV status.*

Voluntary Counselling and Testing has emerged as a proven HIV prevention and care strategy in a number of countries especially in Africa.

## ACTIVITY 8

*“Voluntary counselling and testing has been named a proven strategy and an integral part of HIV prevention.”*

*Give a critical analysis of this statement.*

### Goals of VCT

- It helps people to know their current HIV status.
- It helps in the prevention of HIV transmission in the following ways:
  - from HIV positive tested people to untested or HIV negative partners
  - from HIV positive mother to child
  - acquisition by HIV negative tested person from HIV positive or untested person
- It facilitates early and appropriate access to services, such as medical, psychosocial and others.

### What is CTC?

CTC is a recent abbreviation that emerged in the Zambian context. It stands for Counselling Testing and Care. It represents a new vision that responds to the signs of the 21<sup>st</sup> century. According to the Ministry of Health of Zambia (2003:116) what CTC has added to the concept of VCT is greater emphasis on care and defining priorities with renewed resolve and affirmative action.

CTC requires that counselling be given as a matter of routine for all chronic illnesses as well as other social and psychosocial concerns. Testing too should not be restricted to HIV&AIDS. It should extend to other opportunistic infections. The care component ensures that those who are directly or indirectly affected by HIV&AIDS and other chronic illnesses are supported and cared for. The emphasis in CTC is not so much on testing out of free will. It is rather on taking affirmative action which is clearly manifested in self-disclosure, partner notification, preventing further transmission and greater involvement in HIV&AIDS activities. The above actions are, in a way, proactive modalities of providing care and support. How can you say you care if you

do not disclose, notify partner or engage in HIV&AIDS activities aimed at prevention, education and support?

## Goals of CTC

Counselling, testing and care aim at achieving the following:

- Provision of factual information on HIV&AIDS
- Provision of counselling routinely for all chronic illnesses
- Provision of testing facilities for all chronic illnesses
- Provision of quality preventive and support care services.

## Components of CTC

- Information, education and communication (IEC) component: It aims at mobilising communities to participate in CTC services, to create awareness about HIV&AIDS and promote risk-reduction behaviours.
- The pre-test and post-test counselling component: Pre-test counselling is done before the test and ensures that reasons for test are established and that implications of the test are explored. Post-test counselling is done after the test and ensures that implications for self, family and community are explored.
- The testing component: involves the testing strategies and the type of tests.
- The supportive care component: refers to the physical, emotional, social and spiritual support due to PLWHA and those affected by HIV&AIDS.

### ACTIVITY 9

1. *Compare and contrast VCT and CTC as explained above.*
2. *In what ways can you say CTC is an improvement on VCT?*

## SUMMARY

In this unit we have learned the following:

- HIV&AIDS counselling is a specialised type of counselling which emerged with the advent of HIV&AIDS epidemic.
- The aims of HIV&AIDS counselling are to prevent transmission and to provide psychosocial support to those affected.

- Over and above the counselling skills and techniques required of an effective counsellor, an HIV&AIDS counsellor needs to have:
  - Basic knowledge on HIV&AIDS
  - A Right attitude
  - The desire to learn by doing more
- VCT is an entry point for HIV&AIDS prevention treatment and care.
- Over and above the advantages of VCT, CTC emphasises a care component beyond testing; it also emphasises that counselling should be given as a matter of routine and that testing should not be restricted to HIV&AIDS alone but should extend to other conditions.

## SELF-ASSESSMENT ACTIVITY

### **Answer All Questions**

1. Define HIV&AIDS counselling in your own words.
2. Outline and discuss the aims of HIV&AIDS counselling.
3. In what way can primary prevention take place in classrooms, youth clubs, sports organisations, church groups and informal gatherings?
4. Discuss the content of secondary prevention according to Nwoye.
5. Outline and discuss qualities and skills required of an effective counsellor.
6. According to your experiences, what form of emotional and material support do PLWHA and the affected need?
7. If you were to choose a strategy would you choose VCT or CTC? Give reasons for your answer





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## GLOSSARY

<b>HIV&amp;AIDS Counselling:</b>	Is an ongoing dialogue and relationship between client and counsellor, with the aims of preventing transmission of HIV infection and providing psychosocial support to those already affected.
<b>Transmission:</b>	The spread of the disease-causing organism from one person to another.
<b>Primary prevention:</b>	Refers to a type of counselling that focuses on people who are at risk of HIV infection but are not known to be infected.
<b>Secondary prevention:</b>	Refers to counselling that focuses on people known or considered likely to be HIV infected.
<b>PLWHA:</b>	Stands for people living with HIV&AIDS.
<b>VCT:</b>	( <i>Voluntary counselling and Testing</i> ). A proven strategy for HIV prevention and care.
<b>CTC:</b>	( <i>Counselling Testing and Care</i> ) It represents a recent strategy originating in the <i>Zambian</i> context which lays greater emphasis on care, and defining priorities with renewed resolve and affirmative action. This strategy also requires that counselling be given as a matter of routine for all chronic illnesses as well as other social and psychosocial concerns.
<b>Voluntary:</b>	Done out of free will without any external coercion
<b>HIV sero-status:</b>	The status of the person's blood with respect to the presence of antibodies which are indicative of the HIV in the person's body.
<b>HIV sero-positive:</b>	Describes a person whose blood shows the presence of antibodies as evidence of the infection. This is commonly referred to as HIV-positive.
<b>HIV sero-negative:</b>	Describes a person whose blood shows no infection with HIV and is referred to as HIV negative.

# UNIT 5

## THE PROCESS OF HIV&AIDS COUNSELLING

### OVERVIEW

Welcome to unit 5. In unit 4, we defined HIV&AIDS counselling and discussed its aims. We also examined VCT and CTC as strategies for HIV&AIDS prevention, treatment, care and support. In this unit we are going to look at the process of HIV&AIDS counselling. This process involves pre-test counselling and post-test counselling. Supportive counselling and crisis counselling which, logically and in terms of sequence, follow a post-test counselling are also discussed.

### OBJECTIVES

At the end of this unit you should be able to:

- ✂ Define pre-and post-test counselling.
- ✂ Identify the steps of pre- and post-test counselling.
- ✂ Describe supportive counselling.
- ✂ Analyse the concept of crisis.
- ✂ Outline and discuss necessary steps to take in dealing with a crisis.

### TOPICS

- ✂ Pre-test Counselling
- ✂ Aims of Pre-test Counselling
  - Conducting a Pre-test Counselling
    - Step 1: Establishing a Relationship
    - Step 2: Risk Assessment
    - Step 3: Decision Making
- ✂ Post-test Counselling
- ✂ Aims of Post-test Counselling
  - Conducting a Post-test Counselling

- Step 1: Sharing the News with the Client
- Step 2: Risk-reduction Plan
- Step 3: Partner Notification
- Step 4: Supportive Care

⌘ Supportive Counselling

⌘ Crisis Counselling

- Components of a Crisis
- Types of Crisis
- Definition of Crisis Counselling
- Dealing with a Crisis Situation

Summary, Self-assessment, Further reading, Glossary

## PRE-TEST COUNSELLING

We will start by defining the term pre-test counselling. We will also discuss the aims and the points that should be covered in a pre-test counselling. You have probably heard of pre-test counselling before. The word is self explanatory. It is made up of three words which explain its meaning. There is pre- which means before. We should be familiar with the meaning of test from unit 4; we also know from unit 2 what counselling is.

So pre-test counselling would be *a counselling process that is undertaken before the test*. It is normally done before an antibody test. A client is strongly encouraged to go for pre-test counselling before doing an HIV antibody test. We should, however, remember that the decision to test and to go for counselling lies with the client.

### Aims of Pre-test Counselling

The aims of pre-test counselling are:

- To provide information on the technical aspect of testing.
- To ensure that any decision to test is fully informed and based on the understanding of the personal, medical, legal and social implications of both positive and negative results
- To provide necessary preparation to those traumatised by a positive result
- To discuss the test as a helpful act linked to changes in risk-behaviour

## ACTIVITY 1

*Make a list of fears and misconceptions that you or other people have about pre-test counselling. After going through the definition and aims of pre-test counselling do you still have those fears and misconceptions? Explain.*

### Conducting Pre-test Counselling

We now turn to how pre-test counselling should be conducted and what points should be covered. The pre-test counselling unfolds in three steps.

#### *Step 1: Establishing a Relationship*

This first step in pre-test counselling is *to establish a relationship*. Like all other types of counselling, pre-test counselling should build on a good, trusting and professional relationship. Clients who come for counselling, especially in view of HIV testing, do so with a high degree of anxiety and nervousness. A good relationship is therefore important in reducing the anxiety. We will do well to recall the attending skills discussed in unit 2, which go a long way in facilitating a relationship of trust between a counsellor and a client. Over and above these attending skills, the counsellor should be neutral, respectful, genuine, and empathic toward the client.

A good counsellor would make sure that the following are covered in the first step:

- **Introducing oneself:** This involves a greeting in a culturally appropriate manner and saying who you are and what you do. This is where a client should also be allowed to introduce him/herself.
- **Establishing a set of rules:** These include a contract that needs to be signed, confidentiality, time available, and boundaries.
- **Socializing:** This refers to a social conversation focusing on non-threatening issues like weather, etc. This should be done if the state of the client allows it.
- **Invitation to talk:** This is where the counsellor invites the client, in a relatively neutral manner, to relate his/her story by asking one of the following questions or similar ones: How can I help you Mrs or Mr..... (Mention the name)? Mr. or Mrs...what would you like to talk about? What brings you here?

## ACTIVITY 2

*You have learned that establishing a relationship with the client is an important step toward fruitful counselling. Drawing from your own experience, briefly write down ways in which this step can be enhanced.*

### *Step 2: Risk Assessment*

In this step, the counsellor helps the client to make sense of his/her concerns. The counsellor should make sure that the following issues are covered:

- Assessment of the client's level of risk (exposure to unprotected sex, drug related behaviour).
- Checking the client's understanding and knowledge of HIV&AIDS and its mode of transmission
- Clarification of misconceptions and myths around HIV&AIDS.
- Advantages and disadvantages of doing a test.
- Explaining the HIV test (the process, meaning of test results and their implications)
- Help people to prepare for problems they may face in the future and to provide support, for them and their families.

As we go through this process together with the client, we should remember to display an empathic and non-judgemental attitude. We should avoid asking too many questions that would give the impression that a client is being interrogated. McDonnell (2004:6) rightly observes that when dealing with HIV&AIDS a balance should be maintained between giving information and finding out how much the client knows about being infected and its consequences.

## ACTIVITY 3

*Get a partner and role play step 1 and 2 of a pre-test session. Exchange roles and remark on how each felt during the conversation.*

### *Step 3: Decision Making*

When the client's understanding of the meaning and implications of an HIV test have been explored, the counsellor should allow the client the liberty to decide. The client after weighing advantages and disadvantages may decide to go or may decide not to go for a test. Alternatively, a client may choose to postpone the test and return later for testing. They may want to discuss the matter with their partners, relatives and friends. Remember that it is their right to choose what they think is best. The best the counsellor can do at this stage is to support the client through this decision making process. If the client is prepared for a test, help him/her with a test and inform him/her how long the results will take. You can then arrange for the follow up session.

## ACTIVITY 4

*Paul (not his real name) is 20 years old he was pressured by peers to have girlfriends. He engaged on more than two occasions in unprotected sex with some of these girlfriends. He has come to you for a pre-test counselling. You have taken him through step 1 and 2. After counselling he decides he is not ready to go for a test. What do you say or do to him? Why?*

### POST-TEST COUNSELLING

Post-test counselling can be defined as *a counselling process that is undertaken after the test*. A post-test counselling follows upon a pre-test counselling. A well done pre-test counselling lays a foundation of a good post-test counselling. It is therefore advisable that a pre-test and post-test counselling be done by the same person. This is for obvious reasons that:

- A relationship will have been established and this provides a sense of continuity
- Knowledge of a client and what to expect in this second encounter can be anticipated.

Every test counselling encounter is unique. No two clients would come to the counselling session in exactly the same emotional state. The counsellor too, needs to work on a constant basis.

## Aims of Post-test Counselling

The aims of post-test counselling are:

- To communicate the HIV test results
- To help clients understand and come to terms with, their results
- To help clients express their feelings about the results
- To help clients to make plans for the future
- To help clients to decide on partner notification
- To help clients to reduce their risk of infection and infecting others
- To help clients access medical, psychological and spiritual support

### ACTIVITY 5

*Imagine you are pre-test counselling a client. Make simple notes on how you would start the session, what points you would cover and how you would end the session. This will help you determine whether you have grasped the main points of the pre-test counselling.*

## Conducting a Post-test Counselling

Post-test counselling unfolds in four steps, namely: sharing the news, creating a risk-reduction plan, partner notification and supportive care.

### *Step 1: Sharing the News with the Client*

When clients have presented themselves for the results, they are greeted warmly and made to sit down. It is important to check with the client that s/he has come for the results. A counsellor may also ask a client if s/he has anything to ask or talk about before results are given. If a client has issues to raise, s/he should be given a chance to do so. Positive results as well as negative results can be communicated in different ways. For example, the results can be given to the client to read for him/herself. This has the advantage of helping the client to own up to the result. It can also be done verbally. When the latter method is followed, the news should be given by the counsellor, in clear and simple terms. It may be necessary to find out from the client how they would prefer to have the results.



*When giving positive results verbally* you may say, for example, “your results are out and the test shows that you are HIV positive”. The positive results are often received with shock and distress. A counsellor should allow time for the result to sink in. No two clients will react in the same way to the positive result. Some may be violently angry, hysterical or just petrified. The role of the counsellor at this stage is to be there for the client and to allow the client to express their feelings in their own way. The counsellor must be prepared to discuss the implications of the positive result for the client.

#### *When giving negative results*

When giving negative results you may say, for example, “your results are out and they show that you are HIV negative”. A client is often relieved to receive a negative test result. The client must be given the chance to experience the pleasure of not being infected. The counsellor should help explore the feelings of the client and what this negative result may mean for the client. It is necessary to discuss the ‘window period’ and the need to repeat the test after three months to ensure that the client is indeed not infected.

#### *When giving indeterminate results*

There are times when the results of the test do not tell whether the test is positive or negative. This result is called indeterminate or inconclusive. This occurs rarely. When it does, a person should have a repeat test. The counsellor should explain to the client what this result mean and what its implications are. Waiting for results in itself is very distressing. Having to redo the test can be very stressful. A counsellor has to be very supportive and should encourage the client to practice safe sex.

## ACTIVITY 6

*Imagine that you are a counsellor and you have just communicated a positive result to your client. She breaks down crying. What do you do?*

*What do you say?*

### *Step 2: Risk-reduction Plan*

The risk reduction plan will depend on the nature of the result. In cases where a result is positive, the counsellor should make sure that s/he:

- Asks the client about his/her intentions upon leaving the counselling session
- Assess the client's social support
- Helps the client to establish a clear plan for medical, physical, dietary and psychological support
- Helps client identify possible actions that may help resolve their problems
- Identifies tasks that clients may be able to accomplish with support.

The risks for transmitting HIV infection to others and the possibility of re-infection should be discussed and planned for. Whatever plan is made it should be within the ability and means of the client. The client should identify with it as his/her own, otherwise s/he will not be able to live by it.

A risk reduction plan is equally important in cases where the result is negative. The client should be helped to make plans to protect themselves. This important goal has to be accompanied by discussion on clear strategies and skills needed to achieve this risk-reduction plan.

## ACTIVITY 7

*Discuss the meaning of risk reduction plan for an HIV positive result, HIV negative result and an indeterminate result. Take your own local experiences into consideration.*

### *Step 3: Partner Notification*

It may be necessary to inform a spouse or sexual partner about the client's HIV test results positive or negative test results. The situation will differ depending on the nature of the result and on how the client became infected. A positive result is often more difficult to deal with than a negative result.

In cases where the client's HIV test results are positive, especially, the decision to disclose becomes difficult. It has consequences for the person living with HIV and

people around him/her. It is therefore important that the decision to disclose be planned for and thought through very carefully. The practical way of doing this, is to discuss the matter as a ‘what if’. In other words, the counsellor does not tell the client that s/he has to tell the partner, but rather to explore it as ‘what would happen if s/he knows that you are HIV positive? What will be the result?’”

The counsellor’s role is to help the client deal with his/her concerns. The counsellor should not, in any way, put pressure on the client to disclose. The counsellor together with the client can play around with or imagine possible reactions in telling others. In that way a counsellor is helping the client to explore his/her feelings and deal with them. Sometimes it may even be necessary for the client to role play telling different people about his/her status. Disclosure is done for a purpose. It is true it may have negative consequences, but it has its own advantages. It helps people to:

- Accept their status and reduce stress of coping on their own
- Access medical services, care and support
- Protect themselves and others (for women especially it helps them to negotiate for protected sex).
- Protect their children from HIV infection
- Reduce stigma, discrimination and denial.
- Take responsibility and plan for the future

## ACTIVITY 8

*Let us imagine you have gone for an HIV test without informing your partner.*

*The result has come out positive. Would you tell your partner? If not why?*

*If yes how would put it?*

### *Step 4: Supportive Care*

Partner notification or disclosure is a giant step out of isolation and secrecy. The latter are barriers for prevention, treatment, care and support. Partner notification is itself a way of caring for self and others. It is critically important that a client who has had the courage to disclose be given as much support as possible; from partner/spouse,

family and friends. The counsellor comes in to help a client identify where, when and how to access support and how best to deal with his/her HIV positive status. Accessing professional support (counsellors and health workers) becomes easier if support from partner/spouse, family and friends is secure.

## ACTIVITY 9

*Critically discuss how partner notification enhances prevention, treatment, care and support in HIV&AIDS situations.*

### SUPPORTIVE COUNSELLING

Supportive counselling in the context of HIV&AIDS is *a process aimed at empowering HIV positive clients and those affected by it to live positively*. Living positively means living as normal as possible and looking after one's physical, psychological and spiritual health and well being. PLWHA face a lot of psychosocial, spiritual and financial problems. They therefore need a lot of support. This support can come from counsellors, health workers, family members and the wider community. It only depends on the nature of problems being presented by the client. While support may be given by a lot of people, supportive counselling as a specialised form of support can only be given by people who are trained in it. The aims of supportive counselling are to:

- Empower clients to manage their own problems
- Help clients realise and mobilise resources for their benefit
- Help clients identify and appreciate strong and positive aspects of their lives that they might otherwise overlook
- Empower clients to take control over their lives
- Empower clients to develop skills for problem solving and decision making

## ACTIVITY 10

*Find out how many support groups there are in your own community and what kind of support they offer. Basing yourself on the HIV&AIDS related problems in your community, list other types of support groups which you think may be necessary.*

### CRISIS COUNSELLING

You have always heard people say that they are in crisis. You may have said so of yourself. We experience a catastrophe like the tsunami and we say it is a crisis. We see a terrible accident, we say it is a crisis. What exactly do we mean? Do we mean the accident itself or what happens as a result of an external catastrophic event, is a crisis? How can we define crisis?

Crisis can be generally defined as a difficult situation, a life-threatening event or an emergency situation that requires immediate attention. Technically, a crisis is *an individual's internal reaction to an external hazardous event*. Though our definition speaks of crisis in relation to an individual, we must not forget that a crisis may also happen to a family or a community. It is clear from this definition that a crisis takes place inside a person. But it is triggered by something that happens outside.

#### Components of a Crisis

According to H.W. Stone, a crisis as an event that consists of four major elements, namely: 1) precipitating event or stimulus 2) appraisal 3) resources and coping methods and 4) crisis (1993:12). Let us now look at these individual components of a crisis.

A *precipitating event* is an external hazard such as loss of a job, death, divorce or being HIV positive. Divorce or death is not a crisis but it can trigger a crisis. The way in which a person perceives an event will render it a threat or a non-threat. If the event is perceived as a threat to their well-being, then this perception of an event by an individual is what we call *appraisal*. It refers to the individual's perception of the external event as a threat or a non-threat. When an event has been perceived as a threat, then the individual's *coping abilities and resources* are mobilised to deal with

the perceived threat. If the person's coping resources are able to deal with the threat, a crisis will be forestalled. If one's coping resources are not able to deal with the threat, then *a crisis* will occur. A crisis should not be confused with an external hazardous event. Stone (1993:13) rightly observes that a crisis happens within people or families, as a response to an external hazardous event.

### Types of Crisis

There are two basic types of crisis, namely: developmental crisis and situational crisis. *Developmental crisis* refer to the normal, predictable experiences that one goes through in his/her growth process. Menstruation may pose problems for young girls who reach the age of puberty. This would be an example of a developmental crisis. *Situational crisis* are unpredictable and they have an element of upheaval that poses a threat to an individual's coping resources. Death, divorce or being HIV positive may be unpredictable and threatening to an individual's coping abilities. We should however remember that people are unique and as such they may perceive an event in different ways depending on their experiences, coping resources and the manner in which the event took place.

## ACTIVITY 11

*Recall a crisis that you or somebody you know had to go through. What was the precipitating event? If it happened to you, Explain in a paragraph how it felt. If it was a crisis that happened to someone else, how did you hear about it and how do you think it felt?*

### Definition of Crisis Counselling

Crisis counselling *refers to a strategy or method of helping individuals and systems to cope with emotionally decisive and life-threatening events in their lives.* The fact that HIV&AIDS is an incurable medical condition, threatens people. As such it has the capacity of knocking someone off balance. Learning that one is HIV positive can evoke feelings of anger and intense fear. These can be expressed in different ways depending on the individual's internal and external coping resources.

## Dealing with a Crisis Situation

From the preceding discussion on crisis and crisis counselling, it becomes very clear that people respond to situations of crisis in different ways. It would be quite easy for counsellors to deal with situations of crisis if 1) external hazardous events were the same 2) people's reaction to that hazardous event were the same and 3) clients' internal and external coping resources were the same. But this is not the case and as such, it becomes difficult to propose a ready made answer for all situations. We can only suggest some guidelines of how a counsellor should react given a situation of crisis. The rest would be left to the personal and individual spontaneity and imagination of a counsellor.

People's reactions to the news that they are HIV positive varies considerably and they can be very unpredictable. In some cases even the pre-test counselling does not help to give a clue of what to expect. An HIV&AIDS counsellor needs to be prepared for this. The immediate concern of the counsellor in a crisis situation is to normalise the situation and to deal with the underlying causes of the trauma later. The counsellor has to remain calm. S/he should remember to allow the client to speak freely and ventilate his/her feelings.

When the situation has been normalised, then the counsellor's first task should be to identify the cause of the crisis. Secondly, the counsellor has to help the client understand the nature and cause/s of the problem (which they do not understand in most cases). This will help in bringing the situation under control for the time being. Lastly, the counsellor has to help the client to look for a program aimed at bringing long term stability. This may include medical, psychological, spiritual and social interventions.

## SUMMARY

This unit has exposed you to four HIV&AIDS counselling interventions, namely: pre-test, post-test, supportive and crisis counselling. Each of these interventions has a specific role to play in the process of helping a PLWHA cope with his/her emerging situation. The meaning, the aims and the steps of pre- and post-test counselling have been explored. We have also learned how to counsel cases of HIV positive, HIV

negative and HIV indeterminate results. Supportive and crisis counselling are particularly helpful during and after the communication of HIV test results.

## SELF-ASSESSMENT ACTIVITY

### Answer All Questions

1. Discuss the difference between pre-test and post-test counselling.
2. Outline the three steps of pre-test counselling and explain the third step.
3. In what ways does a well done pre-test counselling lay the foundation for a good post-test counselling?
4. Put down in writing how you would prepare for the sharing of an HIV test result. Explain how you would communicate it and why that way?
5. 'Partner notification is a giant step out of isolation and secrecy.' Discuss.
6. What are the aims of supportive counselling?
7. Outline and discuss the components of a crisis.
8. Would you classify HIV infection as a developmental crisis or a situational crisis? Give reasons for your answer.



### FURTHER READING

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## GLOSSARY

<b>Pre-test counselling:</b>	A counselling conversation that is undertaken before the HIV test.
<b>Post-test counselling:</b>	A counselling conversation that is undertaken after the HIV test.
<b>HIV antibody test:</b>	A laboratory test on a small sample of blood to detect whether the body has reacted to the presence of HIV.
<b>Partner notification:</b>	Process where a person informs his/her spouse or partner about the outcome of the HIV test. It is used interchangeably with disclosure.
<b>Indeterminate results:</b>	This is when an HIV test does not tell whether the test is positive or negative. It sometimes called an inconclusive test result.
<b>Supportive counselling:</b>	A process aimed at empowering HIV positive clients and those affected by it to live positively.
<b>Crisis:</b>	An individual's internal reaction to an external hazardous event.
<b>Developmental crisis:</b>	A normal, predictable experience that one goes through during his/her growth process.
<b>Situational crisis:</b>	An unpredictable event that poses a threat to an individual's coping resources.
<b>Crisis counselling:</b>	A process of helping individuals and systems to cope with emotionally decisive and life-threatening events in their lives.

# UNIT 6

## HIV&AIDS COUNSELLING AND THE AFFECTED

### OVERVIEW

Welcome to unit 6. HIV&AIDS counselling is useful not only to people living with HIV&AIDS. It is also useful to people who are in one way or the other related to and therefore have to care for PLWHA—such as partners, family and caregivers. We call such people the ‘affected’. The role they play in caring for their loved ones often times makes them vulnerable to stress and burnout. It is for this reason that we have a section within this unit on the causes and management of stress and burnout.

### OBJECTIVES

Upon completion of this unit you should be able to:

- ⌘ Define couple counselling.
- ⌘ Discuss how families in the context of HIV&AIDS can be placed where people can be formed, transformed or deformed.
- ⌘ Outline and discuss different types of caregivers.
- ⌘ Make a brief comparison between stress and burnout.
- ⌘ Describe how caregivers are vulnerable to stress and burnout.
- ⌘ Identify ways of managing stress and burnout.

## TOPICS

- ⌘ Couple's Counselling
  - Aim of Couple's Counselling
  - Couple's Counselling and HIV&AIDS
  - Counselling Challenges
- ⌘ Counselling the Family
  - Family Counselling and HIV&AIDS
- ⌘ Counselling the Caregivers
- ⌘ Stress and burnout
  - Causes of Stress and Burnout
  - Symptoms of Stress and Burnout
  - Stress and Burnout Management

Summary, Self-Assessment, Further reading, Glossary

## COUPLE'S COUNSELLING

In unit 5 we touched briefly on the issue of partner notification as a step in post-test counselling. Here we want to move beyond partner notification to couple's counselling. Let us start by defining what a couple is. A couple may be defined as *two people living together with a common commitment of love to each other, such as that of marriage*. Couple's counselling would, therefore, refer to *a helping relationship that involves a counsellor and a couple aimed at facilitating them (a couple) to utilise the resources they have to solve or cope better with their problems*.

### Aim of Couple's Counselling

The aim of couple's counselling is to provide information on strategies that could be adopted by persons that are married or co-habiting in order to live more effectively and cope with their problems.

### Couple's Counselling and HIV&AIDS

Couple's counselling has been identified as an optimal entry point for HIV prevention, treatment, care and support among persons who are married or co-

habiting. For a couple who has gone for a test, the results can be *discordant*. A result is discordant if one partner has tested positive and the other negative.

## ACTIVITY 1

*List some of the issues that make couples seek counselling. Take your own local situation into consideration.*

Where a result is negative, the role of the counsellor is to alert the couple to the question of *window period*. This refers to a period between exposure to HIV and the development of detectable HIV antibodies. The couple should be informed that the test done during this period may not be a true reflection of their status. Hence it would be important that the couple be allowed to discuss and decide on the issue of *safer-sex practices* and to try another test after 3 months.

In cases of an *HIV positive result for both couples*, the role of the counsellor would be to discuss the risk of re-infection, pregnancy and breastfeeding and the use of condoms properly and consistently.

For a *discordant couple*, the counsellor should focus on helping the couple to work on a plan to reduce chances of infection of the HIV negative partner. The issue of window period is equally valid. It, therefore, has to be raised with the couple. The issue of child bearing in marriage ranks high in Africa. Its implications for the couple, their health as well as that of a child, should be thoroughly explored. This will make it easier for the couple to make an informed decision.

## ACTIVITY 2

*Thomas and Grace are a couple. They have been tested for HIV and found that they are discordant. They would love to have a child. They have approached you for counselling. Explain three issues you explore with them and what would be your role as a counsellor.*

You may wonder if it better for a couple to be encouraged come to counselling together or individually. If a couple decides to come together for counselling this is indeed useful in a number of ways:

- It ensures that both receive pre-test counselling together, which prepares them emotionally and psychologically to conduct the test
- It creates an atmosphere of trust between the couple
- It promotes commitment to remain negative
- It enhances adoption of risk reduction behaviour
- It encourages support and commitment to positive living in cases where both partners are HIV positive or discordant

Ideally, couples must be encouraged to counsel, test and receive results together. In cases where one partner receives results alone, s/he must be encouraged to notify the other partner. If a partner is not ready to disclose the HIV result to their partner, s/he should not be coerced rather s/he should be allowed time for reflection.

### ACTIVITY 3

*In half a page discuss whether it is better for a counsellor to counsel the couple together or separately. Take your own local context into consideration.*

### COUNSELLING CHALLENGES

Couple's counselling has its own specific needs and challenges. Not all couples prefer to come for counselling together. A partner who knows that s/he has been exposed to risky behavioural patterns, would not want to go through counselling, testing and receive results in the presence of a spouse. This is because some spouses, after testing positive resort to violent behaviour against their spouse. This is the case for the majority of women who are seen as culprits for the infection of their husbands or partners.

When an individual prefers to do counselling alone, the counsellor should be available to help. It is the counsellor's role is to help each individual to cope with his/her

emotional reactions to the test results. Even those who choose to come together are not without their problems. One counsellor in UNAIDS, *Knowledge is power*, shares this experience:

Some of our most challenging cases are couples who arrive seemingly healthy and discover they are discordant...If the husband is positive, sometimes he will say: "I have been with my wife for a long time and she has not been infected yet. Why should we start using condoms now?" He will take the free condoms we offer and the wife will return later and tell us he is refusing to use them (1999: 31).

UNAIDS, further observes that:

- Overall, clients who come for counselling as couples have much lower rates of infection than those who come as individuals.
- Among couples already married, 18 per cent are discordant and 15 per cent are both infected
- It is difficult to share discordant results to couples who practice unprotected sex.
- It is difficult to explain negative results to couples engaging in high-risk behaviour (19:31-32)

The counsellor's role should be to help the client to think through the reasons for opting for the test.

In couple's counselling, the counsellor should:

- Avoid taking sides (this is called the skill of neutrality).
- Avoid getting involved in any blaming
- Avoid telling the couple what to do
- Avoid talking on behalf of one partner
- Facilitate informed decisions and choices
- Allow both partners equal time to talk
- Encourage shared responsibility
- Encourage joint planning and consensus
- Support the couple emotionally (Ministry of Health:Zambia 2003:136).

## ACTIVITY 4

*Imagine that your friend has tested HIV positive and his/her partner has tested negative and yet they have been practicing unprotected sex. How do you label such a couple? Explain what make it difficult for a counsellor to share such results?*

### COUNSELLING THE FAMILY

H. Clinebell (1984:244) contends that the family is the garden of human personality—the primary place where persons are formed, deformed, and (hopefully) transformed. As such, the family becomes a very important source of support for every individual that comes for counselling.

## ACTIVITY 5

*Give your own understanding of family. In half a page discuss ways in which families resolve their own problems in your culture.*

The family here is understood as group of people that interact closely with each other because of biological and other ties (A. Haworth 2001:50). The family, therefore, has a life of its own consisting of interdependent individuals or subsystems. As such, whatever affects one part (individual) of the family will automatically affects all others. This is what is referred to as *systems approach* to counselling. This approach corresponds to the way an African sees the world around him/her, in which everything is interconnected. In most African countries the concept of community is entrenched in our societal structures. An individual can only be defined in relation to the family or community. M.W. Dube articulates this well in her module: Theology of Compassion (unit 4). Every individual, therefore, has the moral obligation to contribute positively toward the good name of the community which includes both the living and the living dead.

Let us look at how this approach (systems approach) is important in addressing the problems of an individual living with HIV&AIDS and the affected family?

- It makes reference to the family and community in resolving problems
- It takes into account the total environment of the individual
- It looks at the context of the individual's problem, be it at community, family, peer group or organisation level
- It focuses on mobilising the natural supportive resources available

## ACTIVITY 6

*Community and family life is a common feature of most cultures in Africa. List some of the values of community or family life that can be used to enhance care and support for PLWHA.*

### FAMILY COUNSELLING AND HIV&AIDS

According to the family systems approach, whenever a member of the family is living with HIV&AIDS, the rest of the members are directly affected by that individual's infection. This new situation or challenge forces the family to adapt. Our experiences are that families adapt differently to a situation of a member living with HIV&AIDS. Some families choose to isolate, reject or stigmatise such a member. Others provide support and care to a PLWHA. In either case, such a member influences the behaviour of the system (family), and the system influences the PLWHA. Any counselling done under these circumstances focuses not on the individual PLWHA, but on the relational process between both the PLWHA and the family. By counselling the family, we are preparing a place for all members of the family (infected and affected) to be formed and transformed on a continual basis. Counselling the individual without rehabilitating the place where s/he lives is counterproductive and anti-therapeutic. This does not only perpetuate the illness of the individual it also perpetuates the illness of the family; for an injury to one member is an injury to the whole family.

The *systems approach*, which is useful in counselling families, does not detract from counselling principles that apply to individual counselling. The only difference is that the family, rather than the individual, becomes the client. In such a situation the counsellor focuses on:



- Helping the family to identify their problems, concerns and issues about how the virus is affecting the system/family (current scenario)
- Helping the family to say what they want or need within limits imposed by the virus (preferred scenario).
- Helping the family identify what they need to do (strategies)
- Helping the family to implement strategies with view to living more effectively with problems created by the virus (action).

## ACTIVITY 7

*Imagine yourself counselling a family affected by HIV&AIDS. Write down your conversation with the family and as you do that remember to include:*

1. *What the family is saying to you?*
2. *What you are saying to them?*
3. *What you are doing?*
4. *How do you respond to the feelings shared by the members of the family?*

### COUNSELLING THE CARE GIVERS

In the context of HIV&AIDS, the care givers are the people who in one way or the other look after the welfare of people living with HIV&AIDS or their survivors. According to the study done by UNAIDS (2000:13-24), in South Africa and Uganda care givers for PLWHA are made up of a wide variety of groups and individuals. We will discuss the people who are most often care givers below.

**Carers in family:** With the epidemic gaining momentum each day, the demand for carers far outstrips the capacity of the health services and workers. As a result the role of caring is borne by non-professional carers within families. UNAIDS (2000:60) calls these people, and rightly so, a precious resource. At the family level, the burden of care is predominantly borne by women and children. While men are also increasingly rising to the challenge of caring for the sick, children are forced by circumstances to care for their ailing parents who have no one else to look after them. We need to mention from the outset that care giving in an African context is a way of life. It emanates from the African understanding of being human. To say, '*Motho ke motho ka batho*' (a person is a person through others) imposes upon us as members of

the community to do to others what we would expect them to do to us. To care for others is giving back what was entrusted temporarily to my care.

**Volunteers:** At the community level one of the least acknowledged resources is volunteers. These are the people who, for one reason or the other, dedicate their time and energy to giving service to the community. Volunteers may be informal or formal. *Informal volunteers* are friends, neighbours and church members who care for the sick out of love or duty. *Formal volunteers* are mostly people recruited, trained and supervised by organisations responsible for AIDS care programmes.

**Health care professionals:** This group is mostly made up of nurses, counsellors and social workers. They work directly with clients or families themselves. Their responsibility is to train and support volunteer carers in the community.

**Indigenous healers:** These are among the most widely consulted practitioners in Africa. However, the role they play in the treatment and care of PLWHA is yet to be recognised in other countries. Some of the concoctions they prescribe to their patients (such as the African potato) have been found to be useful. Working in conjunction with doctors trained in the west, traditional doctors would be able to ensure that they were prescribing traditional medicines in the correct dosages and ensure that their traditional medicines were not harmful when mixed with ARVs. In Lesotho, for example, some western trained doctors encourage PLWHA who consult traditional healers to bring along the medicine they got from them to appointments.

## ACTIVITY 8

*We have said above that responsibility of care at the family level is borne mostly by women. Why do you think this is the case? Explain and illustrate your answers through examples. Suggest and put down in writing ways in which other groups at the family level can be encouraged to help in providing care to PLWHA.*

## STRESS AND BURNOUT

Stress and burnout are used together so often that it would appear they mean one and the same thing. It is true that the two terms are closely related but technically they are different. *Burnout* is a stress experience that results from being over-involved in interpersonal relationships with clients. *Stress* on the other hand does not have to be a burnout experience. It is not necessarily related to over involvement with clients. A person who is not able to cope emotionally with the demands of work, for example, is likely to experience stress. It is in this sense that Haworth defines stress as an *emotional imbalance between demand and the ability to cope with a situation* (2001:88). The nature of the work that caregivers do renders them most vulnerable to stress and burn out.

### ACTIVITY 9

*Write about the experience of stress or burnout that you, or a person you know, have gone through as a result of HIV&AIDS. How did you or s/he feel? What were the causes of these stress or burnout experiences?*

### Causes of Stress and Burnout

We now focus our attention on the main causes of stress and burnout. HIV&AIDS is an incurable condition responsible for the death of millions of people. It causes a lot of suffering and is heavily stigmatised. HIV&AIDS affects relationships and families and it forces people to care for others, with inadequate training, skills and preparation for the work. Clearly, having to work under such conditions can be very challenging and might lead to either stress or burnout.

UNAIDS (2000:39) lists the causes of stress and burnout among care professionals and volunteers working with HIV&AIDS care programmes as financial hardships, stigma associated with HIV&AIDS, oppressive workloads, over-involvement with PLWHA and their families, and fear of infection.

**Financial hardship:** The following are the words of a training officer in Uganda, “The messages about living positively, eating well and looking after your health can seem cruel when people are struggling to bring food to the home”. A volunteer

caregiver in KwaZulu-Natal, South Africa notes: “We go to see hungry people and we are hungry too”. These statements are a reflection of financial hardships that caregivers have to go through (UNAIDS, 2000:28).

**Stigma associated with HIV&AIDS:** HIV&AIDS related stigma has a negative impact on both the PLWHA and the caregivers. Care givers are avoided by families, friends and society for working with PLWHA. This adds the burden on the already overwhelmed care givers.

**Oppressive workloads:** Often times HIV&AIDS programmes are funded by donors who have specific targets and deadlines. If these are not met, programmes may lose the financial support they depend upon. Many care givers face internal pressure and push themselves beyond their own limits.

**Over-involvement with people with AIDS and their families:** In countries where almost every family is affected by HIV&AIDS, becoming over-involved is not a matter of choice. At work one is involved with HIV&AIDS as a duty and at home one is involved as a matter of obligation to family and friends. As a result the risks of stress and burnout are very high.

**Fear of infection:** With or without information and education caregivers are living with a danger of exposure to infection. This is especially true in cases where the demand for service far outnumbers the resources of an individual facility.

There are many other causes of stress and burnout. These are listed below, however for lack of space we will not be able to go into greater detail about them. They include:

- The fact of AIDS being incurable
- Inadequate support and supervision
- Lack of clarity about what care givers are expected to do
- Lack of recognition for work done by volunteers
- Lack of medication and health care materials

### Symptoms of Stress and Burnout

Stress and burnout, though technically different have more or less the same symptoms. These symptoms manifest themselves in a variety of ways ranging from mild, moderate to severe. The most common signs and symptoms include:

- Loss of interest in work
- Failure to observe punctuality and neglect of duties
- Feelings of inadequacy, helplessness and guilt
- Loss of sensitivity in dealing with clients
- Loss of quality in performance
- Irritability
- Sleeplessness

Caregivers are an extremely important resource in the care and support of PLWHA and the affected. No family or society, therefore, can afford to lose its caregivers to stress and burnout. There is therefore a need for helping caregivers the skills to taking care of themselves. This is the matter for the next section.

## ACTIVITY 10

*You have related the experience of stress or burnout that you or somebody you know experienced in the previous activity. Please say what symptoms you or s/he experienced and in what ways they affected your or his/her work, relationship and health. Did anybody help you or him/her to manage? If somebody helped, in what ways did s/he help? If you or s/he managed without external assistance, how did it happen?*

### Stress and Burnout Management

Stress and burnout can be attributed to physical, psychological and spiritual causes. Helping people, especially in the context of HIV&AIDS, requires a lot of physical involvement (washing clothes, cooking, feeding, and turning the sick). It affects people mentally and emotionally (thinking about what should or could be done). It further involves religious or spiritual issues (what have I done to God to deserve this?) A comprehensive approach to its management has to take into consideration all these aspects. The following approaches and skills can help caregivers in working with people living with HIV&AIDS:

**Realistic expectations and performance goals:** Every caregiver should know their strengths and their limitations. Their expectations and goals have to be set and achieved within their own limits and strengths.

**Care for self:** There is no better medicine for stress and burnout than taking care of oneself. This means eating a balanced diet, taking enough rest and keeping one's body healthy by regular exercising. The observation of Anne Finnegan, the director of a Life Line branch in South Africa is equally valid for caregivers. She says, "We impress upon our counsellors the importance of looking after themselves, pointing out that if they allow themselves to get sick or burnt out they will be unable to help anyone" (UNAIDS, 2000: 46). **Using support systems:** Support, both at a personal and an organisational level is a must for care givers who are working with PLWHA. At a *personal level* they should talk to and use their spouses or partners as their support systems. At the *organisational level*, care givers should be encouraged to form their own social and spiritual support groups or clubs if none are in existence. They should also avail themselves of counselling opportunities as they are very useful in remedying stress-related problems. **Teamwork:** working as a team ensures equitable distribution of labour to spread the burden of care among all members.

## SUMMARY

In this unit you have learned mainly about HIV&AIDS counselling with respect to the couple, the family and the caregivers. I hope you have noted the importance of couple's counselling especially in the context of HIV&AIDS. The family is ideally a place and a context of personality formation. The whole family should be offered counselling, regardless of whether they are supportive of the PLWHA. I have also indicated that care givers in their different forms are an important resource in situations of HIV&AIDS. Their greatest enemy is stress and burnout. They (care givers) or indeed other people involved in working with PLWHA are likely to experience stress and burnout. Because of this, it is important that they be should exposed to ways of managing stress and burnout: i.e. setting realistic goals, caring for self, using available support system and working as a team.

## SELF-ASSESSMENT ACTIVITY

### Answer All Questions

1. Define couple counselling in your own words.
2. Discuss the role of a counsellor in situations where a couple is discordant.
3. What are the advantages and disadvantages of having a couple go together for counselling?
4. In your cultural context, who is most likely to go willingly for counselling especially counselling for HIV&AIDS; men or women? Explain
5. Discuss the principles that should guide a counsellor in counselling a couple.
6. Explain why it is important to counsel the family of a PLWHA.
7. Describe systems approach and its importance in counselling families.
8. Care giving in an African context is a way of life. Discuss this statement.
9. What are the common causes of stress and burnout in HIV&AIDS situations?
10. Discuss management of HIV&AIDS related stress and burnout.



### FURTHER READING

A WCC Study Document. 1997. *Facing AIDS: The Challenge, the Churches' Response*. Geneva: WCC Publications.

Egan, G. 2002. *The Skilled Helper: The Problem-Management and Opportunity-Development Approach to Helping*. CA: Brookes/Cole.

Haworth, A. et al. 2001. *HIV&AIDS Counselling: A Generic Training Manual*. Lusaka: Ministry of Health.

Paterson, G. 1997. *Love in a Time of AIDS: Women, Health and the Challenge of HIV*. Geneva: WCC Publications.

UNAIDS. 1999. *Knowledge is power: Voluntary HIV counselling and testing in Uganda*, Geneva, UNAIDS.

UNAIDS. 2000. *Caring for carers: Managing stress in those who care for people with HIV and AIDS*, Geneva, UNAIDS.

## GLOSSARY

<b>ARVs:</b>	Antiretroviral drugs. These are the drugs that are given to people whose CD4 count is below 200 to help boost their immune system.
<b>Couple:</b>	Two people living together with a common commitment of love to each other, such as that of marriage or co-habitation.
<b>Couple's counselling:</b>	Is a helping relationship that involves a counsellor and a couple with the aim of facilitating the couple to utilise the resources they have to cope better with their problems.
<b>Discordant couple:</b>	Used often in HIV situations, this term is used to indicate that one partner has tested HIV positive and the other is HIV negative.
<b>Care giver:</b>	This is the term used of people—professional and non-professional—who care for people who are sick as a result of AIDS.
<b>Volunteers:</b>	These are a type of caregivers. They are the people who, for one reason or the other, dedicate their time and energy to giving service to the community without expecting payment in return.
<b>Formal volunteers:</b>	They are volunteers recruited, trained and supervised by organisations responsible for AIDS care programmes.
<b>Informal volunteers:</b>	They are volunteers such as friends, neighbours and church members who care for the sick out of love or duty.
<b>Stress:</b>	Is an emotional imbalance between demand and ability to cope with a situation.
<b>Burnout:</b>	Is an individual stress experience that results from being over-involved with clients.



# UNIT 7

## HIV&AIDS COUNSELLING AND SPECIAL CASES

### OVERVIEW

Welcome to unit 7 of our module. This unit deals with the application of HIV&AIDS counselling to abused clients, pregnant women, orphans and the terminally ill. We have referred to these as special cases for want of a better term. Abuse in itself is a traumatic experience. It becomes even more traumatic when a survivor of abuse becomes HIV, positive as a result of abuse. Lastly, we will deal with grief and grief counselling.

### OBJECTIVES

By the end of this unit you should be able to:

- ✂ Define abuse and its different forms.
- ✂ Describe signs of abuse in abused clients.
- ✂ Identify the unique experience of pregnant women in HIV&AIDS contexts.
- ✂ Discuss the experience of orphans in situations of HIV&AIDS.
- ✂ Describe the specific needs of the terminally ill.
- ✂ Discuss grief, grief counselling and stages of the grief process.

## TOPICS

- ⌘ Counselling Abused Clients
  - Forms of Abuse
  - Women, Girls and Abuse
- ⌘ Counselling Pregnant Women
- ⌘ Counselling the Orphans
  - The Impact of HIV&AIDS on Children
- ⌘ Counselling the Terminally Ill
  - Specific Needs of Terminally Ill People
- ⌘ What do Terminally Ill People Require from a Counsellor
- ⌘ Grief Counselling
  - Definition of Grief Counselling
  - Grief Counselling and African Culture

Summary, Self-Assessment Activity, Further Readings, Glossary

## ACTIVITY 1

1. *In one sentence define abuse in your own words*
2. *Name two of the most common forms of abuse in your locality*
3. *In most cases, who are the perpetrators and who are the victims of these two common forms of abuse?*

### COUNSELLING ABUSED CLIENTS

We have certainly heard people use the word abuse. We have probably used it as well. What is abuse? How can we define it? The Brainy Encyclopaedia defines *abuse as a general term for the misuse of a person or thing, causing harm to the person or thing* ([www.brainyencyclopedia.com](http://www.brainyencyclopedia.com)). Though from the definition above, a thing or a person can be an object of abuse, our concern is on abuse that is directed at human beings. Someone who is abused is someone who is treated badly or misused or harmed. Abuse can affect anyone: women, children and men, though, generally, women and girls are the ones who suffer mostly from abuse. T.M. Hinga asserts that women, from a very tender age, are vulnerable to sexual abuse by so called ‘child molesters’ (2000:138).

#### Forms of Abuse

Abuse takes place mostly in families, but it is also found in the workplace, schools, the public domain and in religious institutions. Abuse can take different forms. It can be physical, sexual, emotional, or it can be a combination of any or all of the above. *Physical abuse* is when a person inflicts physical violence or pain on another. It involves actions that cause physical injury or physical pain to the other party. It includes hitting, kicking, whipping, beating and throwing things at someone. *Sexual abuse* is an improper use of another person for sexual purposes without their consent or under physical or psychological pressure. Sexual abuse includes inflicting pain during sex or not allowing the partner to use protection against HIV/STIs. *Emotional abuse* is when a person uses emotional or psychological manipulation to compel another to do something they do not want or that is not in their best interest. It is sometimes called psychological abuse.

All these forms of abuse may be entrenched in and fuelled by culture or religion. Wife beating has become a norm in some societies. In religious institutions or churches some abusive behaviour is justified on biblical grounds. For example, some people would say that wives are expected to submit to their husbands, and failing which they need to be disciplined. It needs to be said that these are selective and erroneous interpretations of the Bible and have to be condemned.

## ACTIVITY 2

- 1. Take a pen and a paper and write an experience of physical abuse done on you or someone you know. What are your feelings as you look back on it?*
- 2. In a paragraph, write down the form of abuse that men and/or women are likely to experience. Give reasons and examples for your answer.*

### Women, Girls and Abuse

We have noted that generally, women and girls are more vulnerable to abuse than their male counterparts. In South Africa, studies show high rates of HIV infection in women who were physically abused, sexually assaulted or dominated by their male partners ([www.powa.co.za/display.asp](http://www.powa.co.za/display.asp)). Given the fact that abusive men are more likely than non-abusers to be HIV positive, the vulnerability of women and girls to HIV infection is very high. This, together with women's marginal status in most African societies renders them incapable of negotiating safer sex practices. The violence that goes with the disclosure of their status increases women and girl's vulnerability to sexual exploitation, abuse and HIV&AIDS. The following story will help us have a feel of the unique experience of women in HIV&AIDS situations:

A high schools teacher shot his wife and mother-in-law dead and critically wounded his father-in-law before killing himself.....a note written on a brown paper which read: "HIV positive AIDS" was found on top of Mpho's (wife) body. According to a relative, the couple went for an HIV test some two weeks ago. She (the relative) suspected that Motlounge (the husband) had blamed his wife for contracting the virus (The Sowetan, 23 August 2000).

This story echoes the experiences of the majority of women—our mothers, wives, sisters and children—who suffer in silence and die in silence.

## ACTIVITY 3

*Describe three things that you would do to champion the campaign against the abuse of women and girls in your community.*

We now turn to the discussion of the common features in the experiences of the abused clients. For most abused people, an instance of abuse is not an isolated incident. It tends to characterise a major part of their lives. The following are some of the signs of abuse:

- Abused clients tend to isolate themselves as a result of being abused
- Abused clients tend to have a negative perception of themselves
- Abused clients develop a feeling of being betrayed and they tend to mistrust people
- Abused clients tend to harbour suicidal feelings.

These experiences make the counselling process of an abused client very special. The three stages of the counselling process discussed earlier should be recalled. It should, however, be remembered that these stages and the features common to them are not intended as hard and fast rules that cannot be discarded when such a need arises. They should be understood simply as guidelines. We will outline the three stages and simply refer to them as the initial stage, middle stage, and the final stage. Let us now identify the common features in each of the three stages.

### Initial stage

**Trust:** It should be remembered that for abused clients the decision to seek help is not an easy one. It is done amidst threats, feelings of denial and shame. In the first contact, the counsellor should remember that s/he represents both the potential healer and the feared abusive person. The gender of a counsellor plays an important role here. A male counsellor would not be the best choice

for a woman or girl that has been abused. The predominant reaction of women or girls abused by their male partners or fathers is that of mistrust for all males. These feelings, therefore, have to be met with assurance the counsellor is trustworthy.

**Setting boundaries:** This refers to agreeing with the client on the frequency and duration of the session. This helps make the session feel predictable and safe for the client. Walker (1992:146) warns us to remember that neither caring nor predictable behaviour has been part of the abused client's experience.

**Controlling the process:** While the counsellor is the one guiding the session, the client should be assured that they are not mere passengers, but that they can take charge of the progress and content of the counselling time. The counsellor should remember that an abused client should not only be taken seriously but that s/he should also feel that s/he is being taken seriously.

### Middle stage

**Facing the abuse:** Once trust has been developed, the client is ready to relate their story. A counsellor needs to be patient as the client may have only vague memories of the experience, or s/he may have repressed these memories for some time. Having to bring them back may be a very painful scenario. The counsellor should be prepared for an outburst of painful feelings, expressed in crying or anger directed at the counsellor.

**Dependency:** As the client begins to trust the counsellor, they may begin to develop a dependency on the newly found carer. This is not necessarily something negative. It is common to people who have a feeling of having been betrayed. The counsellor should build on their strengths and guide them towards more independence.

**Empowering the client:** The counsellor has no choice but to believe the story of the client. S/he should listen attentively, empathise and avoid making judgements. A client's feelings have to be validated. This is because abused clients tend to have mixed feelings about the abuser. They may be angry, afraid, sad, loving, guilty, and hopeful. They should therefore be allowed time to vent these feelings. They must be assured that these are normal.

**Facing abusers:** The decision to face the abusers rests entirely with the client. The role of the counsellor is to assist the client through the process, by first thinking through methods of approaching their abuser and then about the implications of their plan.

### Final stage

**Termination:** Termination of the counsellor/client relationship should involve both the counsellor and the client. Some clients may decide on their own that they are ready to terminate counselling. Others come to depend on counselling and are unable to make this choice and therefore need some help to decide. Whenever termination of counselling is done, it should take into account the client's level of self-esteem. It should also be done when the losses have been sufficiently mourned and feelings of anger been dealt with. The counsellor should remember that complete healing may have to wait for another year. A client does not have to be completely healed in order to terminate counselling, but should have made reasonable and sufficient progress.

**Reviewing:** This is where the counsellor and the client review the journey they have had together. Clients have to be taken through the road they have come down to discover what they have achieved, overcome and missed. Disappointments have to be accepted as part of the journey and successes celebrated. This feature is important as it makes the client own up to the whole process as his/her achievement.

Illustrate the stages and what happens in each stage through the following diagram:

Initial stage	Middle stage	Final stage
Trust	Facing the abuse	Termination
Setting boundaries	Dependency	Reviewing
Controlling the process	Empowering the client	
	Facing the abusers	

## ACTIVITY 4

*Imagine that a young woman of 18 years has come to you for counselling. She claims to have been raped repeatedly by her father. She has had to conceal this for years, but she feels she cannot take it anymore. In the middle of narrating her story, she suddenly starts crying and insulting her father, you and all men who are responsible for her suffering. What do you do as a counsellor? What do you say to her?*

### COUNSELLING PREGNANT WOMEN

Most women, as we have shown above have very little say, if any at all, on issues of sexual relationships in general, and safer sex practices in particular. The use of a condom as a protection against infection or as a contraceptive is often a unilateral decision by a husband or male partner. Women, therefore, become pregnant as a result of a forced sexual relationship. In most of these relationships, a husband who has HIV infects the wife who gives birth to an infected child as well.

As a result of their situation, pregnant women often battle with the multiple trauma caused by constantly forced sexual intercourse; pregnancy as a result of that forced sexual relationship; guilty conscience for having to carry the child that is likely to be infected; fear of stigma and discrimination as a result of not breastfeeding the child (this is always associated with the fact that the woman is HIV positive); possibility of terminating pregnancy; and a lack of support and care from partner.

A counsellor who has to work with pregnant women has to take into consideration all these issues and deal sensitively with them. There are several things a counsellor should do when dealing with a pregnant woman in this circumstance:

- Empathise with their situation
- Avoiding making judgements
- Refrain from blaming her for the situation
- Listen carefully to her story and her fears in order to identify issues that hurt her most.
- Offer appropriate help and adequate information about HIV&AIDS and the implications for mother-to child transmission.



## ACTIVITY 5

*Pick a partner. Imagine that s/he is a pregnant woman and you are a counsellor. She has been suspicious that her husband is sleeping around. She has had to go to the clinic for STD treatment. She now fears that she might be infected. When she told her, husband he blamed her. Role play the conversation and write it down.*

### COUNSELLING THE ORPHANS

The number of orphaned children as a result of AIDS is growing at an alarming rate. In Africa alone, there are millions of orphans. Sub-Saharan Africa is the worst affected with 12 million children having lost one or both parents to AIDS. It is further projected that by 2010, this number will have risen to more than 18 million (UNAIDS (2004:61).

But before we start talking about the unique situation of orphaned children and the challenge that it raise for counsellors, we need to define who the orphan is. UNAIDS defines an orphan *as a child under the age of 18 who has had at least one parent die* (2004: 62). It further distinguishes between a *maternal orphan* (a child whose mother has died); a *paternal orphan* (a child whose father has died); and a *double orphan* (a child who has lost both parents). We are however aware that different countries have different age limits for defining a child.

## ACTIVITY 6

- 1. Find out the number of orphaned children in your community.*
- 2. Make a list of interventions that have been made to help the situation.*
- 3. Are they being successful or not? Give reasons for your answer.*

### Impact of HIV&AIDS on Children

The impact of HIV&AIDS is most discernible among children whose parents succumb to illness and eventually die. When parents become seriously ill children have to take care of them. This implies that they withdraw from school or they do not attend school regularly. They have no access to adequate food, shelter and health-care

services. We have shown above that care giving has its own demands. It is emotionally and physically strenuous. Apart from this, children who care for their infected parents run the risk of being infected with HIV. In Africa, the extended family is under tremendous strain because of HIV&AIDS. Extended families turn away orphaned children for fear of the consequences of caring for them. It has become quite common for orphans to be cared for by grandparents or great grandparents. They too die while the child is still young. Many children, therefore, experience a string of multiple caregivers before they finally reach the age of independence. This has lasting psychological and physical repercussions on the child. How?

- Having to lose both parents often in quick succession is bound to affect orphaned children economically and psychologically.
- Having to be separated from siblings causes a lot of emotional and psychological suffering.
- Having to head households with no life skills, orphaned children are often exposed to discrimination, child labour, sexual exploitation and harsh street life conditions.

If an orphan by definition is a child under the age of 18, then any other issue that affects children has to affect them. Childhood is a stage in life that is distinct from other life stages in terms of the meaning of life, its expectations and goals. This, therefore, makes counselling for orphaned children both general and particular. General in that whatever principles are valid to counselling for children will also be valid for counselling orphans. Counselling for orphaned children is particular in that orphans are children who lack economic, psychological and material privileges that all other children have. So, we can say that counselling for orphaned children is a specialised form of counselling for children.

In the light of this we have to stress that in counselling children in general and orphaned children in particular, counsellors need to understand and appreciate processes that govern the child's physical, social, emotional and intellectual growth. Counsellors also need to remember that the life of orphaned children is often characterised by the following psychological and emotional imbalances:

- Bitterness and hostility
- Unhappiness within family setting
- Poor performance at school
- Antisocial and disruptive behaviours
- Emotional stress that may lead to suicide
- Trauma

Cape Times of 17th April 2001 reports a story that vividly paints the sad experience of Slindelo, a 16 year old orphaned boy who also has to care for his 4 year old sister, who is sick and his 8 year old brother: “We have nothing. Some people chase us away when we ask for food or for little jobs to get some money. They say we are a nuisance”.

Indeed, S. Lucas (2004: 29) is right in saying that children need more than education and food, especially children who have experienced the trauma of losing one or both parents and have taken on early responsibilities for caring for sick adults, and often, the responsibility for younger siblings. What they need is psychosocial support.

## ACTIVITY 7

*Pause for a while and think about the plight of Slindelo and his younger brother and sister. Write a paragraph about the kind of psychosocial support would you give to Slindelo, his brother and sister.*

### COUNSELLING THE TERMINALLY ILL

In the preceding units we have emphasised the need to distinguish between being HIV positive and having AIDS. These are two different medical conditions. We have described AIDS as a *syndrome* (collection of symptoms that occur in the body as a result of the weakening of its immune system). When the body’s immune system has been completely paralysed by the HI virus the infected person becomes prone to different types of *opportunistic infections*. In Africa the most common opportunistic infection associated with AIDS is tuberculosis (TB). Because the body is not capable of fighting the opportunistic infections, a person becomes terminally ill. It is in this sense that AIDS is called a terminal illness. Let us now turn to the specific needs of terminally ill people.

## Specific Needs of Terminally Ill People

Smith observes that *becoming dependent upon others*, is a common experience of most persons who are seriously ill (1988:105). However, dependent upon others terminally ill people may be, their need to *have control over their lives* has to be respected. It is expressed in the person's desire to be left alone. While this is often times interpreted, albeit wrongly, as ingratitude or rejection, it should be seen as a normal psychological strategy to take control of one's life even at this most difficult moment. In cases where a person has gone through experiences of *rejection and abandonment*, it is highly likely that such an experience will intensify as s/he becomes seriously ill. This is true even in cases where a person is being supported by family members and friends.

### ACTIVITY 8

*Recall an experience in which either you, your close relative or friend was seriously ill. What did you spend time talking about? What kind of feelings flooded your mind when you were alone? What kind of care did you like most?*

## What do Terminally Ill People Require from a Counsellor?

An effective counsellor to terminally ill people as a result of AIDS needs to arm themselves with the knowledge of the needs of such people. So, what do people living with AIDS want in a counsellor? Over and above the qualities required of a good counsellor discussed in unit 2, counselling the terminally ill person requires:

- **Being supportive:** Counsellors and indeed everybody who is called to participate in the care of terminally ill people should be able to provide practical and emotional support.
- **Understanding:** The unique experience of stigma and discrimination of PLWHA, needs to be met with a caring attitude as opposed to a judgemental and holier-than-thou attitude.

A. Van Dyk, in *HIV&AIDS: Care and Counselling*, quotes the advice that Palermino, that a person living with AIDS, gave to all health care professionals who care for terminally ill people with AIDS:

As in life, people facing death have a right to do it their own way. Do not pry or force patients to feel feelings or 'face' death. It's a disservice to force patients to give up their denial or to give cheery false hopes. Sometimes I just want someone to listen. Sometimes I do not want to talk about my medical treatments. Sometimes I do not want to talk at all. If you stay in the moment, contribute what you can, and permit the patient to do the same, you cannot fail (2001:399).

This advice summarises well what the terminally ill person requires from the counsellor.

## ACTIVITY 9

*In one page, discuss the differences between the following terms: death, bereavement, grief, mourning and funeral. Discuss what we can learn from how Jesus, in the New Testament, dealt with these situations.*

### GRIEF COUNSELLING

Grief and bereavement have always been identified with death. Our conviction is that this need not be the case, as we shall discuss here below. We include this topic here because grief and bereavement are experiences some people with terminal illness have to go through. The counsellor needs to know how to respond to such challenges. But first let us discuss what grief and bereavement are.

*Grief is defined as an emotional response experienced after the loss of a significant attachment. Grief is closely related and often confused with bereavement. The former refers to a person's internal experience, and the thoughts and feelings related to the experience of loss. Bereavement would normally refer to the state of being deprived of somebody or something. The following example serves the purpose of clarifying the distinction between the two: 'I am bereaved of my beloved friend through death and I grief this loss'. Though commonly used to describe the death of people, bereavement also covers losses that are not related to death. Loss can be defined as being deprived of someone or something of attachment, through accident, misfortune, or natural*

*occurrence (real or perceived)*. But both grief and bereavement are related to loss as cause to effect. They have been and they continue to be an integral part of our existence.

Grief may be anticipatory or actual. The moment we perceive the impending loss, physical or psychological, we begin to experience *anticipatory grief*. But experiencing *actual loss*, physical or psychological, evokes feelings of grief. WCC, *A Guide to HIV&AIDS Pastoral Counselling*, observes that grief begins as soon as the person becomes aware of the possibility of being HIV-positive. S/he begins to mourn the forthcoming loss of life and all the other physical, mental, social, economic and spiritual losses (1990: 37).

### Definition of Grief Counselling

How would we define grief counselling then? *Grief counselling is an intervention aimed at helping a person to cope with emotional feelings of loss*. Grief counselling as an intervention is complicated by the fact that every individual reacts differently to the experience of loss. Below is the chart that outlines the stages of the grieving process. It lists features common to each stage as well as the suggested counselling responses (WCC 1990: 38).

<b>Stages of Grief</b>	<b>Features common to each stage</b>	<b>Counselling responses</b>
1. Shock and Denial	Numbness Feeling of betrayal Not accepting the reality of impending or actual loss	Help client regain composure and accept the loss
2. Anger	Agitation Negative emotions directed against: Self Others God	Explore and identify sources of anger and help client to cope
3. Guilt	Blaming oneself for: • Infecting the other • Wishing the other dead • Not resolving issues before death	Help client accept inevitability of death and appreciate the negative effects of self blame etc.
4. Depression	Inability to sleep Feelings of inadequacy Hopelessness Sadness and crying	Help client reflect and reorganise him/herself and to cope with situation
5. Acceptance	• Sleep returns to normal • Pain gradually lessens	Encourage and support client

### Grief Counselling and African Culture

Each person has their own way of acknowledging loss, grieving and mourning. Africans have their different ways of acknowledging loss, grieving and mourning. Hence the chart above should not be taken to be a universally valid grieving code for all people. No loss is given more attention than loss through death of a human person in Africa. In many African cultures, death is explained in terms of a passage or a journey into the land of the ancestors. The funerary rites are performed to redress the situation of death. They have a two-fold purpose: 1) to accompany the dead into the land of the ancestors 2) to help those affected to cope with the loss. It is in this sense that we can call African therapy 'social' therapy. Through the rituals, both society and the affected individual (patient) are healed. By identifying the cause of death and by being present at the home of the deceased, the affected are healed (*therapy by identification and presence*). By telling and re-telling their story to those who visit, the affected members are taken through the process of healing (*therapy by exhortation*). Through observing the rituals, members not only give the deceased member a proper send off, they also appease the ancestors, who will in turn give peace and comfort to those who remain behind (*therapy by ritual observation*).

## ACTIVITY 10

1. *Describe ways in which people in your culture understand loss through death.*
2. *Describe how they mourn their dead through funerary rites.*
3. *Explain what healing purpose these rites serve.*

### SUMMARY

In unit 7, we have discussed issues that a counsellor needs to take into consideration in helping abused clients, pregnant women, orphans and the terminally ill as a result of AIDS and those who grieve as result of AIDS. We have called these 'special' cases because while counselling skills and stages seen in the preceding units are, for the most part, applicable to these cases, they require a specialised attention. We have also discussed grief and grief counselling and its implications and meaning in an African context.

## SELF-ASSESSMENT ACTIVITY

### **Answer All Questions**

1. How would you define sexual abuse?
2. Give examples of abuse that takes place in the family, at school, in the workplace and in the religious institutions.
3. In what way are women and girls vulnerable to sexual exploitation, abuse and HIV&AIDS infection?
4. Mention two common features in the experience of abused clients.
5. List psychosocial issues that pregnant women usually have to deal with in the context HIV&AIDS.
6. Discuss three specific needs of terminally ill people.
7. Outline the stages of the grieving process and counselling responses proper to each. Compare and contrast to your own culture.





## FURTHER READING

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- Lucas, S. 2004. *Community, Care, Change, and Hope: Local Responses to HIV in Zambia*. Washington DC: Synergy Project.
- Paterson, Gillian. 1997. *Love in a Time of AIDS: Women, Health and the Challenge of HIV*, Geneva, WCC Publications.
- UNAIDS. 2004. *Report on the Global AIDS Epidemic*.
- Van Dyk. 2001. A. *HIV/AIDS Care & Counselling: A Multidisciplinary Approach*, Cape Town, Pearson Education South Africa.
- WCC. 1990. A Guide to HIV&AIDS Pastoral Counselling, Geneva, WCC Publications.

## GLOSSARY

- Abuse:** A general term for the misuse of a person or thing.
- Abuser:** A person who misuses or treats others badly.
- Physical abuse:** When a person inflicts physical violence or pain on another. Involves actions that cause physical injury or physical pain to the other party. It includes hitting, kicking, whipping, beating and throwing things at someone.
- Sexual abuse:** Is the improper use of another person for sexual purposes, without their consent or under physical or psychological pressure. Sexual abuse includes inflicting pain during sex or not allowing the partner to use protection against STIs/HIV.
- Emotional abuse:** When a person uses emotional or psychological manipulation to compel another to do something they do not want or that is not in their best interest. May be called psychological abuse.
- STI:** Sexually transmitted infection.
- Orphan:** A child under the age of 18 who has lost a parent.
- Maternal orphan:** A child whose mother has died.

<b>Paternal orphan:</b>	A child whose father has died.
<b>Double orphan:</b>	A child who has lost both parents.
<b>Grief:</b>	An emotional response experienced after the loss of a significant attachment
<b>Bereavement:</b>	The state of being deprived of somebody or something.
<b>Grief counselling:</b>	An intervention aimed at helping a person cope with emotional feelings of loss.

# UNIT 8

## LEGAL, ETHICAL AND POLICY DIMENSIONS OF HIV&AIDS

### OVERVIEW

Welcome to unit 8. It has been said elsewhere that HIV&AIDS is a multidimensional epidemic. In this unit we will discuss the impact of HIV&AIDS on the legal, ethical and policy frameworks of our different countries and institutions. We will discuss the rights and duties of PLWHA as enshrined in internationally recognised charters. The issues of privacy, confidentiality and informed consent will also be discussed.

### OBJECTIVES

By the end of this unit you should be able to:

- ⌘ Explain the rights of people living with HIV&AIDS in law
- ⌘ Analyse the legal dimension of HIV&AIDS
- ⌘ Identify ethical principles and apply them to cases of HIV&AIDS
- ⌘ Explain the importance of policy on HIV&AIDS in the workplace

### TOPICS

- ⌘ Legal Dimension of HIV&AIDS
- ⌘ Ethical Dimension of HIV&AIDS
- ⌘ Management and Policy issues
  - Definition of Policy
  - HIV&AIDS Policy
  - Importance of HIV&AIDS Policy
  - Policies against HIV&AIDS Related Stigma and Discrimination

Summary, Self-assessment Activity, Further reading, Glossary

## ACTIVITY 1

1. *List clauses in the constitution of your country, or any other legal document in your country that protect the rights of people living with HIV&AIDS.*
2. *Explain how each of these clauses protect the rights of people living with HIV&AIDS.*

### LEGAL DIMENSIONS OF HIV&AIDS

Many of our countries are signatories to the international charter of Basic Human Rights. They have, therefore, committed themselves to upholding and respecting the rights and duties of all their citizens in accordance with this charter. The Basic human rights are founded on a principle that recognises equal worth and dignity of all human beings (WCC Study Document 1997:70). These basic human rights are enshrined into most countries' constitutions to protect the rights and duties of all citizens. They have, therefore, a force of law.

The United Nations Commission on Human Rights in its 63<sup>rd</sup> meeting of 1993, noted with concern the discriminatory laws denying people with HIV infection or AIDS, and their families and associates, the enjoyment of fundamental rights and freedoms. It further called upon states to ensure that their laws, policies and practices introduced in the context of AIDS respect basic human rights standards.

People living with HIV&AIDS should enjoy the same basic rights and responsibilities as any other citizen. But then, what does this have to do with counselling in an HIV&AIDS context? Counsellors are supposed to be professional agents. As such they are expected to discharge responsibilities associated with their work within national and international systems of law. A counsellor, especially an HIV&AIDS counsellor needs to be well informed as regards the law in order to protect the rights of his/her clients. Relevant to the situation of HIV&AIDS are the following rights which have legal implications:

- The right to privacy
- The right to non-discrimination, equal protection and equality
- The right to marry and raise a family
- The right to highest attainable standard of physical and mental health
- The right to informed consent before a medical procedure is carried out
- The right to information for choices about one's health and well being

Counsellors in HIV&AIDS situations would do well to remember that they are liable to their clients in relation to counselling in general and HIV&AIDS counselling in particular. Counselling in HIV&AIDS situations has legal implications. This means that violation of any of the above rights in respect of PLWHA person and indeed any other person who has come for a professional service, is punishable by law.

## ACTIVITY 2

1. *Do health care professionals in your country have any code of ethics?*
2. *What does it say about the rights of clients or patients?*
3. *Do counsellors in your country have an association?*
4. *Are they governed by any code of ethics?*

### ETHICAL DIMENSIONS OF HIV&AIDS

What do we mean by ethics? *Ethics* is generally defined as *a branch of philosophy that concerns itself with human conduct and moral decision making*. It seeks to discover the principles that guide people in deciding what is right and what is wrong. A counsellor is a professional and his/her dealings with clients have to be governed by certain principles or guidelines. These principles or guidelines are normally referred to as professional codes of ethics. They set boundaries and limits within which counsellors practice their profession. Failure to act within these boundaries means that as a professional you have acted unethically or wrongly.

Some of the ethical principles that should guide counsellors in dealing with clients in situations of HIV&AIDS are autonomy, beneficence, confidentiality and privacy, shared confidentiality and informed consent.

**Autonomy:** Simply means that people living with HIV&AIDS enjoy the same right of autonomy as any other person. They enjoy the right to make their own decisions on matters affecting them. This principle has limitations. A person's right to make decisions may be limited by immaturity, lack of relevant information or physical or mental constraints such as physical or mental impairment.

### ACTIVITY 3

*Robby a forty-five year old male, was hospitalised and had an operation the following day without any prior information. The operation was successful. Upon leaving the hospital, he charged the hospital and the doctor who performed the operation.*

*1. Name the ethical principle/s that the doctor violated.*

*Is it possible for Robby to take up this matter with the courts of law? Explain.*

**Beneficence:** A moral duty on the side of professionals to do good and not harm to those entrusted to their care. Discrimination against PLWHA, which is unfortunately occurring in our communities, is a violation of this principle. How? According to A WCC Study Document, discrimination violates this principle in two ways:

- It is an obstacle to effective control of the epidemic
- It renders the whole community—both those who discriminate and those discriminated against—more vulnerable to HIV (1997: 58).

Discrimination against PLWHA violates the principle of beneficence in that it does harm and not good to both the perpetrator and the survivor.

## ACTIVITY 4

*John is 28 years old. He is HIV positive. He is deeply in love with a girl, Four years younger, whom he intends to marry. He is faced with a dilemma. He informed his previous girlfriends about his status and they all deserted him. He decided not to mention this to any future girlfriends for fear of losing them. John has not told his present girl friend about his HIV status. John has come to you as a counsellor.*

- 1. Write in one page how you would response to John.*
- 2. List the ethical principles that are involved here.*

**Confidentiality and privacy:** This principle is about keeping information to oneself and not revealing information received from the client. The counsellor must promise or contract to reveal nothing about the client without the express consent of the client. This principle stems from and is closely related to the client's right to privacy.

The right to privacy implies that every person has a right to determine what to keep to him/herself as confidential information. PLWHA have the right to confidentiality about their health and status. A counsellor should under no circumstances put pressure on the client to disclose information that s/he is not prepared to share. Counsellors are bound in conscience to respect this right.

## Activity 5

- 1. When might confidential information be shared with the third party?*
- 2. If so, under what circumstances can it be shared?*
- 3. What do counsellors need to take into consideration when doing so?*

Professionals, such as counsellors or medical doctors are sometimes faced with a dilemma in having to choose between two conflicting principles. For example, take a case of a counsellor who is in possession of confidential information of a husband who is HIV positive and a wife who is at the risk of infection by her partner. In such a case, there is a principle of beneficence, i.e. the right of the wife to have her life protected. There is, on the other hand, the right of the husband to client/counsellor

confidentiality. The answer to this dilemma is partly covered in the next sub-topic: shared confidentiality.

**Shared confidentiality:** This is when information about the client is shared with another person who is directly involved in the care of the client. But this has to be done with the client's consent. This can only be done when:

- It is necessary
- When it benefits the client more than the counsellor

When confidential information is shared, the following should be considered:

- The client must be given time to make up his/her mind on sharing confidential information.
- Ideally it is the client who should share the confidential information and not the counsellor.
- The role of the counsellor is to assist and to support.

## Activity 6

*Martha is 15 years old. She is a student doing standard 5. She has been in and out of the hospital. Her parents, out of concern, have advised that she goes for an HIV test. You are a counsellor in a hospital and Martha has approached you for counselling and testing.*

1. *What would be your initial reaction?*
2. *Write a letter to Martha counselling her and include a counselling plan.*

**Informed Consent:** This principle, in the context of HIV&AIDS, means that a person has been informed and that s/he understands the implications of any medical diagnosis, test or treatment that is done on him/her. A person should be given necessary information in order to make an informed decision.

We will recall also that to every right there is a corresponding duty. We have emphasised the rights of PLWHA, which ought to be given to them by others. But on the other side, people living with HIV&AIDS also, have the moral responsibility and duty to respect the rights of others and to ensure that their health integrity is fully respected. This, in the concrete, means that they have the moral obligations to protect



others from infection. They also have the obligation to protect themselves from re-infection. Before we move on into the next topic let us do the following exercise.

## ACTIVITY 7

1. *Take a pen and a paper and list some of the policies by governments or organisations which discriminate against people living with HIV&AIDS.*
2. *Give reasons why you think insurances should or should not grant policies to people before they do an HIV test.*

Having discussed these principles, we need to reiterate what we mentioned in units 3 and 6. We have learned how the life of an individual is intertwined with that of the community and how an individual's being is realised in community. So to talk about privacy, confidentiality and autonomy seems to contradict what the ethic of *ubuntu* (being human) stands for. This tension raises an important question: To what extent can we maintain confidentiality and privacy when the community is there to account for who 'I am'?

### Management, Policy Issues and HIV&AIDS

The United Nations Commission on Human Rights sounded an alarm on the emergence of discriminatory policies and practices denying people with HIV infection or AIDS their fundamental rights and freedoms. Governments and states are, as a result, called upon to introduce policies that respect rights of people living with HIV&AIDS. Before we discuss the importance of policy in creating an enabling environment for prevention, care and support, let us define what a policy is.

### Definition of Policy

*A policy is a guideline that defines the organisation's stance and practice in relation to its employees and its clientele.* If an organisation sets a policy, all employees and stakeholders should follow and are bound by that policy. Though policies are not laws, a legal case can be made against an organisation that has violated a policy in respect of a client or employee.

## HIV&AIDS POLICY

In the context of HIV&AIDS, organisations have had to enact policies that guide dealings between both management and the clientele of such organisations who are HIV positive. The purpose of an HIV&AIDS policy would be to:

- Define the organisation's position and practices for preventing the transmission of HIV and for handling cases of HIV infection or AIDS among employees
- Guide workplace behaviour and activities designed to prevent and treat HIV&AIDS among managers, labour leaders and employees

### Importance of HIV&AIDS Policy

These policies are important in protecting individuals against stigmatisation and discrimination by fellow workers. Let us look at some examples of stigmatisation and some examples of discrimination in the workplace due to lack of policy or commitment to implementing a policy:

- Co-workers may refuse to work with an infected individual
- Co-workers may harass the person
- The individual may be isolated during meal or break times
- The individual may be asked to use separate restroom or other facilities

The following story of an HIV positive man aged 27, is an example of workplace discrimination by fellow co-workers:

*"Nobody will come near me, eat with me in the canteen, nobody will want to work with me, I am an outcast here"* ([www.avert.org/aidsstigma.htm](http://www.avert.org/aidsstigma.htm)).

The lack of an HIV&AIDS policy in the workplace or implementation thereof, may also be seen in the following examples. PLWHA:

- May be fired
- May be passed up for a promotion or denied salary increment
- May have unfair job restrictions placed upon them
- May find that the organisation refuses to accommodate them
- May be denied health insurances or other benefits

Let us look at the following quote, from a Head of Human Resource Development in India. It is an example of discriminatory attitudes by managers in the workplace:

*“Though we do not have a policy so far, I can say that if at the time of recruitment there is a person with HIV, I will not take him. I’ll certainly not buy a problem for the company”* ([www.avert.org/aidsstigma.htm](http://www.avert.org/aidsstigma.htm)).

## ACTIVITY 8

1. *Recall and write down discriminating policies or attitudes against PLWHA in your church.*
2. *Discuss whether there can be justification for discrimination in the Bible.*

### Policies against HIV&AIDS Related Stigma and Discrimination

You will recall that in unit 1 we argued that HIV&AIDS related stigma and discrimination can be expressed through laws and policies by governments and non-governmental organisations. In fact, in many countries, laws, policies and regulations around HIV&AIDS have been formulated. These efforts, good as they are, have been frustrated by lack of political will.

We are encouraged by efforts in other countries that focused on the implementation of laws and policies around HIV&AIDS issues. In South Africa, for example, professional associations and bodies such as Treatment Action Campaign, AIDS Law Project, Health Professions Council of South Africa, South African Human Rights Commission, have made it their duty to advocate for, educate and implement the laws and policies that protect the rights of PLWHA (see AIDS Law Project, *HIV&AIDS: Current Law + Policy: Testing for HIV – Know your rights*, Centre for Applied Legal Studies, University of the Witwatersrand (2004:12)).

## ACTIVITY 9

1. *Engage a friend, a group, or your congregation, on whether or not the church and the government are each doing enough in terms of advocating for policies that promote the cause of people living with HIV&AIDS.*
2. *Make a summary of emerging issues.*

### SUMMARY

In this unit we have learned that the HIV&AIDS epidemic has legal, ethical and policy dimensions. HIV&AIDS is a human rights issue. And as such, it calls for the commitment of all countries that uphold the rights of every individual as contained in the Universal Declaration of Human Rights and in the Declaration and Charter on HIV&AIDS. These rights and duties have to be adhered to as a matter of law. HIV&AIDS also has ethical implications. It confronts all of us with many difficult ethical questions. Policies that promote or frustrate the welfare of people living with HIV&AIDS have been made. It is the duty of every person, individually and collectively to work towards HIV&AIDS policies that enhance the worth and dignity of every person.

## SELF-ASSESSMENT ACTIVITY

### **Answer All Questions**

1. In what way do the policies in your country protect people living with HIV&AIDS?
2. Why is it important for a counsellor to know about the basic rights and responsibilities of people living with HIV&AIDS?
3. Discuss critically the relevance of the right to marry and start a family in the context of HIV&AIDS.
4. What is the code of ethics and what is its importance in the context of HIV&AIDS?
5. Describe the principles of beneficence, confidentiality and privacy.
6. How does the principle of beneficence conflict with the principle of autonomy?



## FURTHER READING

AIDS Law Project, *HIV&AIDS: Current + Policy: Testing for HIV — know your rights*, [www.alp.za/resctr/jdgmnts/pdf/20000928\\_judhoffman.pdf](http://www.alp.za/resctr/jdgmnts/pdf/20000928_judhoffman.pdf).

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## GLOSSARY

<b>Confidentiality:</b>	Refers to non-disclosure of information shared with the counsellor or health provider without the client's consent.
<b>Discriminatory laws:</b>	Laws that directly or indirectly sanction discrimination of people by another or others.
<b>Duty:</b>	In legal and ethical terms, a duty is something of moral goodness that each person owes to others.
<b>Ethics:</b>	A branch of philosophy that concerns itself with human conduct and moral decision-making. It seeks to discover principles that guide people in deciding what is right and what is wrong.
<b>Guideline:</b>	An optional point of reference used to help people to arrive at their goals.
<b>Informed consent:</b>	It is the agreement to perform an action based on knowledge of what the action involves and its likely consequences.
<b>Policy:</b>	A guideline that defines an organisations stance and practice in relation to its employees or clientele.
<b>Principle:</b>	A norm or rule that is accepted as true and that can be used as a basis for reasoning or conduct.
<b>Principle of autonomy:</b>	Refers to a right that people have to make their own decisions on matters affecting them.
<b>Principle of beneficence:</b>	Refers to a moral duty to do good and not harm to others.
<b>Right:</b>	In legal and ethical terms a right is something of moral goodness that is owed to us.
<b>Shared confidentiality:</b>	It is when information about the client is disclosed to another person directly involved in the care of the client—with the client's consent.

# UNIT 9

## HIV&AIDS COUNSELLING AND THE CHURCH

### OVERVIEW

Welcome to unit 9. This unit defines the mission of the church in general terms. Questions such as who is the church? What is it sent to do? These questions are asked and a response to them is given. This unit also discusses ways in which the church can be present to PLWHA, the terminally ill and those who are grieving as a result of AIDS. With regards to grief counselling, the church has traditionally been present by conducting funerary rituals and being available to individuals who grieve. This unit argues that the church can do more to enhance its ministry in these areas.

### OBJECTIVES

Upon completion of this unit you should be able to:

- ✘ Define in general terms the mission of the church.
- ✘ Discuss the role of the church in HIV&AIDS situations.
- ✘ Identify ways in which the church can be present to PLWHA.
- ✘ Describe ways in which the church can be present to the terminally ill.
- ✘ Analyse the role of the church in grief counselling—through funerary rites and individual counselling.

## TOPICS

- ⌘ The Church's Call in HIV&AIDS Situations
  - But Who is the Church?
  - The Church's Call is to be Sent
  - The Church Sent to do What?
  - The Church Called to Minister
- ⌘ The Church and PLWHA
  - Concerns of PLWHA
  - Ways in which the Church can be Present to PLWHA
- ⌘ The Church and the Terminally ill
  - Concerns of the Terminally ill as a result of AIDS
- ⌘ The Church and Grief Counselling
- ⌘ What the Church can do
- ⌘ Funerary Rituals
- ⌘ Ministers and Funerary Rituals
- ⌘ Ministers and Individual Grief Counselling



## THE CHURCH'S CALL IN HIV&AIDS SITUATIONS

In an interview with Contact Rev Dr. Samuel Kobia, the WCC General Secretary, says that the fight against HIV&AIDS is an essential part of the Church's mission (No. 177/178 Winter/Spring 2004: 5). This conviction is reiterated by Rev. Vitillo in the same Contact magazine, in these words, "Christians do not have a choice on whether or not they could respond to HIV&AIDS, the gospel of Jesus mandates them to do so (no.177/178 Winter/Spring 2004: 34).

*But who is the Church?*

The church is all Christians who, through baptism, share in different ways, in the royal, priestly and prophetic ministry of Jesus. Indeed within the church there are a variety of gifts, there are different ways of serving, but it is always the same Lord working in each one of us (1 Cor.12: 4-11). The church, therefore, in its ministerial and lay aspect has been called to bring God's love to all humanity.

*The Church's Call is to be Sent*

Indeed the call of the church to minister or to be sent belongs to its nature. The church is missionary by its very nature. Without this essential missionary component the church ceases to be the church. The church's missionary activity takes place in the world where it is called to be the sign of God's encounter with his people.

*The Church Sent to do what?*

The content of the church's missionary activity is God's love to all humanity. This love has to permeate the entire ministry of the church as received from the Lord, who said, 'Love one another as I have loved you' (John 13:34). When Jesus launched his mission, he chose the twelve to be with him; to be sent to proclaim the message and to heal (Mark 3:13-14; 6:13). Being with Jesus (communion with Jesus), therefore, was absolutely essential to the success of the mission of the twelve.

## ACTIVITY 1

*Take a pen and a paper and list activities that the church is sent to achieve.*

### THE CHURCH CALLED TO MINISTER

Today, at the top of the agenda of the church's missionary activity is the HIV&AIDS epidemic. It constitutes, in Dube's words, a historic moment of crisis (2003:46). The church is challenged to recommit itself to the mandate that Jesus gave to her by ministering to the people in this historic moment of crisis. We have identified three stages in which the church can be present to the people in the context of HIV&AIDS. They are: the stage of HIV infection, the stage of being terminally ill and the stage of grieving. Under every stage we will discuss the concerns of the affected and ways in which the church can be present to them.

## ACTIVITY 2

1. *How would you define the mandate that Jesus gave to his Church?*
2. *In what ways would you say that HIV&AIDS is a moment of crisis?*
3. *Has your church ever been challenged to respond to a crisis? In what way did it respond?*

### The Church and PLWHA

Let us start pointing out the differences between people who are infected with HI virus but who are not sick and people who have actually developed AIDS. We need to be constantly reminded that these are two different medical conditions, with different needs requiring different caring needs. We are going to look at the special pastoral concerns of people who are infected with HI virus but who have not yet developed AIDS and how the church can be present to such people.

### Concerns of PLWHA

The psychosocial concerns of PLWHA are summarised in the story of an HIV positive person quoted in Van Dyk, *HIV&AIDS Care and Counselling*:

My mind was racing. I could not concentrate on anything for more than a few seconds. Ninety per cent of my thoughts were death-related or reflections on what life choices I had made. Mistakes, broken dreams...what would my funeral be like? My obituaries? What infection would finally kill me? Suffering and grief were what I felt.....on top of that you feel you have no future, you will not feel the wind against your skin....and you will not love or be loved. I had crossed the line. The line between the living and the dead. I feared to be alone and yet needed to be alone. In my 20s I grew to believe in God, or my higher power, as I prefer to call him. Had he betrayed me? I felt ripped off (2001:254).

The concerns and needs of HIV infected person are of a psychosocial, spiritual and material nature. They fear discovery as a result of stigma and discrimination. They feel guilty; they feel hopeless and helpless; they doubt the existence of God; they question the legitimacy of suffering; they lose trust in people.

### ACTIVITY 3

1. *Explain the difference between HIV and AIDS?*
2. *According to your experience, what are the psychosocial concerns of PLWHA?*
3. *How has the church contributed in stigmatising people who are HIV positive?*

#### Ways in which the Church can be Present to PLWHA

We need to emphasise that despite incidences of silence and indifference, the majority of people still regard churches as places of refuge and solace. As the church we can learn from Jesus who, confronted with a similar situation (Mark 1:40-45) did the least expected. He touched the leper as a gesture of acceptance, support and solidarity with the afflicted. His action was driven by compassion and Jesus restored the leper to his rightful place in society. The church is called to feel pity and offer healing to those who, because of their HIV status, are separated from the church and society. This, in the concrete, means mixing freely with PLWHA, supporting them and caring for them. How can the church do that?

At the level of ministers

- There is a need for more collaboration among ministers of different churches.
- Sharing of resources and networking beyond denominational limits and boundaries, especially in Africa where there are very few professional counsellors, is necessary. Sue Parry in *Responses of Faith-Based Organisations to HIV&AIDS in Sub Saharan Africa*, observes that, in general, churches in West Africa and central Africa are ill equipped to confront the epidemic (2002:11). Among the problems faced by the clergy concerning HIV&AIDS are lack of knowledge on:
  - preventative measures
  - counselling
  - advocacy
  - community mobilisation and networking
  - cultural taboos about open discussions on sexual issues.
- Educating people and thus de-stigmatising PLWHA
- Community mobilisation in necessary

At the level of the laity

- There is a need for empowerment and mobilisation at the village level.
- Exhortation has always been at the heart of the African community. This is where the church lives its daily struggles and fights its battles.
- The laity need to form support groups or clubs to take care of various needs of PLWHA.

At the level of the institutions

- The church boasts some of the best infrastructure that reaches even the remotest of areas: schools, clinics, places of worship, and hospitals. Through such infrastructure, the church should be exemplary in striving for support and concern that is imbued with the spirit of compassion and selflessness

- The church needs to source funds for sustaining holistic pastoral care attending to physical, moral and spiritual dimensions of human caring.

## ACTIVITY 4

1. *Take a pen and a paper and list some of the human and material resources that the church has, that can help in improving the lives of people living with HIV&AIDS.*

The lack of knowledge on the side of the clergy should not, however, make us overlook the success stories that can be replicated as models for other African churches. In a number of African countries, different denominations and ecumenical bodies have shown commitment in building capacity within churches and the local communities. To cite just a few examples:

In *Mozambique* different churches have collaborated to bring about an interdenominational AIDS organisation ‘Kubatsirana’ (meaning helping one another) to address HIV&AIDS.

In *Namibia*, Catholic AIDS Action is using 90 parishes, 300 Christian communities, hospitals, clinics, schools and hostels as a basis for spreading the message of prevention and care on the basis of Christian values of spiritual and physical care for others.

In *Botswana*, collaborative efforts through BOCAIP (between different Christian denominations) have led to the establishment of counselling services and networks.

The church in *Uganda* showed commitment by working with the government to preach ‘Love Faithfully’, as opposed to ‘Love Carefully’ which was the government’s campaign.

In *Senegal* interfaith efforts have led to UNAIDS callingis collaboration ‘Best Practices’ ([www.fhi.org/NR](http://www.fhi.org/NR)).

### The Church and the Terminally Ill

We now explore issues facing those who are terminally ill as a result of AIDS. The New Testament gives many incidences of Jesus restoring people to health, both bodily

and spiritual. This portrait of Jesus is well represented in the Gospels. He further commissioned his disciples to preach, teach and heal the sick. The church and the disciples of Jesus in the modern world, continue to offer healing in different ways, to the sick in keeping with the mandate of Jesus. Before we start talking about how the church can be present for the terminally ill as a result of AIDS we need to look at their concerns and needs.

## ACTIVITY 5

- 1. Identify and discuss two examples from the New Testament where Jesus restored people to health—bodily, social and/or spiritual.*
- 2. In what way is your church called to continue this healing ministry of Jesus in the context of HIV&AIDS?*

### Concerns of the Terminally ill as a Result of AIDS

We have seen in unit 7 what the specific needs of terminally ill people are. We have also discussed the type of care and support they require from a counsellor. The church, through its members, pastors or laity need to recall these issues as they are required of every counsellor including pastoral counsellors. However, there are specific issues that can best be addressed by specially trained personnel within churches, such as pastoral counsellors and health professionals because they are spiritual or religious in nature:

- The fear of death and uncertainty
- Search for the meaning of death
- Feelings of guilt
- Feelings of hopelessness
- Making peace with the past

Most pastors and laity, especially in recent years, are well placed to deal with religious and spiritual issues such as death, guilt, hope, reconciliation and forgiveness that confront terminally ill people as a result of AIDS. Their training equips them to handle such issues comfortably. However, this is not automatic. It further requires a minister, pastor or a trained lay person's awareness of:

- People with AIDS
- Disease
- Caring for terminally ill people

A church minister in such situations needs to remember that compassion, love and sensitivity are the key in ministering to terminally ill people. We are aware that different denominations lay emphasis on different aspects when it comes to pastoral care of the sick. Some lay emphasis on scriptures while others rely heavily on the sacraments as sources of solace and comfort. Whatever the case may be, Christians (pastors and laity) need to be careful to assess the person's needs first. The following two examples will illustrate how much harm can be done by a Bible wielding or Sacrament administering pastor who did not take the terminally ill person's needs into consideration:

David was admitted in a hospital. He was hospitalised for recurrent pneumonic infection. David was visited by a Catholic priest. Baptised and raised in the Roman Catholic faith, David had been a non-practicing nominal Catholic since he entered college. Because David had noted on his admission record his religious affiliation as 'Catholic' and since his medical condition was grave, he was automatically visited by the Catholic chaplain. Upon entering his room, the chaplain was attired in his habit and wore a purple stole around his neck. He was friendly and jovial. After a few opening remarks, he announced: "Well, David, let's get a few things straight with the Lord. I'll hear your confession and then give you the sacrament of the sick. Now how long has it been since your last confession, son?" David was clearly stunned and agitated by the priest's approach to him, but he was not strong enough physically to confront him. He simply said, "Father, could we do this some other time?" The priest said: "No son. Just make a good act of contrition and I'll give you absolution". With that he raced through some scarcely audible prayers while anointing David's forehead and hands. As he concluded, the priest smiled and

made some light comment and departed waving a farewell blessing (Smith 1988: 90).

Following is another example:

A pastor visited a sick person in hospital. On arrival he opened his Bible and started preaching to the sick person. Incidentally, the sick person had soiled himself and had been left as such for the whole day and nobody had taken trouble to listen to what he had to say. After preaching, the pastor said prayers and left (story of one of the participants from Swaziland in a TOT workshop in Kempton Park, South Africa in 2000).

These two stories are examples of how pastoral care to the sick can be mismanaged by people who are inattentive and negligent to the needs of sick people. Smith has this advice to give to pastoral carers:

Take time to establish a relationship with a sick person. The “Who are you?” and “What do you need?” questions are indispensable. The formation of an accepting and understanding relationship makes it possible for pastoral carers to begin assessing the person’s psychosocial resources and needs (1988:91).

## ACTIVITY 6

1. *How does your church empower lay members to take part in the healing ministry of the church?*
2. *Recall and describe an incidence in which a member of your family or a friend was a victim to the negligence of a pastor when s/he was terminally ill.*

## THE CHURCH AND GRIEF COUNSELLING

Grief is an integral component of all human relationships. Whenever we love and care for others, we invest and commit our physical, emotional, spiritual and material resources in those we love and care for. When such relationships are interrupted or



broken we feel the loss. Loss through death is something that is bound to happen to all of us, but over which we do not have control. According to C.V. Gerkin in *Crises Experience in Modern Life*, living in time is living toward death (1979:74). Loss of an object loved, necessarily leads into grief.

We see the church in action in its very early stages, when Jesus presented himself at the grieving family of Mary and Martha, the sisters of Lazarus (John 11). Jesus' presence at this trying moment, portrays Jesus as one who was always there for the people giving hope and encouragement.

## ACTIVITY 7

*Pause for a moment and recall a loss that you have experienced.*

- 1. Explain how you grieved this loss. Did you rely on your coping abilities or on some external help?*
- 2. In what ways did the church play a role in helping you cope with the loss?*

### WHAT THE CHURCH CAN DO?

There are a number of things that churches can do in the face of loss and grief. The two that comes to mind immediately are: 1) funerary rituals which are, in most cases if not all, communitarian in nature, and 2) individual counselling.

#### Funerary Rituals

Churches have rituals that recognise loss. Such rituals help us acknowledge and celebrate what would, otherwise, be difficult life transitions. A minister of the church who works in and for the church exercises a pivotal role in performing these rituals. Funeral rites are not meant only for the dead, but for the grieving as well. It is to this end that funerary rituals and grief counselling are done. These services—from a Christian perspective—are done for, and on behalf, of the dead and the grieved, underpinned by the central belief in the resurrection of the dead. The Apostle Paul articulated that: 'If there is no resurrection of the dead, then Christ cannot have been raised either, and if Christ has not been raised, then our preaching is without substance, and so is your faith' (1 Corinthians 15:12-28).

You may have noticed that different denominations, informed by this central premise, have celebrated the death of their members in a variety of ways. For some, funerals include a mass. For others a prayer service normally includes a reading and scriptures. All these are done with the intention of bidding farewell to the deceased and consoling the rest of the members of the family who are grieving the loss of their member. In Africa, people attach special importance to this critical stage in the life of the believing community.

### Ministers and Funerary Rituals

- Ministers, as far as it is possible, should journey with terminally ill people towards their death. In that way, they understand better the adaptive processes that the terminally ill person and the family have to go through.
- If a minister has been effective in helping a terminally ill person, they should continue as much as possible, to support the surviving family members.
- Work towards founding interfaith collaborative ministry drawing on clerics and lay people who would bring healing to those who suffer and those who grieve.
- In Africa death and funerary rituals are everybody's business and ecumenical networking among ministers working in a given locality should be encouraged.
- Ministers too should be present in funerary rituals irrespective of the deceased's denomination, and officiate or co-officiate if possible.
- It would be useful to produce an ecumenical prayer book that incorporates the traditional funerary rituals, especially of ancestor veneration.
- Through preaching, people should see God's compassion and acceptance for those who have died. They should feel love and comfort for those who mourn.
- Organise religious services to support PLWHA and their care-providers, to remember those who have died of AIDS.

## ACTIVITY 8

*Churches have their different ways of conducting funeral services. Traditional African people have their own ways too. Explain whether or not it is necessary to merge these different ways of celebrating the death of our beloved ones?*

## Ministers and Individual Grief Counselling

- Should be available for individual grief counselling of their members as group counselling offered by funerary rituals may be inadequate or superficial
- Because ministers are an important resource for people who are hurting, they should be there to listen. Smith emphasises the importance of listening by citing an old saying: “When in doubt, listen” (1988:180).
- Foster knowledge and appreciate the traditions of people’s traditional death rites, as they are important for effective individual counselling.

## SUMMARY

In this unit, we have discussed the following points:

- The mission of the church in general
- The call of the church in three specific HIV&AIDS areas: PLWHA, the plight of terminally ill people as a result of AIDS, and grieved people as result of HIV&AIDS
- The prominent concerns of people in these HIV&AIDS situations
- The church can be present to these people in a number of ways which include: counselling, availing infrastructure, being compassionate, conducting funerary rituals, preaching and organising religious services for PLWHA.

## SELF-ASSESSMENT ACTIVITY

### **Answer All Questions**

1. In what way could we say Christ and even the church is HIV positive?
2. Briefly describe how you would explain the relationship between mission and the church.
3. Discuss the content of the church’s mission.
4. Critically discuss in what two ways your church can improve in caring for and counselling the terminally ill.
5. Identify ways in which the church can enhance its ministry towards the grieved?



## FURTHER READING

Dube, M.W. 2003. "The Prophetic Method in the New Testament," pp.43-58. In Dube, M.W. ed. *HIV&AIDS and the Curriculum: Methods of Integrating HIV&AIDS in Theological Programmes*. Geneva: WCC Publications.

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[www.fhi.org/NR](http://www.fhi.org/NR)

## GLOSSARY

- Clergy:** normally used as a collective term that refers to a group of ministers ordained to perform religious tasks.
- Community mobilisation:** Is a process of bringing together a community to demand and work for a particular development programme.
- Compassion:** A deep and religious awareness of, and sympathy for, another's suffering.
- De-stigmatise:** The process of reversing or removing stigma.
- Funerary rituals:** A series of rites for, and on behalf of, the dead.

<b>Grief counselling:</b>	Counselling given to those experiencing periods of grief or loss.
<b>Individual counselling:</b>	One-to-one counselling, in which the counsellor works with the client to come up with solutions to the client's stated problems.
<b>Kubatsirana:</b>	A term which literally translates as 'helping one another'. This term is used to refer to an interdenominational AIDS organisation in Mozambique.
<b>Pastor:</b>	An ordained minister charged with the spiritual care of a local community. This term is loosely used to refer to a minister in charge of a congregation.
<b>Therapy by presence:</b>	Therapy or healing that is achieved by the presence of the people to the person who is going through a difficult time.
<b>Therapy by exhortation:</b>	Therapy or healing that is achieved by the power of the words directed to the person who is going through a difficult time.

# UNIT 10

## CHURCH, ADVOCACY IN THE HIV&AIDS CONTEXT

### OVERVIEW

Welcome to unit 10 of our module. In unit 9 we have explored the call of the church in relation to HIV&AIDS. The previous nine units focused on prevention, treatment and care. However, our understanding will be incomplete if we do not explore the root causes of HIV&AIDS. In order to begin to eradicate the HIV&AIDS epidemic, the church must begin to undertake advocacy work. Both of these concepts will be explored in this unit. By showing the connection between prophecy and advocacy we will underline the connection between the church's ministry of healing and the eradication of the causes of sickness.

### OBJECTIVES

By the end of this unit, you should be able to:

- ✂ Define advocacy and identify its essential components.
- ✂ Link the church's prophetic call and advocacy work.
- ✂ Identify the focus of HIV&AIDS related advocacy.
- ✂ Discuss the prophetic call of the church in HIV&AIDS situations.

## TOPICS

- ✚ What is Advocacy?
  - Essential Components of Advocacy
  - Expressions and Forms of Advocacy
- ✚ The Church and Advocacy
- ✚ The Church and HIV&AIDS Related Advocacy
  - What does the Church have to do with HIV&AIDS Advocacy?
- ✚ Areas for HIV&AIDS Advocacy
  - Human Rights
    - What can the Church do?
  - Gender Inequality
    - What can the Church do?
  - Involving People with HIV&AIDS
    - What can the Church do?
  - HIV Testing
    - What can the Church do?
  - Children and Youth
    - What can the Church do?

Summary, Self-assessment, Further reading, Glossary

## ACTIVITY 1

1. Write down your own definition of advocacy.
2. Give some examples of advocacy done in your community and define who the targets of the advocacy were, and who were to benefit from it, and how it was implemented.

### WHAT IS ADVOCACY?

We will start our discussion by defining the key word in this unit: advocacy. Advocacy has been defined in various ways, by different people, and depending on the context within which it is defined. Let us look at some of these definitions.

- Advocacy is the act or process of supporting a cause or issue (J. Hamand 2001:304).
- Advocacy is a process of bringing about changes in the policies, laws and practices of influential individuals, groups and institutions (International HIV/AIDS Alliance: Advocacy Skills-building workshop for HIV/AIDS, Zimbabwe, July 2001).
- Advocacy is speaking up, drawing a community's attention to an important issue, and directing decision-makers toward a solution (Cucuzza, and Moch, 2000:312).

### Essential Components of Advocacy

In the face of these different definitions we can only identify what appear to be essential components that would distinguish advocacy from other related concepts.

- It is a process focusing on an issue
- It is aimed at change, transformation, influencing policies, laws and practices
- It targets decision-makers, leaders, policy makers and people in positions of influence
- The beneficiaries are people affected by the issue

These components distinguish advocacy from other related concepts such as information, education and communication (IEC), and community mobilisation. Advocacy essentially implies the development of the capacity to intercede for, speak publicly and promote a cause of group interest ([www.ippfwhr.org](http://www.ippfwhr.org)).



## ACTIVITY 2

*List words that are associated with advocacy in your own context.*

### Expressions and Forms of Advocacy

Advocacy can be expressed in different ways. It can be expressed through writing, song, speech or drama. Advocacy can take different forms depending on how it is initiated. It can either be reactive or proactive. It is *reactive* when the problem or issue is there and forces people to act and solve the problem. It is *proactive* when it is used to prevent a problem before it happens.

## ACTIVITY 3

1. *List ways in which the church in your locality has assumed a prophetic or advocacy role.*
2. *Has it been successful or not?*
3. *To what can you attribute its success or failure?*

### THE CHURCH AND ADVOCACY

The leading questions here would be: What has the church to do with advocacy? Advocacy is central to Christian life and witness. The notion of advocacy as applied to the church tallies with the prophetic call of the church. How? A prophet is generally someone who speaks on behalf of God—the mouthpiece of God. Though a prophet is one who speaks on behalf of God, it is not God, but the people on whose behalf the prophecy is done, who stand to benefit from that prophecy. A prophet's mission is summed up in the narrative of Jeremiah. He has been set over nations and kingdoms, 'to root up and to tear down, to destroy and to demolish, to build and to plant' (Jeremiah 1:10). This antithesis brings out the twofold nature of the prophet's call: to demolish what serves no purpose and to restore or deepen what was misrepresented.

Jesus, became a prophetic sign in the mould of Jeremiah (Luke 2:25-35). He was anointed to bring good news to the poor; to proclaim release to captives; the recovery

of sight to the blind; to let the oppressed go free (Luke 4:16-19). In her article, “The Prophetic Method in the New Testament” Dube says, “not only did Jesus read from the book of prophet Isaiah, he also identified himself with Isaiah and took up Isaiah prophetic agenda” (2003: 49). By so doing, Jesus became the advocate of the marginalised, the disadvantaged and the voiceless. He spoke on behalf of God for the benefit of the needy. It is on the basis of Jesus’ prophecy and advocacy that the Christian church must fully embrace the advocacy and prophetic role. To whom is this prophetic ministry or advocacy directed? J.W. De Gruchy in his book *Theology and Ministry in Context and Crisis: A South African Perspective*, has this answer, “The prophetic task in the life of the congregation, and the prophetic ministry to society, are in the end, however structured, the ministry of Jesus through the same Spirit speaking both *to the church and to the world*” (1987:79).

*What would be the content of the Church’s prophetic role or advocacy?* The church is called to actualise God’s kingdom of justice and peace. This involves challenging social injustice, hypocritical religiosity, corrupt and uncommitted leadership, and announcing hope (Dube 2003:48).

## The Church and HIV& AIDS Related Advocacy

What is HIV&AIDS advocacy and what does the church have to do with it?

HIV&AIDS advocacy is a process that focuses on:

- Creating awareness of the magnitude and seriousness of HIV&AIDS
- Diminishing HIV&AIDS related discriminatory practices
- Removing policy and other barriers to HIV&AIDS prevention and care
- Campaigning for the availability of affordable ARVs, and for effective and sustainable action.

HIV&AIDS-related advocacy targets, especially but not exclusively, the highest authorities in the church and/or the country to provide leadership, political support and commitment.

## What does the Church have to do with HIV&AIDS Advocacy?

Dube defines HIV&AIDS as a historical moment of crisis that requires an all out prophetic commitment from the side of the Christian church (2003:46-48). She goes on to show how HIV&AIDS is a crisis moment. It has the potential to infect all of us;

it affects all of us; it works through social injustice and attacks mostly the marginalised and disadvantaged populations. We will recall that the focus of Jesus' ministry were the marginalised and disadvantaged groups. The gospel of Luke, especially, depicts Jesus as the friend and saviour of sinners, women, the sick, rich and poor, the persecuted and the disadvantaged (Luke 5:29-32; 8:1-3; 5:31-32; 12:33-34; 21:12-19; 10:29-36). The church, taking cue from Jesus, is called to do the same. In this moment of crisis, the church should raise a prophetic voice on behalf of the voiceless and challenge those who are sustaining the structures which create and perpetuate social and religious injustices.

## ACTIVITY 4

1. *In the area of HIV&AIDS, in what ways has your own church done advocacy?*
2. *If you were called to do HIV&AIDS advocacy in your area, what issue would you address? Give reasons.*

### AREAS FOR HIV&AIDS ADVOCACY

We have seen in Unit 1 and elsewhere in this module that HIV&AIDS is a problem that pervades the social, economic, cultural and religious spheres of our lives. It works through social injustice. Where there is gross violation of human rights, gender inequalities, child abuse, gender-based discrimination, abject poverty, or economic imbalances, there HIV&AIDS finds its home. We are going to look at the individual areas through which HIV&AIDS thrives and see how they can be addressed through advocacy.

#### Human Rights

A number of people have become survivors of human rights abuse, in society and in churches, as a result of their HIV status. As seen in unit 7 and 8, HIV&AIDS are fuelled by the violation of human rights. Many people who are infected with HIV are denied, directly or indirectly the right to treatment and services; they have been denied the right to work; the right to attend school; the right to inherit money and property; the right to marry simply because they are HIV positive.

What can the Church do?

A WCC Study Document: *Facing AIDS: The Challenge, the Churches' Response*, outlines some of the things churches can do in the face of human rights' violation.

These are:

- To safeguard the rights of persons affected by HIV&AIDS and to study, develop and promote the human rights of PLWHA through mechanisms at the national and international levels.
- To promote sharing of accurate information about HIV&AIDS, to promote a climate of open discussion and to work against the spread of misinformation and fear
- To advocate increased spending by governments and medical facilities to find solutions to the problems—both medical and social—raised by the epidemic (1997:93-95).

## ACTIVITY 5

*Read Luke 17:11-19 and list things that we can learn from Jesus' actions and words about advocacy, in the area of human rights violations.*

### Gender Inequality

HIV&AIDS uses gender inequality as well as poverty and culture, as argued elsewhere in this module, to attack individuals, families, children and communities. Many African cultures sanction and support the subordination of women. As a result they are subjected to forced sexual intercourse; they have no power leverage to negotiate safe sex practices; they have no access to information as a result of disparity in educational opportunities; they have no right to inheritance or possession of land. In many cases, in the event of the husband dying, women become so poor and desperate that they turn to sex work. This makes them more vulnerable.

What can the Church do?

In situations of gender inequality and its consequences, the church is called to:

- Work with women as they seek to attain the full measure of their dignity and express the full range of their gifts

- Focus on situations that increase vulnerability to HIV&AIDS, such as migrant labour, mass refugee movements and commercial sex activity
- Recognise the linkage between HIV&AIDS and poverty, and to advocate measures to promote just and sustainable development.
- Promote advocacy initiatives that target young boys who are valuable in enhancing more gender-equitable relationships between men and women.
- Advocate elimination of all forms of violence against women and campaign for the change of laws where appropriate.
- Advocate for the empowerment of women and give them more negotiating skills as a tool for combating HIV&AIDS.
- Advocate for women's access to education and economic resources.

## ACTIVITY 6

*What does the story of a woman caught in adultery (John 8:1-11) teach us about gender inequality and on how we should advocate for gender equity?*

### INVOLVING PEOPLE WITH HIV&AIDS

Non involvement of PLWHA in issues that affect them directly is a reflection of stigmatisation and discrimination. It is a case of 'talking about them without them', which is something which creates a chasm between them and those who claim they are not infected.

What can the Church do?

In response to the situation, the church is better placed to:

- Provide a climate of love, acceptance and support for those who are vulnerable to, or affected by, HIV&AIDS by providing space for these concerns to be raised within regular worship events, through support groups and by visits to those affected by HIV&AIDS
- Advance theological Unity: the church needs to identify with PLWHA by underlining that if one part is hurt, all the parts share its pain and if one part is honoured, all the parts share its joy (I Corinthians 12:26).

- Work for better care of persons affected by HIV&AIDS
- Advocate involvement of those affected by HIV&AIDS in designing and carrying out strategies for prevention and care
- Advocate for employment and empowerment of PLWHA
- Support and empower PLWHAs to articulate their concerns

## ACTIVITY 7

*Identify lessons that the story of the Good Samaritan (Luke 10:25-37) teaches us on advocacy in the area of caring for PLWHA.*

### HIV Testing

There have been concerns regarding HIV testing, in terms of its accessibility, quality and policies governing it. Facilities and equipment are still scarce in a number of countries for Voluntary Counselling and Testing (VCT). In places where it is accessible, it is the quality that make people reluctant to test. In other places, policies that govern cases of HIV&AIDS are discriminatory.

### What can the Church do?

The church through its influence, infrastructure and involvement with the people, even in the remotest of areas, is better placed to:

- Advocate for good quality and accessible counselling and testing services
- Encourage voluntary counselling and testing
- Advocate for elimination or the change of discriminatory policies around HIV&AIDS
- Discourage mandatory testing
- Insist on and advocate for confidentiality of services

Participate in a society-wide discussion on ethical issues posed by HIV&AIDS advocates.

## ACTIVITY 8

- 1. Analyse Voluntary Counselling and Testing in your locality in terms of accessibility, quality and policies governing it.*
- 2. How can the church help to improve on or intensify the quality of service?*

### Children and Youth

Children and youth are among the most vulnerable groups. In the developing world, close to 60 per cent of new infections are among 15-24 year olds. Biologically and socially, young women are more vulnerable to infection than their male counterparts. The increase in the rate of infection among women means there is an increase in HIV-infected babies born to them ([www.ippfwhr.org](http://www.ippfwhr.org)). A lot of other young people are rendered vulnerable because they are denied access to HIV education, information, health care and means of prevention.

### What can the Church do?

The Church can assume its prophetic role by:

- Improving access to information, health care and prevention for young people
- Advocating for social change, which would go a long way in correcting popular myth that having sex with a virgin will cure a man of AIDS. This myth is currently fuelling intergenerational sex and rape of the girl-child.
- Speaking strongly against harmful practices which contribute to HIV infection, such as female genital cutting, sexual exploitation and abuse/rape.
- Involving young people in the development of HIV&AIDS prevention programs.

## ACTIVITY 9

1. *Take a pen and a paper and write down the factors that contribute toward the vulnerability of children and young people to HIV& AIDS in your area.*
2. *In what ways can the church help to reverse or change the situation?*

We affirm with the WCC Study Document that,

The church as the body of Christ is to be the place where God's healing love is experienced and shown forth. As the body of Christ the church is bound to enter into suffering of others, to stand with them against all rejection and despair. Because it is the body of Christ—who dies for all and who enters into the suffering of all humanity—the church cannot exclude anyone who needs Christ. As the church enters into solidarity with those affected by HIV&AIDS, our hope in God's promises comes alive and becomes visible to the world (1997:102).

### SUMMARY

Unit 10 has exposed us to different definitions of advocacy. Despite the differences in emphasis between those definitions, we have identified essential components that distinguish advocacy from other related concepts. The church's role towards advocacy is understood along side its prophetic role after the example of Christ who was a prophet par excellence. The unit has also outlined areas of HIV&AIDS advocacy and a corresponding series of activities that can motivate the church to more HIV&AIDS advocacy-oriented responses.



## SELF-ASSESSMENT ACTIVITY

### Answer All Questions

1. What are the essential components of advocacy?
2. Mention any two ways through which advocacy can best be expressed in your own local context.
3. In your opinion, does the church have any obligation to do advocacy work? Give reasons for your answer.
4. Give the scriptural basis for the church's participation in HIV&AIDS advocacy.
5. In the context of HIV&AIDS, what is the prophetic task of the church, both internally and externally?



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A WCC Study Document. 1997. *Facing AIDS: The Challenge, the Churches' Response*. Geneva: WCC Publications.

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[www.ippfwhr.org](http://www.ippfwhr.org)

## GLOSSARY

<b>Advocacy:</b>	the act of supporting a cause or issue and lobbying on behalf of the cause or issue.
<b>Child abuse:</b>	Any form of cruelty to a child's physical, moral or mental well-being.
<b>Crisis:</b>	It is a crucial time and a turning point. A time when exceptional action is required.
<b>Gender inequality:</b>	Giving men and women different opportunities because of their gender.
<b>HIV&amp;AIDS advocacy:</b>	A process that focuses on creating awareness of the HIV&AIDS problem, works to diminish HIV&AIDS discriminatory practices and remove policy that frustrates HIV&AIDS prevention and care activities.
<b>Proactive advocacy:</b>	It is when people act to prevent a problem before it happens.
<b>Prophet:</b>	Someone who speaks on behalf of God or as the mouthpiece of God.
<b>Reactive advocacy:</b>	It is when people are forced to act and solve a problem that is already present.
<b>Sex-based discrimination:</b>	Is discrimination on the basis of one's sex or gender.
<b>Social injustice:</b>	A concept relating to the perceived unfairness of society and unfair distribution of power and privilege.

# ASSIGNMENT I

Answer 4 questions only

## QUESTION 1

List any three sectors of society.

Discuss how HIV&AIDS affects each one of them in terms of supply and demand.

Explain briefly how stigma and discrimination hinder prevention, treatment and care in HIV&AIDS situations.

## QUESTION 2

State the four components of the definition of counselling

Discuss in detail, in your own words, any of these components.

Show how important attending skills are for counselling.

## QUESTION 3

Every person is a combination of both universal and individual traits.

Explain this statement.

Discuss the importance of the concept of community in providing healing in an African context.

State and briefly describe the three stages of the helping process according to Egan.

## QUESTIONS 4

Give the four aims of pre-test counselling.

Give three steps of pre-test counselling and briefly discuss each one of them.

Discuss the role of an HIV&AIDS counsellor in any HIV&AIDS counselling transaction.

## QUESTION 5

What is the meaning of discordant couple?

Discuss what the focus of the counsellor should be in counselling discordant couples.

Discuss how the systems approach to counselling corresponds to the way an African sees the world. Discuss this statement.

# ASSIGNMENT II

Answer 5 questions only

## QUESTION 1

List forms of abuse most common in the workplace.

List ways in which abuse can be present in schools

What are the most common forms of abuse in religious institutions?

## QUESTION 2

Why do you think the issue of gender is so important in counselling abused clients?

How should the counsellor deal with the issue of dependency from an abused client?

Is it a good thing to encourage an encounter between an abused client and an abuser?

Give reasons for your answer.

## QUESTION 3

Orphanhood is not a new phenomenon. Discuss traditional ways in which people in your culture have dealt with orphans.

Find out in your locality some of the common psychological and emotional imbalances found in orphaned children.

Discuss three specific needs of terminally ill people.

## QUESTION 4

Funerary rites are performed to redress the situation of death. Discuss ways in which funerary rites help people cope with loss through death in your culture.

How do stages of grief given in unit 7 compare with stages of grief in your own culture?

## QUESTION 5

Discuss the relationship between the right to privacy and the right to confidentiality

Briefly discuss the tension that could exist between the ethical principles discussed

in unit 8 and its application in your culture.

In what ways can policies that protect the rights of PLWHA be introduced, improved or effectively implemented?

#### QUESTION 6

‘The fight against HIV&AIDS is an essential part of the church’s mission.’ Discuss in detail the implications of this statement.

List and discuss two ways in which the church can be present to PLWHA.

#### QUESTION 7

Discuss the difference between reactive and proactive advocacy.

In what two ways can the church be an advocate on issues of gender inequality?

# TEST

Answer 4 questions only

## QUESTION 1

Discuss ways in which HIV&AIDS poses a challenge to counselling.

Explain briefly the qualities required of an effective counsellor.

Discuss the difference between the attending skills and the exploratory skills.

## QUESTION 2

Compare and contrast VCT and CTC as HIV&AIDS intervention strategies.

Discuss the importance of both supportive and crisis counselling in relation to post-test counselling.

Outline and discuss the components of a crisis.

## QUESTION 3

State the challenges faced by caregivers in HIV&AIDS situations.

Discuss the distinction between stress and burnout.

Suggest three ways through which stress and burnout can be managed.

## QUESTION 4

The experience of abused clients makes their counselling process very special. Argue for or against this statement.

Outline and discuss very briefly the common features of the initial stage in counselling abused clients.

What makes counselling a pregnant woman a special intervention or case.

## QUESTION 5

What do legal issues have to do with HIV&AIDS?

Discuss briefly the call/mission of the church in situations of HIV&AIDS in terms of:

- Source of its call/mission.
- Beneficiaries of its call/mission.
- Content of its call/mission.

# EXAMINATION

## QUESTION 1

Describe in writing how you would prepare for and conduct a pre-test counselling.

Very briefly discuss the pastoral dimension of counselling.

Discuss the importance of couple's counselling in HIV&AIDS situations.

## QUESTION 2

According to the study done in Uganda and South Africa by UNAIDS, care givers for people with HIV infection and AIDS are made up of different groups of people. Mention and discuss two of these groups.

Name and discuss three forms of abuse.

What is it that makes women and girls more vulnerable to abuse? Taken your own local situation into consideration.

## QUESTION 3

Define an orphan and discuss three types of orphans

Discuss the impact of HIV&AIDS on children.

Discuss specific needs of terminally ill people and what is required from a counsellor.

## QUESTION 4

Define the following three terms and show how they are related:

Grief/ Bereavement/ Loss

Mention and discuss any three ethical principles that should guide counsellors in dealing with clients in HIV&AIDS situations

What is a HIV&AIDS policy and what is its importance in the workplace?

## QUESTION 5

Discuss ways through which the church can be present to PLWHA?

What can the church do in the face of grief and loss?

What can the church do in human rights advocacy within the context of HIV&AIDS?

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