

**"WHAT I DID IS JUST TO TALK; NOTHING ELSE":
THE EXPERIENCES OF HIV/AIDS COUNSELLORS ATTACHED TO LIFELINE,
KHAYELITSHA, CAPE TOWN.**

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STATEMENT

I, the undersigned, hereby declare that the work contained in this thesis is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

ABSTRACT

Counselling has been recognised as an important component of HIV and AIDS care, and an essential part of HIV testing. Counsellors are involved in a dynamic interrelationship with their clients as well as with the organisations in which they work. From a psychoanalytic framework, unconscious anxieties can play a role in the work of the counsellor. Transference and countertransference are processes, which are involved in the counselling situation. While these processes can be a source for understanding the client, they may also become problematic for the counsellor when they overwhelm the counsellor. This study explores the experiences of HIV/AIDS counsellors attached to Lifeline, Khayelitsha in Cape Town. Twenty-nine counsellors were interviewed using individual interviews and focus group discussions. Results explore the counselling training and activity; the difficulties of counselling; what helps the counsellor to cope; and the general impact that counselling has had on the counsellors' lives. The findings reveal the difficult and often distressing aspect of counselling persons with HIV and AIDS. A number of issues facing the client, as well as cultural and workplace issues may cause difficulties for the counsellor. In addition, the nature of the disease, and the issues it creates for the patient, can arouse a number of anxieties in the counsellor related to their own past. The results reveal some possible limitations to an individual client-centred approach. The study concludes that psychodynamic issues should form part of the counsellor's training, and be explored during regular counsellor supervision.

OPSOMMING

Berading is erken as 'n belangrike komponent in HIV en VIGS sorg, en 'n essensiele deel van HIV toetsing. Beraders is betrokke in 'n dinamiese verhouding met hul kliënte so wel as die organisasies vir wie hulle werk. Vanaf 'n psigoanalitiese raamwerk kan aangs in die onderbewussyn, 'n rol speel in die werk van beraders. Oordrag en teenoordrag is prosesse wat betrokke is by die beradingsituasie. Alhoewel die proses 'n bron is wat tot beter verstandhouding met die kliënt kan lei, mag dit ook die berader oorweldig. Hierdie studie verken die ervarings van beraders verbonde aan LifeLine, Khayelitsha in Kaapstad. Nege-en-twintig beraders is individueel onderhoude mee gevoer en het aan fokus groepe deelgeneem. Resultate ondersoek die berading opleiding en aktiwiteite; die problematiese aspek van berading; wat die berader help om klaar te kom; en die algemene impak wat berading het op die lewe van 'n berader. Die resultate onthul die moeilike en dikwelse stresvolle aspek van berading met HIV en VIGS pasiënte. 'n Aantal aspekte wat die pasiënte mee toe doen kry so wel as kulturele en werksplek faktore kan sake vir die berader beïnvloed. Verder kan die aard van die siekte en die probleme wat die siekte vir die pasiënt veroorsaak lei tot aangs vir die berader ten opsigte van sy of haar eie verlede. Die resultate onthul verskeie tekortkominge tot 'n individuele kliëntgesentreerde berading. Die studie besluit dat psigodinamiese probleme dalk deel moet vorm in die berader se opleiding, asook verder ondersoek moet word in gewone berader toesighouding.

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CONTENTS

	<u>pp.</u>
STATEMENT	ii
ABSTRACT	iii
OPSOMMING	iv
ACKNOWLEDGEMENTS	v
LIST OF ABBREVIATIONS USED	viii
1. INTRODUCTION	1
1.1 The HIV/AIDS epidemic in South Africa	1
1.2 Counselling as part of HIV and AIDS care	2
1.3 Social and cultural factors that play a role in HIV counselling	5
1.4 Counsellor issues	9
1.5 Counsellors and the work-place	11
1.6 Rationale for this study	12
2. METHODS AND ETHICAL CONSIDERATIONS	13
2.1 Context	13
2.2 Entry into study	15
2.3 The sample	15
2.4 Data gathering and analysis	17
2.5 Ethical considerations	19
3. RESULTS	21
3.1 Counselling training and activity	21
3.2 Difficulties of counselling	25
3.2.1 Client difficulties	25
3.2.2 Counsellor difficulties	39
3.2.3 Cultural difficulties	54
3.2.4 Organisational Issues	62
3.3 What helps the counsellor cope	66
3.4 Impact of their work on the counsellors' lives	72
4. DISCUSSION AND CONCLUSION	75
4.1 Counselling activity	75
4.2 The client-counsellor relationship	76
4.3 Counsellors and the workplace	81
4.4 What helps the counsellor to cope	83
4.5 Limitations of the study	84

4.6 Conclusion	85
REFERENCES	88
ADDENDA	
ADDENDUM A: Places where Lifeline lay counsellors work	101
ADDENDUM B: Outline of Lifeline's training courses	102
ADDENDUM C: Counsellor questionnaire and consent form	104
ADDENDUM D: Table 1: Details of counsellors as at March 2002	105
ADDENDUM E: Interview Schedule	106
ADDENDUM F: List of codes used in thematic analysis	108

LIST OF ABBREVIATIONS USED

AIDS	Acquired Immune Deficiency Syndrome
ATICC	AIDS Training, Information and Counselling Centre
AZT	Azidothymidine - an anti-retroviral drug
HIV	Human Immunodeficiency Virus
MSF	Médecins Sans Frontières
MTCT	Mother-to-child-transmission
NGO	Non-governmental organisation
STD	Sexually Transmitted Disease
TB	Tuberculosis
VCT	Voluntary Counselling and Testing

1. INTRODUCTION

1.1 The HIV/AIDS epidemic in South Africa

Sub-Saharan Africa is facing an HIV/AIDS epidemic of disastrous dimensions. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2001), sub-Saharan Africa is the region most affected by HIV/AIDS in the world, with an estimated 28.1 million people living with HIV/AIDS. According to global estimates (UNAIDS, 2001), seventy percent of people estimated to be living with HIV/AIDS live in Sub-Saharan Africa. HIV/AIDS is considered to be the leading cause of death in sub-Saharan Africa, with 2.3 million AIDS related deaths in 2001 (UNAIDS, 2001).

According to the Department of Health (2001), the prevalence of HIV infection among pregnant women attending antenatal clinics in South Africa is 24.5%. It is estimated that a total of 4.7 million South Africans were infected with HIV at the end of 2000 (Department of Health, 2001). South Africa has the largest number of people living with HIV in the world (Dorrington, Bourne, Bradshaw, Laubscher, & Timæus, 2001). The Western Cape province, where the present research was conducted, has the lowest estimated infection rates among antenatal clinics attendees (8.7%) in the country (Department of Health, 2001). The largest proportions of people infected in this country are between the ages of 20-39 (Department of Health, 2001). This represents the economically productive age group. The social and economic consequences of HIV/AIDS for South Africa are discussed in the book *AIDS: the challenge for South Africa* (Whiteside & Sunter, 2000). Some key issues discussed are:

- the fact that AIDS is killing off the economically productive age groups will have an effect on the macroeconomics of the country, as skills are lost, the labour force diminishes, and savings are spent on health.
- households will be adversely affected as the lengthy illness results in the lengthy depletion of the household's resources.
- AIDS increases poverty as the resources of the poor get used up.
- The deaths of parents will increase the number of orphans, who are dependent on the state.
- Increased rates of crime as a result of increasing poverty, and decreasing supervision and care of children and youth.

The South African government's response to the country's HIV/AIDS crisis has been often controversial. In 1995, there was the scandal surrounding *Sarafina II* (Cresswell, 1998), a lavish stage musical production, where there were irregularities in the awarding of the tender,

and where the value in terms of AIDS awareness was questioned. Shortly after that, large support was given to research on Virodene, thought to be the wonder treatment for HIV that was later outlawed (Staff reporters and SAPA, 1997). In addition, there has been the government's continued reluctance to approve access to anti-retroviral treatments for HIV positive pregnant women (Underhill, 1999). In 1992 the National AIDS Co-ordinating Committee of South Africa (NACOSA) was formed, and a national AIDS strategy was developed. This national AIDS strategy was recently reviewed with the release of the HIV/AIDS/STD Strategic Plan for South Africa 2000-2005 (Department of Health, 2000). In this plan, counselling forms a key component of the primary goals of prevention of HIV transmission, and the reduction of the impact of HIV/AIDS on individuals and society (Department of Health, 2000).

1.2 Counselling as part of HIV and AIDS care

Counselling has been recognised as important for the prevention of HIV transmission, and support for those infected and affected by HIV (Brouard, 1998; Tallis, 1994; UNAIDS, 1997a). Counselling has been recommended as being an essential component of HIV testing in South Africa (Ijsselmuiden et al., 1988). There have been two major international reviews of studies conducted on the efficacy of Voluntary Counselling and Testing (VCT) (Higgins et al., 1991; Weinhardt, Carey, Johnson, & Bickham, 1999). A review of 66 studies by Higgins et al. (1991) showed mixed results as to the efficacy of VCT. Weinhardt et al (1999) published a meta-analysis of 27 studies published between 1985 and 1997. They concluded that VCT is an effective secondary prevention strategy, but not effective for primary prevention of HIV infection. Primary prevention refers to the reduction of risk behaviour among HIV-negative individuals, and thus preventing the spread of infection. Secondary prevention refers to the reduction of risk behaviour among HIV-positive individuals. A randomised controlled trial by Kamb et al. (1998) found short and enhanced counselling to be an effective prevention strategy. The authors furthermore concluded that "effective counselling can be conducted even in busy public clinics." (Kamb et al., 1998; p. 1161).

Studies in Africa, have found that VCT has been effective in reducing risk behaviours and helping patients cope with their illness (Allen et al., 1992; Buwalda, Kruijthoff, De Bruyn, & Hogewoning, 1994; Heyward et al., 1993; Kaleeba et al., 1997; Kamenga et al., 1991; Meursing & Sibindi, 2000; Müller et al., 1992; The Voluntary HIV-1 Counseling and Testing Efficacy Study Group, 2000). Meursing and Sibindi's (2000) study showed the importance of a comprehensive pre- and post-test counselling, and ongoing counselling with regards to

coping. Ongoing counselling and support groups were also found to be a benefit for HIV-infected women in Zimbabwe (Krabbendam, Kuijper, Wolffers & Drew, 1998). Wilkinson and Wilkinson (2001) show that there is a high level of acceptance of VCT at prenatal clinics among women in rural South Africa. However, Ladner and colleagues (1996) found that pregnant women in Kigali, Rwanda, are often reluctant to return to learn their test results and continue with ongoing counselling. The main reason for this is fear of receiving a positive test result, which would confirm the fear of being infected.

UNAIDS (1997b) defines HIV counselling as "a confidential dialogue between a client and a counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS." (p.3). HIV/AIDS counselling has as its aims the prevention of further HIV transmission, and the supporting of those who are directly and indirectly affected by HIV and AIDS (Chippindale & French, 2001). Pre- and post-test counselling became established as a means to prepare the individual for the consequences of the test results, and support the individual after the results are given (Green, 1989). A person tested positive is faced with a number of psychological issues related to financial worries, their children, problems in personal relationships, social relationships, self-image, treatment, and denial (Vollmer & Valadez, 1999).

There is no single approach to HIV/AIDS counselling (Bor, Miller, Scher, & Salt, 1991), with approaches deriving from client-centred techniques, cognitive-behavioral therapy, psychoanalysis, health education, and others (Richter, Durrheim, Griesel, Solomon, & Van Rooyen, 1999). It is useful here, to distinguish between directive and non-directive counselling.

HIV counselling has traditionally been more directive, and based upon behavioural theory (Balmer, 1991). Pre- and post-test counselling provided the opportunity to educate the client about HIV transmission and methods of prevention. The assumption is, that if clients are sufficiently informed about the health risks of unprotected sex, they would be motivated to change their sex behaviour, and reduce their risk of HIV infection (Kelly, Parker, & Lewis, 2001). However, there are a number of reasons, both psychological and social, why an individual would not change risky behaviour, despite having adequate knowledge about HIV infection and prevention.

Balmer (1991; 1992) has argued for a move towards a more client-centred approach to HIV counselling. A client-centred approach is a non-directive method of counselling. Non-directive counselling explores the context of the individual, their strengths and weaknesses, and empowers them to make choices that are suitable for them. However, non-directive counselling is difficult in instances where clients are not aware of the facts of HIV transmission, and the choices with regards to prevention. Balmer (1991) thus argues for a unified approach to counselling which involves both a disease-centred or directive approach and a person-centred or non-directive approach.

Richter and her colleagues (1999) found the majority of counselling services in South Africa to follow a mixture of client-centred and a more directive, health-advising counselling technique. The client-centred approach follows a Western approach to counselling with emphasis on the individual. It has been debated whether this individualistic, Western model of counselling is appropriate for the culture of Africans (Mkhize, 1994; Seeley, Wagner, Mulemwa, Kengeya-Kayondo, & Mulder, 1991). Counselling and advice-giving has traditionally occurred from older members to younger members of the family (Seeley et al., 1991). Mkhize (1994) argues that counselling and psychotherapy is a concept which black South Africans are unfamiliar with, and psychologists and counsellors are viewed as medical doctors. A study in Kenya (Vollmer & Valadez, 1999) found that of the people seeking HIV/AIDS counselling many presented with physical health complaints. Many individuals are also sent from clinics for testing and counselling, already presenting with symptoms of AIDS, and thus testing, from the patients view, becomes part of a process of treatment for their symptoms (Fawcett, 2001). Richter et al. (1999) found that while counsellors emphasised a client-centred approach as a model to their counselling, clients required health education, and the counsellors expressed difficulties in including health education within this non-directive approach. In Richter et al.'s study (1999), counsellors found it stressful to counsel in a non-directive way, "while, at the same time, holding strong views regarding preferred outcomes, such as disclosure to a partner and behavioural change." (Richter et al., 1999; p.80). This was also found to be the experiences of counsellors at Baragwanath hospital, the major hospital in Soweto (Allwood, Friedland, Karstaedt, & McIntyre, 1992).

As already mentioned, counselling is regarded as a valuable part of the treatment and prevention of HIV/AIDS. Counselling in South Africa, however, has been found to be limited in its impact (Richter et al., 1999; Richter, van Rooyen, Solomon, Griesel, & Durrheim,

2001). Counselling is needed to combat some of the difficulties identified in the fight against AIDS, such as stigmatisation, denial and secrecy, and continuing risky sexual practices.

1.3 Social and cultural factors that play a role in HIV counselling

Arthur Kleinman (1980; 1988) takes a relativist approach to health care, by viewing health care as a "special cultural system" (1980; p.24). By this he means that health and health care, must be defined within the specific society and culture in which it is embedded. Kleinman distinguishes between *disease* as biological and *illness* as experiential: "disease as the malfunctioning of the body, and illness as the lived experience of suffering." (Swartz, 1998; p.14). If we use the approach suggested by Kleinman (1980; 1988), we can conclude that counsellors, stand at a point of negotiation between AIDS as a biological disease, and AIDS as the patients experiential illness. It is at this position of negotiation that a "common ground and a basis for treatment that is acceptable to both" (Swartz, 1998; p.15) is ideally found. Thus, when examining AIDS and AIDS care and treatment in South Africa, it must be examined within the country's specific social interactions and culture. The experiences and perceptions of counsellors can give us insight into how AIDS as a disease and AIDS as an illness can come closer together so that a culturally appropriate treatment for AIDS is formulated. A look at some of the social and cultural factors that play a role in counselling, and some of the counsellors' experiences of counselling, will now follow.

Counsellors have reported difficulties with regard to patient's denial of AIDS (Allwood et al., 1992; Ngubane, 1995). Allwood et al. (1992) mention three ways in which this denial is experienced: denial of the diagnosis given during the counselling session; denial by the patient of having already been told their diagnosis when meeting another health professional; and not disclosing their status to other medical personnel in other health care institutions. A study by Stein (1996) shows that participants favour avoidance coping strategies, which includes passing of as "normal" instead of HIV positive, and rejecting negative ideation regarding HIV. Coping by denial was also found to be the case by Meursing & Sibindi (2000). HIV is often considered by the clients to be a social and physical death (Meursing & Sibindi, 2000; Stein, 1996). A positive diagnosis is difficult for both the client to receive (Krabbendam et al., 1998), and for the counsellor to give (Grinstead & Van der Straten, 2000). The counsellors fear the unpredictable reaction of the client to a positive diagnosis (Allwood et al., 1992; Bor, Miller, Goldman, & Scher, 1993; Buwalda et al., 1994; Grinstead & Van der Straten, 2000). The presence of dedicated counsellors in health facilities resulted in

the clients more likely to accept a positive result (Ethier, Fox-Tierney, Nicholas, Salisbury, & Ickovics, 2000; Ladner et al., 1996).

Leclerc-Madlala (2000) refers to denial as a "stubborn and multi-layered AIDS silence" (p.27). This denial can be reflected in the low levels of safe sex behaviour in the population (Blecher, Steinberg, Pick, Hennink, & Durcan, 1995; Lindegger & Wood, 1995; Perkel, Strebel, & Joubert, 1991). This risk behaviour has largely been attributed to cultural constructions of sexuality and power in sexual relationships (Campbell, 1995; Heise & Elias, 1995; Lamond, 1996; Leclerc-Madlala, 2000; Lindegger, 1996; Mane, Rao Gupta, & Weiss, 1994; Meyer-Weitz, Reddy, Weijts, Van den Borne, & Kok, 1998; Rao Gupta & Weiss, 1993; Strebel, 1995). These authors, largely consider women to be a vulnerable group with regards to HIV and AIDS in sub-Saharan Africa, in that men are justified in having multiple sexual partners, and women are powerless in negotiating safer sex practices. Attempts to negotiate sex are often met with violence and coercion (Varga & Makubalo, 1998; Wood, Maforah, & Jewkes, 1998). There is very little open discussion about sex between the sexes, in African cultures (Heise & Elias, 1995; Mane et al., 1994; Meyer-Weitz et al., 1998; Tillotson & Maharaj, 2001). Many studies show that men refuse to wear condoms, giving such reasons as: that they diminish sexual desire, they create mistrust between partners, they promote promiscuity, are "unnatural", unhealthy and even dangerous (Buga, Amoko & Ncayiyana, 1996; Campbell, 1997, Campbell, Mzaidume & Williams, 1999; Dladla, Hiner, Qwana & Lurie, 2001; Meyer-Weitz et al., 1998; Ratsaka & Hirschowitz, 1995; Romero-Daza, 1994; Tillotson & Maharaj, 2001). Given the previous Apartheid government's campaigns to reduce South Africa's black population, condoms were also regarded with scepticism in the earlier years of the emerging HIV epidemic (Crewe, 1992). Women are also seen to be both the source and disseminators of STD's and HIV, rather than men (Leclerc-Madlala, 2001, Meyer-Weitz et al., 1998; Temmerman, Moses, Kiragu, Fusallah, Wamola, & Piot, 1990).

Another issue with regard to HIV transmission and prevention, is pregnancy. In traditional Xhosa and Zulu cultures, childbearing is seen as a woman's role. Images of femininity are dominated by fertility, and procreation is rated highly, and is a measure of a woman's worth (Meyer-Weitz et al., 1998). A main subject of concern for HIV positive women is having more babies (Allwood et al., 1992). Temmerman et al. (1990) found that HIV positive mothers, knowing that there is a chance of having an uninfected baby, desired to have more babies so as to increase the number of uninfected children.

Such cultural issues surrounding gender and sex have implications for education about AIDS prevention, and thus counselling. They impact on the decision to wear condoms, and to introduce condoms into the relationship. This can create difficulties for the counsellor who is promoting the use of condoms.

Adolescents are also regarded as a vulnerable group. A study has shown that adolescents in the rural Eastern Cape Province, engage in sexual initiation at an earlier stage than previously, and have frequent sexual encounters but with low contraceptive usage (Buga et al., 1996), which increases the risk for HIV infection. A study of adolescent girls in rural KwaZulu / Natal shows adolescent sexual behaviour to consist of multiple partners, relationships with older men, and coercive sex (Harrison, Xaba, Kunene, & Ntuli, 2001). Leclerc-Madlala (1997) found that HIV and AIDS was considered by the youth as an inevitable part of their lives, and those suspecting themselves to be HIV positive, seek to spread the virus, so that they may all be in it together.

South Africa's migrant labour system, has placed men who are migrant workers in stressful living conditions, which make them vulnerable to HIV infection; the men, living away from their wives for long periods of time, visit sex workers (Campbell, 1997; Campbell, Mzaidume, & Williams, 1999; Jochelson, Mothibeli, & Leger, 1991). In addition, the high level of danger and risk of their work, cause them to diminish the dangers and risk of HIV infection (Campbell, 1997; Campbell et al., 1999). Migrant labour also puts the women, living mostly in the rural areas, at risk of HIV infection when re-united with the men (Dladla et al., 2001). Women also enter into extra-marital relationships when their husbands are away for long periods of time (Romero-Daza, 1994).

It has been argued that individuals will be motivated to engage in safer sex only if they perceive themselves to be at risk of contracting HIV (De Zoysa et al., 1995). Ngubane (1995) also points to the fact that HIV shows no symptoms for some time, and thus AIDS is an "invisible" disease, and suggests this as a possible explanation for its denial: how can a patient be sick, when he or she feels well? Ratsaka and Hirschowitz (1995) found that most respondents in their study in an informal settlement, had heard about AIDS, but were not convinced of its existence, due to never having seen or heard of someone having AIDS in their community. This was also found to be the case in other studies (Allwood et al., 1992; Cambell, 1997; Leclerc-Madlala, 2001). There is also a belief that AIDS is not a new disease,

and that a cure exists (Green, 1999). Counsellors find it a difficulty to have to try and convince the client that AIDS does exist (Allwood et al., 1992).

Caldwell, Orubuloye and Caldwell (1992) have argued that the underreaction that has existed towards AIDS in sub-Saharan Africa is attributable to the "multiple antecedents of misfortune and plural explanations of death" (p. 1169). The authors argued that Africans do not fully believe that biomedical determinism is the only cause of illness, but that there is rather a malevolent or punitive force that triggers the illness (Caldwell et al., 1992). Sexually transmitted diseases are regarded as spiritually caused diseases, which are best treated by traditional healers (Green, Zokwe, & Dupree, 1995; Meyer-Weitz et al., 1998; Romero-Daza, 1994). Susser & Stein (2000) found that AIDS is associated with witchcraft in Southern Africa. Many persons with HIV and AIDS in the African communities make use of both medical services as well as traditional healers. Meyer-Weitz and colleagues (1998) found that some patients come to the clinics in order to treat the symptoms of AIDS, and go to the traditional healers in order to cure them of the cause of AIDS.

Another factor to consider is the extent to which AIDS is considered as a threat, in relation to many other threats experienced on a daily basis in sub-Saharan Africa, for example poverty and violence (Lindegger & Wood, 1995). Vollmer and Valadez (1999) reported in their study in Kenya, that the most frequently mentioned concern of people seeking HIV/AIDS counselling, was financial. In a study conducted in Rwanda, the most pressing needs of HIV-positive women were food, housing, money and childcare (Keogh, Allen, Almedal, & Temahagili, 1994). For clients facing already difficult lives, HIV and AIDS becomes just another burden amongst many: "HIV infection became yet 'another nail in the coffin'" (Strebel, 1992; p.60). Poverty is also suggested to be a risk factor in HIV infection (Ratsaka & Hirschowitz, 1995). There are also barriers to HIV testing, such as fear of stigma and discrimination, the potential for adverse consequences in relationships, worry over coping with a positive result, as well as a perceived lack of risk for HIV testing (Phillips & Coates, 1995). Many clients are concerned with the social consequences of having HIV, rather than the technical aspects of the disease (Lie & Biswalo, 1994, Stein, 1996).

Stigma of HIV and AIDS is a very real issue in South Africa. Public disclosure of HIV/AIDS status can have dire consequences as evidenced by the murder of Gugu Dlamini by members of her community, after she publicly revealed her HIV-positive status ("Aids sufferer," 1998). As a consequence, many HIV-positive individuals do not disclose their statuses to their

partners or others, for fear of any negative consequences (Mathews, Kuhn, Fransman, Hussey, & Dikweni, 1999, Meursing & Sibindi, 2000). This reluctance to disclose, results in the patient being unable to find social and family support, and thus aggravates the clients sense of helplessness and loneliness (Meursing & Sibindi, 2000).

1.4 Counsellor issues

Counsellors have expressed difficulties in dealing with the issue of confidentiality, when there is a strong desire from the counsellors for the patient to inform their sexual partners (Allwood et al., 1991; Grinstead & Van der Straten, 2000; Richter et al., 1999). Fear of stigma and discrimination causes patients to require confidentiality from their counsellors (Lie & Biswalo, 1994, Meursing & Sibindi, 2000). Much of the counselling takes place in specially allocated rooms, which become known to be rooms where HIV and AIDS counselling takes place. Paradoxically, this compromises confidentiality to some extent, and clients are reluctant to use such services, or visit the clinic, for fear of being seen and being suspected of having HIV (Brouwer, Lok, Wolffers, & Sebagalls, 2000; Fawcett, 2001). Confidentiality is regarded as a cornerstone of counselling practice, but it has been argued that confidentiality may serve to maintain the silence and denial surrounding HIV/AIDS and further fuelling its stigma (Uys, 2000).

Counsellors are involved in a dynamic interrelationship with their clients as well as with the organisation in which they work. From a psychoanalytic framework, unconscious anxieties can play a role in the work of the counsellor. Unconscious anxieties about one's capacity to heal and harm can be stirred as a result of the task of counselling a client: "The closeness to people who are suffering, ... is taxing and stressful, particularly because it stirs up deep-seated fears about one's capacity to damage and about one's capacity to repair." (Hinshelwood & Skogstad, 2000; p.12).

Roberts (1994) argues that those who work in the caring professions may be drawn there by an unconscious need to make reparation. She develops her argument drawing from the works of Melanie Klein. According to Klein (1959), the infant has a split perception of its mother, into the good and nurturing mother that is loved, and the bad, neglecting mother that is hated. This splitting is a feature of what is called the paranoid schizoid position. As the infant matures, the infant shifts into the depressive position, where the infant perceives its mother as a whole, for whom it feels both love and hate. With this comes the realization of the damage that the infant's hate towards the 'bad' mother has caused in phantasy, which results in feelings

of guilt for the damage done. This guilt results in a drive to make reparation. Roberts (1994) argues that in the caring professions, frustration and failure is inevitable when working with damaged patients. This arouses the person's anxiety, and may result in a primitive defence of splitting reality into good and bad, as in the paranoid schizoid position of the infant. With HIV/AIDS counsellors this is particularly relevant, as counsellors are working with clients who ultimately are not going to get better, and thus the counsellor is unable to "repair" the damaged client.

Gibson, Swartz & Sandenbergh (2002), describe how transference and countertransference are processes which are involved in the counselling situation. The authors describe transference as occurring when the client transfers his or her feelings towards another to the therapist (or counsellors). The client's past feelings and relationships influence how he or she relates to the counsellor. The therapist or counsellor ideally then contains these feelings and emotions. Containment describes the process where the counsellor helps the client cope with and own these feelings. A boundary is maintained between the counsellor and the client, so that the counsellor is not contaminated by the client's feelings, which are being contained.

Countertransference refers to the feelings aroused in counsellors during their work with clients. These feelings "include feelings that relate to one's own issues, as well as those evoked by the client." (Gibson et al., 2002; p. 54). Countertransference can be a source for understanding the client, but may also become problematic for the counsellor when they relate to unresolved issues and unconscious anxieties.

Counsellors bring unconscious anxieties with them when they become counsellors. Given the high prevalence rates of HIV infection, it is highly unlikely that the counsellors have not been personally affected by HIV/AIDS in their own lives. Baggaley, Sulwe, Kelly, Macmillan & Godfrey-Fausett (1996) noted that many counsellors have had personal tragedies related to AIDS in their own lives, which interferes in counselling when there are unresolved issues. Counsellors may be motivated to enter caring work, as a defence against the impact that HIV has had in their own lives. Feelings and anxieties experienced by the clients may be projected and transferred to the counsellor during the counselling interaction. Counsellors may experience what is also known as *projective identification*, where they, as "recipients of a projection react to it in such a way that their own feelings are affected" (Halton, 1994; p.16).

Furthermore, counselling persons with HIV and AIDS, exposes the counsellor to many intimate topics such as sex, disease, death and dying, and victimisation, about which the counsellor may have strong feelings. Unresolved feelings and anxieties in the counsellor can be aroused when talking about such subjects. Counsellors may find it emotionally stressful to be dealing with such difficult topics (Buwalda et al., 1994). Clients often come to counsellors expecting their problems to be solved, and the counsellors to 'save' or 'rescue' them (Grinstead & Van der Straten, 2000). However, there is no cure for AIDS, and the unchangeable circumstances of this can make the counsellor feel helpless and anxious as a result (Brugha, 1994).

1.5 Counsellors and the work-place

Pain experienced by the counsellors as a result of the unconscious anxieties aroused during counselling, affects the organisation in which they work. How the organisation deals with these anxieties and conflicts can serve to manage and ease the stress it generates. If the anxieties are not sufficiently managed, the organisation begins to work defensively and can damage the staff and the work done (Halton, 1994; Hinshelwood & Skogstad, 2000). Menzies (1960), later known as Menzies Lyth, showed how a nursing organisation, structured how work is done in order to defend against primitive anxiety that the work of nurses arouses. The organisation acts as a social defence system, and stands in the way of effective management of anxieties. Van der Walt and Swartz (1999) have shown similar institutional defence patterns in TB clinics and programmes in the Western Cape, similar to TB clinics in which the counsellors of the present study work.

HIV counselling is a relatively new aspect of health care, and counsellors are a new addition to the health care system. Lay counsellors are at a lower level of hierarchy amongst health professionals. The position of counsellors within the workplace can add to the stresses experienced by the counsellor in their work. Drennan (1998) shows how the undefined job role of interpreters in a psychiatric institution in the Western Cape, cause stress for the interpreter who is unclear as to his or her role within the organisation. HIV counsellors find it stressful when they don't receive the support or recognition from superior staff members in the workplace (Allwood et al., 1992).

It is important for there to be an adequate support and supervision system for counsellors, in order to support counsellors and help them cope with the problems encountered in their work (Allwood et al., 1992; Brugha, 1994; Buwalda et al., 1994; Grinstead & Van der Straten,

2000; Kiemle, 1994). Counsellors have found talking to and sharing problems with other counsellors to have helped them cope with difficulties (Grinstead & Van der Straten, 2000). The countertransference feelings of the counsellors are processed and managed in supervision, which acts as a container for the feelings (Van den Berg, 2002).

1.6 Rationale for this study

It has been shown above that a number of social and cultural factors play a role in HIV counselling, creating possible difficulties for both the client and the counsellor. There are also issues related to the counselling task that may be problematic for counsellors. Given the importance placed on counselling in the care of HIV and AIDS, and what has been discussed above, it is surprising to find very few studies (for example Allwood et al., 1992; Baggaley et al., 1996; Grinstead & Van der Straten, 2000) exploring the experiences of the counsellors themselves. Only one study was found regarding the experiences of HIV/AIDS counsellors in a South African context (Allwood et al., 1992).

Much of the research has been conducted as to the method and efficacy of counselling. Research has also investigated social and cultural factors that impact on HIV and AIDS. On this basis counselling programmes are organised. However, there is not much research done on the implications for the counsellors themselves. The psychology of the counsellor is just as important as the psychology and circumstances of the client. For there to be an effective counselling, one needs an effective counsellor. Learning from the experiences of counsellors, can help to identify the stresses that contribute to burnout, so that suitable and effective training and management programs can be constructed, in order to ensure continuity of counselling.

In addition, as an existing counselling service, Lifeline Khayelitsha can provide some information with regards to counsellor training program and supervision and support structures. The HIV/AIDS counsellors themselves can provide valuable insight into the practice of counselling and some of the real issues facing them as counsellors.

2. METHODS AND ETHICAL CONSIDERATION

2.1 Context

Lifeline is a non-governmental organisation that offers 24-hour counselling services free of charge to individuals and communities in need. Lifeline began its services in the Western Cape in 1968 as a crisis telephone line, and has since then had an increasing number of calls to a current monthly average of 3000.

Lifeline has had offices in Khayelitsha since 1996. The Lifeline offices are in one half of a community centre that houses various non-governmental organisations (NGO's). Lifeline, Khayelitsha also offer telephone crisis counselling and face-to-face counselling at the offices, as well as Childline services.

Khayelitsha is an impoverished black township in Cape Town, established in 1983 as a result of Apartheid's segregated settlement policies (The Surplus Peoples Project, 1984).

Khayelitsha is a peri-urban settlement on the outskirts of Cape Town. The size of its population is disputed, with estimates of between 350 000 and 900 000 (Dyantyi & Frater, 1998). In a survey conducted in 1997, the majority of households had lived in the area for longer than five years, with strong familial ties to rural areas in the Eastern Cape (Dyantyi & Frater, 1998). Khayelitsha is an over-crowded area, with no significant economic base, and high rates of unemployment (Dyantyi & Frater, 1998). Housing consists predominantly of serviced and unserviced informal shack dwellings.

Khayelitsha has shown a rapidly increasing HIV prevalence rate since 1994, with an estimated prevalence rate amongst pregnant women visiting antenatal clinics, of 22% in 1999 (cited in Abdullah, Young, Bitalo, Coetzee, & Myers, 2001). Lifeline, Khayelitsha trains counsellors, who are then employed by the Department of Health as HIV/AIDS counsellors in health clinics in the area, and surrounding suburbs. Some counsellors also are employed by Médecins Sans Frontières, an international humanitarian aid organisation that monitors and provides assistance to the Mother-to-Child Transmission (MTCT) program in Khayelitsha. A list of the clinics where the counsellors work is included as Addendum A.

At the time the research was started, there were approximately 43 counsellors at Lifeline Khayelitsha (as indicated by Mpho Modise, manager of the counselling centre, in a

conversation, which took place in November 2001). As indicated by Mpho Modise, counsellors are split up into 6 different counselling tasks, namely:

- counsellors working in health clinics with TB and HIV infected patients
- counsellors working for Médecins Sans Frontières (MSF)
- counsellors working at the Mother-to-child-transmission (MTCT) clinics
- counsellors facilitating support groups of mothers from the MTCT programme
- counsellors providing Voluntary Counselling and Testing
- and counsellors providing counselling services at the Lifeline offices.

Counsellors are trained in a client-centred approach to counselling modelled on the approach of Carl Rogers (1967, 1980). Training comprises two courses, the Personal Growth Course, and Communication and Counselling Skills Course (A course structure informed by the Lifeline training manuals [Lifeline, 1988; Lifeline, n.d.] appears in Addendum B). Once training courses are complete, trainee counsellors are selected, and are placed on six months probation. Counsellors receive ongoing training and supervision on a regular basis, at the Lifeline offices in Khayelitsha. Counsellors receive general HIV/AIDS training by Lifeline, which includes counselling for VCT (Voluntary Counselling and Testing) and MTCT (Mother-to-child-transmission). Further HIV counselling training is provided by the AIDS Training, Information and Counselling Centre (ATICC), another NGO.

I have made a few visits to one of the clinics in which one of the counsellors that I interviewed works. This visit was part of another project that I have been involved in, so I did not go there to make observations of the counselling facilities. However, I did get an impression of the kind of places where the counsellors work. The clinic is located on a busy road, opposite a market area, with numerous stalls selling fruit, cooked meat, and clothing. The surrounding area consists mainly of informal shack dwellings as well as a few formal houses. My visits to the clinic took place at about 8:30 in the morning. At this time the clinic was already very full. The main doors of the clinic enter into a waiting hall, with rows of chairs. At the end of the hall is what I presumed to be an admissions office, behind a glass window. At each visit, this hall was over-crowded, with many people standing around the sides, due to there being nowhere for them to sit. On either side of the hall, are corridors with a number of consultation rooms. During my visits, I only saw one of the corridors, where TB patients were being treated, and the main waiting hall. Along this corridor are some consultation rooms, and a dispensary of medicines. There are two waiting areas in this

corridor, but the whole corridor was crowded with people waiting to be seen to. On each visit, I was approached by at least one person, asking me for money, food or clothes.

2.2 Entry into study

This study was to form part of a broader evaluation of Lifeline's counselling services in Khayelitsha, for which Prof. Leslie Swartz, my supervisor, was approached. This offered me an opportunity of contributing to a larger study, and learning of the experiences of the counsellors. I was interested in conducting this research, as it provides me with an invaluable opportunity to learn a bit about HIV and AIDS in South Africa. Although I have met and known people who are HIV positive, and HIV/AIDS is an epidemic that affects all our lives in South Africa, I have not been personally affected by HIV and AIDS. For this reason, HIV and AIDS had remained an area that I had limited knowledge of. I felt that it was vital for me to know some of the issues surrounding HIV and AIDS if I wanted to pursue a career in mental health.

Prof. Swartz first introduced me to Mpho Modise, the manager at the Khayelitsha offices. This was an informal visit, and provided me with some impression of what research I could do. Once I had decided to do the research, and had thought of a topic, Prof. Swartz introduced me to Stephanie Kilroe, who was then the executive director of Lifeline in the Western Cape. I also made contact with the counselling supervisor at Khayelitsha, Johann van Greunen.

Once I had drawn up a research proposal, I gave copies to Stephanie Kilroe, Mpho Modise, and Johann van Greunen for comment and approval. A final proposal was submitted to the research ethics committee at Stellenbosch University for their approval, which was granted.

2.3 The sample

I arranged with Mpho Modise and Johann van Greunen, to introduce myself to all the counsellors at the start of their supervision meetings. I introduced myself to all the counsellors, explaining the aims and purposes of the study, as well as the use of tape-recording, and assured them that confidentiality would be maintained. I stressed that participation was voluntary. All the counsellors were asked to fill in a questionnaire (included as Addendum C) asking descriptive questions which helped in selecting a representative sample. The counsellors also gave their signed consent on each questionnaire. All but two counsellors gave their consent. Unfortunately, these two counsellors were two of the counsellors who had been with Lifeline for the longest periods. It is not clear how this may

have impacted on the results. I do not know their reasons for not wanting to be interviewed. As participation was voluntary, and the counsellors were not asked for reasons for not giving their consent, I decided not to enquire. As it turned out, one of these counsellors left the organisation during the course of my study.

Of the 41 counsellors that gave consent to be interviewed, a sample of 30 counsellors were chosen to represent the 43 counsellors in terms of age, gender, and period of working as counsellors, as well as to represent the different counselling activities of the counsellors. This selection was done manually because of small numbers. There were only three male counsellors at the time, so all three were selected in the sample. The counsellors aged between 24 and 58, with an average age of 37. The counsellors had been with Lifeline between 1 month and 72 months, with the average of 24 months. Addendum D shows a table (Table 1) which indicates the age, gender, and job activities of all 43 counsellors, as well as the sample who were interviewed individually and in focus group. Sixteen counsellors were interviewed individually, and thirteen counsellors participated in focus group discussions.

Each of the sample counsellors was contacted to arrange an interview, and they were once again asked if they consented to the interview. At this stage, three counsellors decided that they did not want to be interviewed. I did not ask the counsellors what their reasons were for changing their minds, but only confirmed that their decision was not to be interviewed at all, rather than at that time. I was, however, concerned that there might have been an expectation from the counsellors that they would be paid for their time. This was never mentioned to the counsellors, but after the first few interviews, two counsellors asked me if there would be pay. After this, the three counsellors decided that they did not want to be interviewed. As a result, the two counsellors who had been with Lifeline for the longest period of time were not interviewed. Furthermore, I was concerned that the sample would be skewed in terms of the counsellors' length of time with the organisation. In the end this was the case, with an average length of time with the organisation of the sample (19 months), being lower than that of the population (24 months). I decided to approach Mpho Modise, the manager, to ask if she was aware of any expectation of payment. She assured me that none of the counsellors had mentioned payment to her. She did express concern that the counsellors did not want to be interviewed. Again, because participation was voluntary, I made no further investigation. Thereafter, the interview processes continued, with no further concern about payment. At the end of the interview process, I decided to make a small donation, in my own capacity, to the organisation as a show of gratitude.

I experienced some difficulties in trying to arrange counsellors for three focus groups consisting of five counsellors in each. Most counsellors were only available at certain times on Fridays, so it was difficult to co-ordinate a time, where all five counsellors would be available. Due to time constraints, I had to settle with whichever counsellor was available. As a consequence, the focus group sample was younger (average age 30), and had been with Lifeline for a shorter period of time (17 months), than the whole population. This was especially so in Focus Group 3, which consisted of only three counsellors below the age of 35 and who had been with Lifeline for less than one year.

2.4 Data gathering and analysis

As this is an exploratory and descriptive study, qualitative research methods were used. Qualitative research allows for data that is rich in detail and embedded in context. Data was collected from individual interviews and focus group discussions. The use of interviews and focus groups provided comprehensive results and a means of comparing the findings from the interviews and focus groups. Focus groups provide an opportunity for participants to explore, discuss and clarify similar or dissimilar issues, in a way that an individual interview would not. Focus groups were conducted after the individual interviews so that specific issues identified in the interviews could be validated and explored further.

Most of the interviews were conducted on a Friday, when the counsellors were available at the Lifeline centre. A total of 29 counsellors were interviewed. Sixteen counsellors were interviewed individually. These interviews lasted from approximately 45 minutes to 1 hour 15 minutes. The remaining thirteen counsellors took part in focus groups: two groups of five counsellors, and one group (Focus Group 3) of three counsellors. The focus group interviews lasted from 1 hour to 1 hour 30 minutes.

In the individual interviews, the counsellors were asked about what their jobs entailed, their difficulties and coping mechanisms, the training received and the impact that their work has had on their lives. An interview schedule is included as Addendum E. The focus groups were asked to talk about what makes their jobs difficult to do, and what makes it easier to do.

The interviews and focus group discussions were tape-recorded. Before starting each interview and focus group, I once again explained the aim and purpose of the research, and the use of the tape recorder. Confidentiality was assured, and consent was verbally asked. No one declined to be interviewed at this stage.

All the counsellors are Xhosa-speaking, so before the start of the study I enquired about conducting the interviews in English. I wanted to plan for interpreters beforehand, and consider the implications of using an interpreter, were it necessary. However, I was told that all the counsellors were competent in English. All the training that the counsellors received were conducted in English. On the questionnaire (Addendum C) the counsellor were asked if they were comfortable in being interviewed in English. All the counsellors indicate "Yes", that they were comfortable being interviewed in English. One counsellor approached me to say that, although she said "Yes", she struggles somewhat with English. I did not interview this counsellor, as there were numerous other counsellors, who I felt could better represent the population in terms of age, length of time with Lifeline, and counselling duties performed. Despite this, language presented some difficulties in two interviews. At the start of the interview, Respondent 5 asked whether the interview could be conducted in Afrikaans, as she was much stronger in Afrikaans than English. The interview was thus conducted in Afrikaans. Although my understanding of Afrikaans is good enough, I do struggle somewhat to speak fluently in Afrikaans. There were no instances when we could not understand each other, but the use of Afrikaans would have limited my ability to probe issues deeply.

I found the interview with another counsellor to be a bit of a struggle with regard to language. The respondent was not very good with English. There were times when we misunderstood and could not understand each other, and we had to clarify what was being said. I felt that we managed reasonably, and were able to talk a lot about different areas of her counselling experience. However, the respondent was a very experienced counsellor, and there was no doubt a lot more I could have learnt from her, but language restricted what and how much was said.

I was the interviewer in all interviews and focus groups. The interviews and focus groups were transcribed verbatim by myself. The transcripts were then analysed by means of thematic analysis, following the guidelines in Boyatzis (1998), and Denzin & Lincoln (1994). Codes were developed from emerging themes, and the transcripts were analysed using these codes. Each transcript was reduced into lists of relevant chunks of text, under each code. These reduced transcripts were then used to write up the results and identify useable quotes. Addendum F contains a list of codes.

The counsellors gave descriptions of their counselling activity, and what is involved in pre- and post-test counselling with voluntary counselling and testing. I decided not to include all

this data in this thesis, as the thesis is more focused towards the counsellors' experience in terms of difficulties and what helps them in their work. Furthermore, this thesis is not an evaluation of the counselling activity. An evaluation would ideally involve direct observations of the counselling process or interaction, and is beyond the scope of this thesis. Thus information gathered from the counsellors is a subjective narrative of the counselling experience, rather than an "objective" insight into the counselling activity. Some of the counselling activity and training will be discussed briefly in the results, but it must be acknowledged that differences may exist between the counsellors' description and interpretation of the counselling activity, and their actual counselling interaction.

As the study was a qualitative one, the data is in the form of narratives given by the counsellors. When presenting the data in the results chapter, quotes are given as examples of results found. Some of these quotes are lengthy. I was concerned that the results chapter may be too long as a consequence of the lengthy quotes. However, I felt that it was important to keep the essence of the narrative. Breaking up the quotes into smaller pieces would lose a lot of the quality of the narrative. Furthermore, I felt that stringing related sentences together by using "[...]" to show continuity, makes part of the narrative to be that of the researcher, and not the respondent, as the researcher constructs meaning in this way. For these reasons, I decided to leave the quotes at the length they are, even in instances where they are long.

2.5 Ethical considerations

As already mentioned, copies of the proposal were given to the ethics committee at Stellenbosch University, Stephanie Kilroe, Mpho Modise, and Johann van Greunen, for approval. It has been agreed that the final report will be made available to Lifeline.

The counsellors were ensured of confidentiality, and their informed consent was received. Counsellors were given the opportunity to change their minds about being interviewed before each interview. To ensure confidentiality, the names of the counsellors are not linked to any of the data and results. In addition, because there were only three male counsellors, all of whom were interviewed, all counsellors will be referred to as female in the results, unless gender is a specific factor in the results.

During the course of data analysis, I was concerned about the ethics of analysing and reporting some data. One of the counsellors talked about difficulties in childhood, which could be linked psychodynamically to difficulties in counselling. The link was made by

myself, not the counsellor. This case study provided a clear example of how past experiences are present in the counselling situation. However, when explaining the aims and purpose of the research, it was not explicitly mentioned that investigation would be made of how the counsellors past experience influence the counselling situation. For this reason, I was concerned about using this material without the counsellor's consent. This is one of the dilemmas of interviewing a "defended subject" (Hollway and Jefferson, 2000). Hollway and Jefferson (2000) argue that if a "defended subject" is forewarned about the possibility of discussing issues that are intimate, the subject is likely to back off. In this case, no questions were made regarding specifically to the counsellor's past or childhood. The counsellor willingly spoke about her childhood. Hollway and Jefferson (2000) argue that a subject who has revealed intimate issues during the course of the interview has made the 'choice' to "reveal something as part of a continuing dynamic between two people" (p. 88). However, the counsellor made no connection of the childhood difficulties to present difficulties. I sought advice from my supervisor and from Stephanie Kilroe in this matter. As a result of this advice, I telephoned the counsellor to discuss the matter, and received the counsellor's consent to use the material. This case study appears in the thesis as Case Study 3.

3. RESULTS

Results from the interviews and the focus group discussions will be discussed in four sections. The first section looks at the counselling training and activity. Most of the results are from the individual interviews, as the focus groups were not asked about the training received, and only a little was discussed around their counselling activity. The second section will look at the difficulties of counselling. This is divided into four parts, namely: client difficulties, counsellor difficulties, cultural difficulties, and organisational issues. The third section will look at what helps the counsellor to cope. The final section will briefly look at the general impact that counselling has had on the counsellors' lives.

When quoting counsellors, counsellors who were interviewed individually will be referred to as respondents, and those that took part in a focus group will be referred to as participants. Quotes used may have been slightly modified for ease of reading, or to disguise the gender of the respondent, but no significant meaning has been altered. In the instance where the gender of the counsellor is important, the counsellor will be referred to as 'male respondent'

3.1 Counselling training and activity.

As detailed above, the counsellors undergo two training courses at Lifeline: the Personal Growth Course, and the Counselling Skills Course. Lifeline trains their counsellors in a client-centred model of counselling. The counsellors are taught to reflect the feelings of the client and be empathetic and non-judgemental. The personal growth course serves to address any unresolved issues that the counsellor may have, in order to have a congruent counsellor. The Counselling Skills course trains the counsellors in the general principles of client-centred counselling. Twelve counsellors in the individual interviews found the training, especially the Personal Growth Course to have been a positive experience, and one which made personal changes.

Respondent 10: And also the most important, it is that Personal Growth. Because sometimes, you can be a counsellor, but in that Personal Growth there... we see because there are unfinished business. We deal with those unfinished business

Respondent 13: And we started about the studying about Personal Growth. So, I had, I had my other traumas, I would say from my background. So, I was relieved by doing Personal Growth, because that was where I shared all my problems that I used to have. So, in other words to me it became a deliverance in my life. I got delivered and healed

Respondent 15: That's why I say counselling changed my life, because there is a Personal Growth. To the Personal Growth, you must tell, you mustn't, don't hide your things. You must just talk to the other person. You mustn't hide there is something, "Oh this, I won't tell them." Just keep out with everything, you can be free.

All the counsellors found the training beneficial, and only one suggested any changes. The counsellor felt that the training videos used in the Counselling Skills Course should be made using local people, and address cultural issues that are relevant to counselling. In this way, trainee counsellors can relate better.

As mentioned, counsellors are trained in a client-centred approach, however further training in HIV and AIDS counselling seems to be more directive. The counselling activity seems to involve a mixture of client-centred and a more directive, educational counselling. Fourteen counsellors, who were interviewed individually, speak of doing education as well as counselling. Five counsellors from the focus group discussions also mentioned doing education.

Respondent 1: There's a lot of education. There's a lot of education because people sit there and stare at you - they don't know what you are talking about: HIV... positive... different from AIDS, you see. So you have got to explain this, and after they have their results, you still have to teach these people

Respondent 4: I educate them first. Then after the education... I do pre-test by in deep counselling -- so they can be ready for test

Respondent 7: Because there's a time whereby you don't counsel, and then you just educate this person

Nine counsellors state that counselling is non-directive, and thus they do not give advice:

Respondent 3: if a person has got a problem, like, she is coming for me for the counselling, I'm telling them that " I'm not going to advise you. You are the one who must think what you must do. "I'm not going to say to you 'Do this'"...I'm not saying that. No, I don't advise them. No, it's not good to them. It must be her or his choice what she or he must do.

Respondent 9: as a counsellor you mustn't advise her. What you must do is to encourage her, you see. So, the advice [...] it must come out of him or her, not from you.

However, it seems as if this is not always easy, especially when one has to promote safe sex and when it's required that the client disclose to the partner or someone at home. Six counsellors do speak of giving advice:

Respondent 1: we advise safe sex, because if - we think that is very important although people are not used to this kind of thing

Respondent 13: you try to find out, where is that person she said she would love that person to know. If that person is here in Cape Town, you can advise her, also is your duty, is not a wrong thing to advise her to go in that place, to that person. [...] You need to advise her, to notify the partner, so that the partner can come for a test

All the counsellors counsel clients individually. If a client, especially when diagnosed HIV positive, is struggling to come to terms with his or her results, ongoing counselling is provided:

Respondent 5: miskien as ek sien persoon wat nou saam met my gepraat het. As sy, hy voel nie lekker nie, nog agter dat ek vir haar gepraat het, of hom gepraat het, dan praat ek, dan praat ek. Dan vra ek, "kan jy nie miskien - wanneer, watter dag sal jy vry wees om my te sien?" [...] Die *ongoing counselling* is reg vir iemand [...] miskien hy nog nie aangevaar vir die siekte nie. Dit hulp.

[**Translation:** *maybe if I see a person that just spoke to me. If she or he does not feel good after I have spoken to her or him, then I talk and talk. Then I ask, "Can you maybe - when, what day will you be free to see me again?" [...] The ongoing counselling is right for someone [...] maybe he hasn't yet accepted his illness. It helps.*]

Respondent 10: I also see that, if maybe they need another session, I will feel that, okay this first session wasn't enough, then I will maybe call them again

Respondent 14: a person who is HIV positive. You can maybe see that person for the first time and you will see that there are other broken pieces that has to be fixed. [...] that person needs an ongoing counselling, because there are things that will make him draw back and then think about their status and things - they are going to die and all that. If maybe that person has been rejected by the boyfriend, then that makes that person not very stable. So, we need to counsel that person more.

There are also support groups for clients that are HIV positive, and for mothers in the mother-to-child-transmission (MTCT) program, which some counsellors facilitate. Support groups provide an opportunity for HIV positive individuals to share their problems with other HIV positive individuals. The support groups provide a place where an HIV positive person can receive the support that he or she is unable to receive at home.

Respondent 3: so we are facilitating the support groups. If our patients, they've got problems, we are asking them if someone is willing to share in the group -Share her or his problem. [...] Support group it helps them a lot, because they don't have families whose is going to support them. So, if they are coming to the support groups, it helps them a lot.

Respondent 12: The purpose of support group, is to support the mothers, to understand we are not alone - who have HIV positive. It, that time the mothers sit together, is the sharing about the HIV and what is happen, the time we get HIV. And share about it. What is happening before, till now. I think support group is very good to - one of the mother is down, and she feel that she alone, she's living with HIV. When we join the support group, she saw the room is full of the mothers. We support each other.

There are some limitations to this client-centred system of counselling. Four counsellors speak of when the client's need to disclose to their partners or families, there is no counselling of the partner or family, who become distressed at the news.

Participant C (Focus Group 1): The support group is very important in our clinics, because is whereby the client they grow up themselves, so they can go out and disclose to their families. But now, our problem is this: how about the people who were, that client who have disclose to other person at home, where do we get the supervisions? Because, that person the client disclose to her, sometimes when the client is sick, he feels bad, because he don't know the time he suppose to live with us. Maybe he, she thinking, maybe now she's going to die.

Participant E (focus group 2): sometimes they just go and say, "I've been told that I've got AIDS", and the partner cannot have a chance of saying "What is AIDS?" Because, by asking a lot of questions, I would think that he's saying I'm the one who bring this virus in. So, the partner would prefer to just keep quite, and that will result on them having problems, because the partner has got a lot of questions. But who is going to answer the questions? That will make things difficult for both of them.

However, six counsellors state that they do counsel the families, but this seems to be an "extra service"

Participant A (focus group 1): But what we are doing, we call the family, we do education, we do counselling, before the patient disclose to the family. Because we found out some of the clients, they came, they are crying, "My mother chase me away!" And then we take the client, we go back at home to discuss with the client mother.

Participant E (focus group 2): And also, when we going on weekends - it's not part of our job, but we are doing it - when one of the clients is being invited by the clients to come, because she wants to disclose to the family. Then she will ask maybe one of

the other counsellors, to accompany her, to go to that particular family. So, we are helping each other in that way.

3.2 Difficulties of counselling.

The difficulties mentioned by the counsellors have been divided into 4 groupings, namely: client difficulties, counsellor difficulties, cultural difficulties, and organisational difficulties. Client difficulties refer to difficulties that arise in counselling and are experienced by the counsellor, as a result of the circumstances, attitudes, knowledge and personal difficulties of the client. These factors are brought in by the client, and causes difficulties and challenges for the counsellor. Counsellor difficulties refer to the difficulties experienced as a result of the counsellor's feelings, attitudes, professional constraints, knowledge and concerns. Cultural difficulties refer to social and cultural beliefs and traditions that may cause difficulties in counselling clients in HIV and AIDS. Organisational difficulties refer to problems experienced within the workplace that may cause personal problems for the counsellor, or making counselling itself difficult.

3.2.1 Client Difficulties:

Denial:

Perhaps one of the first difficulties concerning the client, is denial. When diagnosed HIV positive, many clients go into what is known as a state of denial, where he or she refuses to accept the diagnoses. It becomes difficult for the counsellor to counsel the client, when he or she is not accepting what is happening.

Respondent 11: because you find people that are on denial, so you can actually see, even if you doing the post-test counselling, that the person is just listening, but nothing is going - like, it comes to this ear, and then goes out to another one

Much of this denial stems from a lack of knowledge and a lack of understanding concerning HIV and HIV transmission. Three counsellors state how some clients believe that because they are monogamous, they cannot get HIV.

Respondent 6: some people do still take the HIV thing away from them - "It can't be me, because I'm not sleeping around from [inaudible] - I only have one boyfriend, and I have not been sleeping around for years. It was the first boyfriend and all that", so which made them to deny the fact that they can be HIV positive. - especially the youth.

One counsellor mentioned how clients do not accept their HIV positive status, and go to another clinic for testing:

Respondent 1: some people really don't accept it. Some they, they go out, and they even go to other clinics to... find out if they are really positive, because they don't, they don't believe it... They're in shock! That's what it is.

One counsellor recalled a client who she recognised as someone who she had tested and counselled before, and he was tested positive. However, the client, in denial, came again for another test, and told the counsellor that he had not been tested previously. The counsellor knew that he had, but could not say so to the client, and thus the counsellor had to go through the whole pre- and post-test session.

Respondent 11: I once had a client who came to me for a test. It was a 21-year-old guy. And then he came for a test. I tested him. I gave him the results, and he seemed okay to me at that point in time. Ja, he was positive. And then after, let's say, four months after that, he came to me again, using another name and a surname. acting as if he had never seen me before. And also I had to pretend, knowing the person [...] I ask him, "Have you ever done a HIV test before?" He said "No". I said, "Okay, before you do the HIV test, you first go to some counselling, and -". I explained everything to him. And then, I had to go through with him, through the pre-test counselling, and take him to the counselling room, because I had to take his word. I just told myself let me just deal with him now, then I will challenge him afterwards. Then we went to the testing room, then he tested positive. So... he accepted his results, and then now, I had to confront him. I said to him... "Are you really serious that you've never seen me before?" He said, "Yes." I said, "What if I say to you, you once came to me for a test, four months back?" He said, "No." [...] I say, "aren't you so-and-so?" He looked at me and say, "Oh, I'm sorry I did came for a test, but at that point in time, I felt like it was.... I, it couldn't be me who's positive, and that." [...] I felt like this guy is, like, I wouldn't say I was angry. I was angry a bit, but I couldn't show it. I felt like this guy is taking me for a fool.

Two counsellors who were interviewed individually, feel that it is the male clients that are more likely to be in denial than the female clients, and then they do not come back for ongoing counselling.

Respondent 16: But you may find that other people do not come back for the ongoing counselling. That is a problem. Especially the guys. Ja, they don't come back for the ongoing counselling. Even that, got the results, is HIV positive. You will talk to him at that point, at that moment. Then you will give the appointment for tomorrow, then he won't come back

Four counsellors that took part in the focus group interviews, said how they found that the husbands of HIV positive women, are often in denial, and would not come to the clinics, because it is the wife's problem:

Participant A (focus group 1): there are few mans come to the support group. Most of them they don't want even to come to the clinic. They say, "I'm not sick. This AIDS it's for you. You came with this. I'm not having AIDS. So, you can go." Maybe the wife is very sick. He came to the clinic for the wife, he can just say, "Okay, I came with this patient. I'm not sick. I'm not had this HIV. Is the wife and the baby." So, he just came to the clinic when he is very sick.

Participant B (focus group 2): And the man doesn't want to come to the clinic, and say "No, it's your problem. Then go, because it's your problem. I'm not having that thing. So, it's your problem. Then go and tell that lady I'm not coming, and I'm busy, and - so many excuses - I'm working. I don't have a chance. So, deal with your problem".

Participant A (focus group 3): And also, some of them, maybe the girlfriend come to the clinic for an STD problem [...] and then maybe you ask her, is it possible for her to come with the partner, so that the partner will get the treatment. She will say, "No, he doesn't want to even know what is going on in the clinic. He doesn't want even to enter the gates of the clinics."

Disclosure:

Disclosure is a major issue facing individuals who are HIV positive. At some stage, others, especially partners and family, will need to know their status. Counsellors try to encourage the clients to disclose to a trusted person at their home, because the HIV positive individual needs support at home, when he or she is sick and taking treatment. One of the criteria of the MSF, for the provision of treatment, is that those receiving treatment have to disclose to someone at home, who will be able to help them in their sickness. It becomes frustrating to the counsellor trying to encourage the client to disclose:

Respondent 15: it's a difficult sometimes.[...] You can know, you can see even now when you ask somebody: "Did you tell somebody?" - "No, I didn't". But it's not easy. But we are trying. We are trying. We are trying. We are trying. [...] Every time you must call her. I mean, after a month or whatever, call her and [*inaudible*] again the counselling, the ongoing counselling.

Interviewer: And how do you feel when that client is not telling somebody, and you trying to -

Respondent 15: You feel bad. I mean, you feel... you feel bad, you know, sometimes. At least you feel... bad, because you are, you want to, what's going on. You are... because you are trying... to help her. Every time you are thinking about this. Always thinking about this. This person. This person. This person. This person. I must see this

person, because she's supposed to tell about [*inaudible*] one of the family. Husband or [*inaudible*]. You can't relax.

Participant A (focus group 3): Most of the time, I felt difficulties, when the person comes, and then, maybe he or she didn't disclose to anyone. And then our criteria at MSF, is that a person at least must have disclosed to a, maybe to a woman, person maybe at home, or the partner [...] So, it's difficult when the person comes, and he or she is the only one who knows that he or she is HIV positive. And then I have to spend a lot of time, assisting him or her.

However, clients find it difficult to disclose, because of fear of rejection by their partners or family, the stigma and discrimination surrounding HIV and AIDS. This fear of disclosure because of stigma, is a factor in denial:

Respondent 1: Denial comes from the stigma that has been attached to HIV and AIDS. The stigma from the family, from the people, from the community. "You have HIV and AIDS, and then you are going to die, and we have got nothing to do with you" - that kind of thing. There's still a lot of that in our community. People do reject people. Mothers do reject their daughters... you can imagine... husbands do reject their wives [...] The people who are able to tell their families and husbands are very... few and very lucky people.

A lot of fear of disclosure stems from financial dependence on the partner or family.

Especially women, who are dependent on their husbands for support, are afraid of telling their husbands, and the husbands rejecting them:

Respondent 1: I think this is one of the reasons why they can't disclose their status to their husbands, because they depending on their man to support them. If you've got nothing for yourself, it's not easy to be, like... talking independently, because they don't know whether this person will accept me, because he's supporting me, and I have got nothing to support myself

Participant A (focus group 1): I think that the culture, make our job difficult, our culture. Because you find out the wife was diagnosed in 1999, but because it's not easy to sit down with her partner to told, "I'm HIV positive", because she got that fear: "My husband can chase me away. I've got these children. I'm not working." And then she just keep quiet. And then, when the husband ask the wife, "Why you are not breast-feed the child?" They just breast-feed. And then she knew that, "I'm HIV positive. I'm not supposed to breast-feed the nurses told me", but because she afraid of the husband, she breast-feed.

Participant D (focus group 2): it's difficult, especially to women to disclose to their partners, because they have this fear of being blamed. That they going to lose the support, the financial support that they are getting from their partners. Then the family will blame this woman, that this woman that she came with this disease to their

family. So, is a lot of that. But, at the end of the day, some of them disclose, some of them did not disclose to their partners.

Two counsellors also spoke about how difficult it is when a client is referred for counselling, because he or she is HIV positive. Then, when the client arrives, he or she does not disclose his or her status, and the counsellor cannot say that she knows that the client is positive.

Respondent 1: the mothers [...] they know they are positive, because the mothers with their babies they are tested when they are expecting babies, and then they are given AZT to protect their babies from getting infected. But you still find a mother who is from a hospital coming to you because they must come to their own clinics and they must be given this formula that they must get free. ... So you have got to know from her, about what is going on. What happened? "No, I've been told to come here to this clinic." - "And why is that?" - "To get some formula." - "And why do you have to get some formula?" - "I don't know." - "Are you going to breast-feed your baby?" - "No." - "Why is that?" - "I don't know." - meantime they do know. That they were told in the hospital that "you can't breast-feed your baby because you are HIV positive", but now they come to their own community, they don't want to, they don't want to accept it. But we actually know that they are HIV positive. I mean, we know, because the very fact that they are referred to the clinic...And you have got to talk to them... Until they come to the truth!

Respondent 11: So I asked her if, "Have you ever done an HIV test before?" Though I knew [...] because sometimes I'm in the reception, so, if maybe a client comes in with a referral letter, maybe a TB - if we have to open a folder for that person, you know you actually open the letter, and then you read it, because you have to know which folder that you must open. So I ask her, "Have you done an HIV test before?" She says, "Yes, I did. And I'm HIV negative." So, I decided to leave it like that at the moment, and then once she next visit, then I will be able to talk to her.

Respondent 1, later said that sometimes she does admit to the client that she knows the client's status:

Respondent 1: I must admit I do, as a counsellor, because... I've got to help her! Because, if I don't say... okay... even if you...hmm, this is very difficult! but I have to, because I've got to help her! Otherwise I can't help her, if I don't tell her!

Lack of awareness and understanding:

Four counsellors mentioned that there are clients who still don't know anything about HIV and AIDS:

Respondent 4: today I found a difficult client. Today, this morning, because she don't even know about HIV, ... and she was positive, you see, then I ask her, what does she feel for the results? Then she said she's feeling happy. Then I ask her: "you know what positive means, or what HIV means?" then she said "No" - she didn't even know. She's

nineteen years nineteen years old - she said, "no, I don't know" - she'd never heard about HIV.

Respondent 11: I feel that there is a need out there. There are many people who don't know anything about this. If only maybe this could be done much more in the rural areas, because some of the people, they don't have TV [*television*], they don't have radios. And then it also far for them to be in town, where they can maybe gather some info. [...] You think that everybody knows about HIV, but when you maybe sit down with one person, and you talk to that person, you see that this person doesn't have any info at all. You do find that people.

However, there were two counsellors that felt that there has been a change with regards to people's knowledge about HIV and AIDS. Two counsellors spoke about how things have improved in this respect:

Respondent 1: Well, people didn't know! And they didn't know what it was! And they kept saying it's not something that's from here, it's something that's from somewhere else. But now - I'm talking about my community I am not talking about everyone, but now the people know that there is something like HIV and AIDS. And they know that they've got to be now - take care of themselves

Respondent 10: I think with - first of all with the HIV clients, those that are positive, it's much better now. Before it was difficult, but now it's much better, because the people now are seeing in the TV where to go - they've got information. So, it is much better. Even when you do the pre-test with client, you'll see that, this person did hear from the TV, maybe from the radio about this. Before when I start doing the counselling it was difficult - with the pre-test we have to maybe to sit for two hours, because this person doesn't know nothing about this.

Thirteen counsellors mentioned that clients still lacked knowledge and understanding around HIV and AIDS. The counsellors spoke about misconceptions and misunderstanding around HIV and AIDS, which require the counsellor to educate the client and explain the facts. For example, many clients do not understand the difference between HIV and AIDS, and think that if they are HIV positive, it means that they have AIDS, and are going to die:

Participant E (focus group 1): is not easy to talk about HIV. Some they don't understand clearly what is it. Because if the client you ask, "What is HIV? What is AIDS?" - they say, "No, this is AIDS." If you try to make it clear, first is the HIV, if you are HIV you don't have AIDS. HIV is a virus. They don't want to - Ja, they can hear in front of you, but even you are the counsellor, they just ask you a difficult question, "Okay. I've got AIDS. So, how long I'm going to stay? How many years?"

Participant A (focus group 2): if a person tested positive, they said "She have AIDS." Then they don't know the difference between AIDS and HIV. So, you must educate more about the HIV and the AIDS also.

One counsellor spoke about how a client misunderstood "HIV positive" for "HIV negative", because the word "positive" refers to something good:

Respondent 13: And then you check the understanding of the results. It might happen, when you are saying the results "Its HIV positive" you mean she doesn't have it, because, when we talk of, without the HIV related thing, when we talk of 'positive', we talk of good things. When we talk of 'negative', it's the opposite. That what it used to mean. So now, you need exactly to check the understanding of results, because what's going to happen when you say a person is HIV positive, and yet he smiles, becomes happy? It happens.

One counsellor spoke of a client who talked about there being a cure for HIV and AIDS, and so not being concerned about his diagnosis:

Respondent 7: Yes, I had a client [...] he told me that, "Hey man, I've been attending the traditional healers in Eastern Cape, you know... twice a year I go to Eastern Cape for medication and so forth to my traditional healer. And then... because I knew that this person is just curing HIV, is taking HIV out of the body, you know. Could you please test me again?" and so forth. I did that. I retest. And then he was HIV positive.

This lack of understanding and misconceptions about HIV and AIDS require the counsellor to explain the facts and provide education. A client-centred system of counselling becomes difficult when a client doesn't know what it is the counsellor is talking about.

Clients who are not prepared for testing:

Testing for HIV is voluntary. Voluntary counselling and testing services are offered at the clinics. Thus most clients have prepared themselves when they come for testing and counselling. However, there are patients, for example TB patients, who are referred from clinics for counselling and testing. Three counsellors mention that such clients are difficult, as they are unprepared, and sometimes unwilling to be tested. It is up to the counsellor then to try and persuade him or her. There are also clients who are forced to come for testing by their partners and families. Five of the counsellors stated that if they feel the client is not ready to be tested, she would not test the client. However, it seems that the counsellor does not have that choice with the referred patients, who have to be tested.

Respondent 13: especially those who are being referred - the referrals from the sister in charge. Those maybe who were sick. Maybe someone had a gland, so he came to the clinic, so a sister will refer, because the gland is one of the related symptoms of HIV. The sister knows, but they will advise "How about go, also, now that you are going to go to the doctor, how about also going and do the counselling of HIV, because it takes twenty minutes?" So those people, they are, some of them they are

very difficult, because they will tell you when you ask, "What makes you come for a test?" They will tell you, "I don't know, because I didn't need, come here at the clinic to know my status, I came for my sickness!" So, now you need to start from the beginning. That's what I do.

Participant A (focus group 1): Maybe she is enforced to come to test. Maybe it's a boyfriend, maybe it's a family, you know. So, she cannot accept the results, because is not her decision. You must discuss those things [*inaudible*]. You must educate clearly to understand what is HIV. She or he is prepared to do this, or not. And then it's her or his rights to say 'No.'. But if you are going to look for the situation of the clinic, they force, because they say, you must, maybe is referred from the doctor, "Do a test", you know. And then that patient don't have a choice because is a doctor.

Participant C (focus group 1): I have had a client, he is referred from the TB room. The clients were admitted from the clinic room, they suppose to do an HIV test, though the client didn't want to do. So it's not easy, because that client he, she didn't volunteer. She didn't want to do the HIV test. So, when on that pre-test counselling, we take a long time, because we suppose to educate this client, and tell why you suppose to do the HIV test.

Two counsellors said that if they feel a client has too many stresses in his or her life at the moment, they recommend that the client not test then:

Respondent 13: So, if there are many things that is going through, and you can see if she's emotional also, she's not feeling okay. Sometimes this, meanwhile she started the conversation she will cry. Now, you will have to contain her, to talk to her, to calm her, and then, so that you can continue with the counselling. But, those cases, that cases, you don't advise her to - you would, sometimes you ask her if "do you feel this is a good time, right time for you to go on with the test?"

Participant D (focus group 1): for instance I had a client, [*inaudible*]. He came to me, he was very shocked, because the partner died, and he said she did abortion. She died. And there are rumours that say she was HIV positive. And you could see he was shocked, because the brother is also dying of HIV and AIDS. And he said, "I want an HIV test." And I said, "Okay. Do you think it's a good time?" - because it was on the 20th December. And he said, "No."

Negative reactions of the client:

For the client, to hear that he or she is HIV positive, can be devastating. People often react in very emotional ways to the news of being HIV positive, with much crying and screaming. Twelve counsellors told about how difficult this is, to be there when the client is crying or reacting negatively:

Respondent 3: I told him that "You are HIV positive." And then after that I ask her or him "How do you feel?"... The others are crying... And the others just keep quiet, you know [...] And especially if the client is crying. Oh it haunts me!

Respondent 9: in post-test, sometimes its difficult when you tell her the results, if she's positive. So, they don't react the same, you see. Some they cry. Some they don't cry. So it's the way they react. [...] Yes. I mean that it... sometimes they cry, you see. So, when I say it's difficult - you see when they cry, as you, as a counsellor.... There's nothing happen to you, but you, you just, we just have a feeling inside you, when she's crying, you see. That's why I say, I'm saying, sometimes there is difficult, because she's crying.

Participant D (focus group 1): For instance, one time I had a little girl, who was about eighteen. She had a partner for the first time, and then this partner was always around, and then she said "I want to take a test, and take, whatever I want to do now from now on." She was tested, and she was positive. She fainted. She fainted, and it took a long time for her to recover. And I was alone in this room with her, and I was holding her up like this, and I was calling him by his name, you know. Trying to feel the, the palm, and the pulse. And then trying to shake him up. But after a long time, he just opened the eyes and then... cried. And then the sister heard the screaming, and then he came to the rescue, and then he examined him, her, and then, you know, but... at that time I felt: Ooh! I had a session! Because it took me more than an hour to counsel that little girl, and I'm still waiting for her to come back.

With a positive diagnosis, there is also the danger of the client later committing suicide. One counsellor mentioned having a client of hers who committed suicide, before she had a chance to do a follow-up counselling session. This incident affected the counsellor strongly, making her feel responsible, and that she did not do her job properly. This raised an anxiety of failure in the counsellor, and unconscious anxiety of her ability to harm as well as repair. These anxieties are discussed further below under counsellor difficulties.

Respondent 7: I had one who committed suicide. I saw that person on Thursday, and then on Friday I was not in clinic. And then we set the appointment on Monday, you know. Then on Saturday... you know. He killed himself [...] I...I feel sorry about myself. About him and the family, and... and I feel that I didn't do my job properly, you know. Because at least for these years, in this field, I understand what is going on. So I was suppose not to do that testing at that time. For he was from a doctor, he was a TB client, you know. So, I was not supposed to do it. I was supposed to make an appointment for Monday, for testing. So that I can have time on Tuesday to see that person. You see, I saw him on Thursday, then on Friday... we didn't do anything. Then on Saturday, he decided to kill himself, you see.

Often, the fear and shock of the client upon hearing the news that he or she is HIV positive, is projected on to the counsellor, and the client reacts negatively to the counsellor. Two

counsellors spoke about the anger of the client towards them, and being accused of lying, or being blamed for the client's status:

One of the counsellors gave an example of a client who blamed the counsellor for her positive diagnosis. The client shouted at her and threatened her publicly, making the counsellor feel offended and concerned for her safety:

Respondent 6: Because I remember one day, there was a lady, which went to the clinic for testing. And when I met her in Site C, she told me that "I am going to arrest you! You said I'm positive! So, I am going to arrest you!" So I felt... I wasn't sure how to respond to that. [...] It was a Sunday afternoon. I met her - I was just coming from church. Then she just... howl at me, saying that I said she's positive, when she's not. She's going to get me arrested. She will call the police and all that [...] I think she was in the denial stage, because I sat down with her again, doing the follow-up on the counselling - I think she's fine, because I still meet her in Site C. But, she's fine. [sighs] It was offending I suppose. It was offending because... I was, what I thought was I wonder what would other people think, because she was with one guy... but the guy was busy talking to someone else - but I was concerned, more concerned with other people which might be listening to her. Because she didn't just whisper that, she told me I was just a distance from her, and... and I was worried! I was worried. Yes. Because what worried me is why does she left the clinic from the very beginning, if she's denying her status, because she could have wanted me to have explain what is not clear to her, instead of howling me in the street, you see.

One counsellor also spoke about a time when she and also a colleague of hers had been threatened by the client, and blamed for their HIV positive test results:

Participant B (focus group 3): I did last year counsel a man, and he threatened me, before I give him the results. And he said, "If I'm HIV positive, I don't know what I will do to you." I said, "No. I'm not the cause of that." But, unfortunately he was negative, so I don't know what will happened if he was positive. [...] And my colleague, the other - it was not a man, it was a woman. She said to me, "If I'm HIV positive, I will hurt you." But, she was positive. She didn't do anything. She was just crying, get cross. Following week, she came to the support group, and she was okay, and she told the support group, "That day I was very angry, and I did tell the counsellor, that I will hurt her if I am HIV positive, but I accept my status now." [...] Some of them they blame you. Some of them if maybe you said "You are negative", she just hug you and say, "Thank you. You are so sweet." - she just says, "thank you. Thank you. Thank you." So, some of them, I think they think that you are the cause of the results.

One counsellor spoke of a client who was so ashamed of her HIV positive status that she could not look at the counsellor. The counsellor was left to counsel the client, who was turned and looking away.

Respondent 12: Some of the mothers, when she's coming to me, I am, the mothers' got a result at MOU, then I am first one she told me she's positive with HIV. She's difficulty - and she sat like this one [face-to-face], she turn around. She close the door, she looked at the door. She did not look at me, when I'm asking. She did not look at me. But, she told me, "I'm HIV", "Oh, okay". When I ask her, "can you speak forward?" Then "M-mm, sorry, I don't want to look at you, because I'm shocked with myself before." Then, she did not want to look at me at all, but I do talk and things, to tell about HIV.

Six counsellors spoke about how difficult it can be when the clients are not being open and truthful when they are being counselled.

Respondent 8: I wish some people, I mean, I wish they could really, really tell me the truth, so that I can deal with it. If they still keep something back, like, I would, I mean... when she get positive, and he - they been together for two years, so... somewhere, somehow, she's... she's being unfaithful. But she's not telling me that.

Respondent 12: It is difficult, if you do pre- and post-test to a man, he is open when you doing pre- and post-testing, and you explain about the results, and she saying "yes, I accept, and it's a long time I think to come to test." When the result is coming, that guy is looking down, and using just her hands. So, it's difficulty, she is not talking, but that time she agree. She accept everything what you saying. [...] So, there is a difficulty in...it's a man, men, most of the men are so... is not open.

Respondent 15: It's not easy. It's not easy. Sometimes it's easy, but sometimes it's not easy, but it's because not all the people want to share the things

Stigma:

It has been revealed above, how stigma plays a role in causing HIV positive people to fear disclosure, and how too it impacts on denial. In Focus Group 2, two of the counsellors mentioned how stigma plays a role in whether clients come to the clinic for testing and counselling. Many of the counselling and testing services are located in clinics, which are known to be for treatment of HIV and AIDS. Furthermore, some patients with HIV and AIDS, fear coming to their local clinics, for fear of people in the neighbourhood learning of their status. They would thus rather go to clinics that are further away.

Participant E (focus group 2): sometimes men seems to be very difficult, especially when you say they must come into the clinic. And especially our clinic, so it's meant for anti-natal care. So, they would say "It's only woman that are there, so I'm going to go there, and the people would know that I'm going for HIV there." [...] And then we would take the person other way around, not the place where lot of women are sitting there.

Participant D (focus group 2): they don't want to go to our local clinics, they go to Salt River, something like that. Far away from their community, because they don't want to be

known that they have gone to the clinic. They've got this fear that people will know that, "I have something wrong with me. Or, I did go for HIV testing, maybe I've got HIV or AIDS."

Couples that are sero-disconcordant:

Twelve counsellors found it difficult to counsel couples that are sero-disconcordant (One partner is negative, and the other is positive). Most couples are counselled and tested separately, but then opportunity is given for the partners to disclose their status to each other, and are then counselled together. When couples have disclosed to each other, most do not understand why it is that the one is negative and the other is positive.

Respondent 8: So it was very, very difficult, it's been a very difficult - I mean, it was very difficult to counsel him. Very difficult to make him understand that... I mean, to accept his status: how could she being a street-, a, sex-worker from South Africa, a very liberal country, and he from Saudi Arabia, being Moslem, from a very strict culture, you see. So... I think for a, about six months, went through the, and for six months I think she came in about two times for counselling and test to us. And still she was negative, and still he was positive, and couldn't come to terms with that.

Respondent 9: what is difficult, sometimes is when a mother is positive, and then the partner negative. So, that is the difficult situation. But, if you are a counsellor, you have to counsel them. So, we are getting people like that. A mother, because usually say a partner must tell the partner. So, that he can... tell her status to her partner, the guy, you see. So, you usually get positive men most, then negative women. Usually get a lot of that. Yes. But, to others is difficult, because they don't accept. Like, guys, she will ask you, "Why I'm negative and she's positive?"

Respondent 15: It was very difficult. And it was painful, because the child was negative. I don't know what's wrong with her, because I didn't see her after that, and I want to see her, because I want to ask her. I didn't ask her at that time, because she was in pain. It's not easy to ask somebody when she is in pain. I didn't ask her. What I wanted to say about that was "What was the point? Because that child was negative." And the mother is positive. It's so funny, after this, the father [...] came for the blood test. He is negative. Is only mother is positive. That's why I say it's very difficult again. Again, is very difficult, because if you can say, boyfriend is negative, child is negative, mother is positive. Again is... mm. It's very difficult.

Three counsellors said how, in such an instance, the couple doesn't understand why the one partner can be negative, when the other partner is positive, and the counsellor finds that she has no adequate explanation, because she doesn't fully understand it herself:

Participant C (focus group 3): And also usually they don't accept that they are positive, because of the partner is negative: "how can I be positive, but my husband, or my boyfriend is negative?" So, it's difficult... They need to educate. And they need explanation. You have to explain to them why this is happening, and then, I don't think

I have enough explanation, because I don't know by which [*inaudible*] or whatever, what's going on, what is really going on. I also need to know that, because they need explanation. So, it's not easy for them to accept their status, if they are not the same.

Participant B (focus group 2): I ask [the doctor] that question, if the man is tested negative, and the female is tested positive, and he said sometimes, he talked about the cells, sometimes the cells is like this, then the virus can't go through like this, and sometimes the cells is like that. So, I couldn't ask/

Participant D (focus group 2): /It was very technical [*laughs*] Then, you have to explain that to the clients, then the clients will not understand what you are talking about, because it's very technical, so - and you're not a hundred percent sure that it's what's going on.

Things can become very difficult for the counsellor when he or she is counselling sero-disconcordant couples separately, and confidentiality restricts the counsellor. Case Study 1 provides a moving account of a counsellor's struggle with a sero-disconcordant couple.

CASE STUDY 1

Here the counsellor (respondent 8) talks about a case that was especially difficult for her. She was counselling a couple, separately, that was sero-disconcordant. The positive partner had not disclosed her status. Due to confidentiality, the counsellor had to sit by and watch over a period of two years, until the husband became infected. This had a huge impact on the counsellor, causing much anxiety and distress. The counsellor struggled with her own feelings of helplessness, anger and blame towards the HIV positive client guilt and anxiety of potentially harming someone (The HIV negative partner). The counsellor discusses how sharing the problem with her supervisor helped her cope with some of the guilt that she felt.

Respondent 8: people who don't disclose their statuses to their partners. Ja, it is difficult for me, because I cannot disclose their status to their partners, so - for instance I've got a case of a lady... and she was diagnosed in 2000... Married [...] she came in for counselling and test, and then she was positive. What she first said to me is that her husband drinks a lot and he goes out at night, and now he's got an STI [*sexually transmitted infection*]. Okay. So I ask her to tell the man to come in for a test, for a counselling test. And he came in. And he was negative. She was positive. Okay... so, she refused to tell him... So, it was difficult for me. I couldn't tell him! She has to be the one to disclose her status to him! I mean, that was her husband. So this went on for some time - every time then she come to the clinic, I used to ask her if she's told the husband already, and she says "No, I'm afraid, because he drinks a lot and he gets aggressive, so I've got no way of telling him." And then I ask her if she uses safer sex: "No I can't, because what would I say to him, all of a sudden if I use a condom?" This went on. And then at one time, I recalled the man, then I told him that he is in the window period. And then after about six months I called him for another test and he was still negative. And the lady still didn't disclose the status to him. And then I had a talk with my supervisor. I told my supervisor about it, because I was getting worried now! Because she kept on refusing to

tell him! And anyway that at one time or other he will be infected. And I talked to my supervisor, and then she said she will talk to the doctor, to the HIV doctor, Dr _____, so that threaten her with telling her husband. Because at one time when I ask her, she said, "Oh, I don't need to disclose to him anymore - he's also positive!". I mean, that was... doing it deliberately. I mean, I was in a... difficult situation... and then ... this part of that confidentiality - the difficult part of that confidentiality issue. Anyway... Last year, eventually she told, she came out, she told me how she was infected - she had a secret partner. So, she must have been infected by that partner. And then last year, he came in for another test, and he was positive - that's the husband. Even then we couldn't say to him "It must have been your, your wife". So you see [...] I feel so bad about it. I really felt, felt very, very bad about it. But, um... anyway, I had told my supervisor about it, so... Mm... I had told my supervisor, so they knew about it, they knew about my situation.

Interviewer: And telling the supervisor - did that help you?

Respondent: Well, in a way it do - it eased of my, my guilt feelings.

Interviewer: Did you feel guilty?

Respondent: Yes I did! I really felt guilty! I felt I should have told him, but how could I break the confidentiality issue?

Interviewer: Did that make you feel helpless?

Respondent: Ja. A lot... it makes me feel, made me feel so helpless.

Interviewer: /How do you, how do you cope with that? Because it seemed to go on for a very long time, trying to, to encourage her to disclose. How do you cope with that?

Respondent: okay, it was to telling (name) about it, at least she eased of my conscience. She told me, she told me it's not my fault. It wasn't my fault right from the beginning. I mean... there was nothing I could do about it.

Interviewer: Did you blame yourself for him being positive?

Respondent: Ja, in a way I did, because... I thought I should have broken that confidentiality... I felt I should have. But, how could I?

Interviewer: How do you feel about that case now?

Respondent: Well at least now I feel better, because the husband, he has accepted his status, and he goes regularly to the clinic, because for his medication, and he's coping.

Interviewer: How did you feel towards the wife?

Respondent: Very angry!

Interviewer: Very angry?

Respondent: Mm. Very, very angry! She shouldn't have done that! In the first place, it wasn't his fault. She had someone else, and she was married with - she had this... person. She's been married for two, three years. And right from the beginning she had this secret person, this other partner. So, that is what I ask, "Did you really love your husband before you got married to him, because if you loved your husband, you wouldn't have had someone else. Why did you get married to your husband?" Well, she didn't have an answer to that. So, those are some of the difficult things that we have to go through.

Interviewer: The anger you felt towards her - how did you deal with that, with your own anger?

Respondent: No, I haven't really dealt with it, because I still think that she's responsible for condition.

Interviewer: You're still angry?

Respondent: Ja! Though I know now she's helpless, because I mean, shame, she's very ill now, but I still feel that she shouldn't have done that... I mean, it was deliberate! ... I'm still not through with it. I'm still really angry with her.

3.2.2 Counsellor Difficulties:

Counsellor's anxieties:

Case Study 1 provides an example of the anxieties that a demanding job like HIV/AIDS counselling can raise for the counsellor. In case study 1, the counsellor has to deal with her own emotional struggles involving anxiety, guilt, helplessness, and anger.

The often distressing aspect of HIV and AIDS, arouses anxieties in the counsellor with regards to his or her capacity for repair and damage. One counsellor spoke of how a negative testing is almost a rewarding experience, and the counsellor feels that her job has been well done. However, a client who tests positive, often arouses anxiety in the counsellor of whether she did something wrong.

Respondent 3: Nice counselling - I can say, It's nice to me especially if people are negative, like Oh!... feeling happy. If our people are negative then I tell myself "Oh my, at least I'm doing my job". It is as if it seems to me that if people are HIV positive, I don't do my job [laughs]. Then if people are negative I say, "I know, I'm happy, I do my job". [...] Like, sometimes it seems as if most of the people are HIV positive - it seem as if "No, man. I didn't do my job" I didn't, like - it seems as if there's something that I didn't do, you know... Like, I didn't tell them about this condom.

One counsellor says that she gets clients who come for ongoing counselling, and continue to not use condoms. Similarly, this arouses anxiety in the counsellor that she is not doing her job properly:

Participant B (focus group 2): to see the clients making the same mistake, like you told her that, you don't say she mustn't get pregnant again, you just telling her about the disadvantages of getting pregnant. And you see that the client is pregnant again. So, sometimes you started to be angry, because you've told her, and the time she staying with this virus inside, the virus is starting to grow and grow. Maybe the time that she going to get pregnant again, maybe the virus is increasing. So you don't know how are the chances of the babies to get infected. So, you thinking about this child, and the mother who's doing the same mistake, you see. So, it makes my work very hard, because it's like I'm not doing my job, although I did, I do my job, but if the client do that mistake again, then you feel that it's like I'm not doing my job, you see.

Ultimately, because there is currently no cure for HIV and AIDS, the counsellor will eventually be counselling a dying patient. With ongoing counselling an intimate relationship has been developed between the counsellor and client. The fact that there is no cure means that the clients condition and problem effectively does not change. This can arouse anxious feelings of helplessness in the counsellor as demonstrated in Case Study 2 below. This case study reveals the loss felt by the counsellor when the client dies, and the helplessness felt in

counselling a patient whose "problem" will not change. The counsellor puts this feeling of helplessness very clearly when she says "what I did is just to talk; nothing else", which gives this thesis its title.

CASE STUDY 2:

A counsellor in focus group 1 clearly tells of the difficulty facing the counsellors when working with people who are HIV positive or have AIDS. At the end of the day, they are counselling people who have a disease for which there is no cure. This raises feelings of helplessness and anxiety due to their inability to save the clients or do anything to cure them. The counsellor uses her religious beliefs of the will of God as a strategy of explanation, and a means to give the client hope and strength to face their situation. The counsellor talks about how they are personally affected by the feelings of lose when clients die.

Participant E (focus group 1): What I'm doing is the counselling for people who are HIV. It's not easy. It's very difficult. What's difficult, we just counsel all this. As a counsellor, I supposed to counsel, and the client go further to the doctors and everything But what is difficult, there's no cure for that. If a client is HIV, there's nothing else we can do. And to me as a counsellor, I build a bond with this client, and then the time this client die, I feel the bond is finish, and what I did is just to talk, nothing else. So, is very difficult. And now is a lot of orphans. Like the children who have got no mothers. And there's a lot of people, they are dying a lot, especially in the winter time. I don't know what's happening. Even now I just lost one of them. I talked with her last, in the treatment room, and the problem was that the family don't accept the, ja, they don't accept what is... they don't want even to hear about the HIV and AIDS. And they want to send him to Transkei. And the Transkei, the people don't know nothing about that. There's no treatment, nothing. She shared me that. She tell me about that, and then really on Sunday afternoon, she died, she passed away. So, as a counsellor; Ja, I did my job, but... where's the cure! Then you just feel helpless.

Interviewer: You can't save them

Participant E: Ja... Ja. So, really is not easy. Is not easy what we are doing. It's not easy... and we supposed to run even the support group. At support group, is not the people are healthy, is the people who are sick. It's not all are healthy, they are sick. And, is not easy to talk about HIV. Some they don't understand clearly what is it. Because if the client you ask, "What is HIV? What is AIDS?" - they say, "No, this is AIDS." If you try to make it clear, first is the HIV, if you are HIV you don't have AIDS. HIV is a virus. They don't want to - they can hear in front of you, but even you are the counsellor, they just ask you a difficult question, "Okay. I've got AIDS. So, how long I'm going to stay? How many years?" As a counsellor, we can't count the years, because we are not the God, is only God who knows what's happening. But you give that hope, but at the same time you feel inside, "this disease is dangerous, she or he is going to die" [...] They want an answer from me. As a result I haven't got an answer, because I'm not a god. Even the doctor they don't know the days of the client, or the patient, what days they going to survive. So, I'm always honest to them, and then I told them, "No, I can't say how many, but is God who knows. Because God on that time he gave you birth, the death was there already. So, nobody knows." So, I mean is a pain, because you are a human being. A counsellor is a human being. Immediately ask you that - he have got that helpless, he feel downs. He don't know what's going on. And as a counsellor, before this client leave, you must give a hope, a strength. Some they touch you, because even our

families, some of our sisters they passed away because of this. So, somehow you are a counsellor, but, the pain is always there.

Interviewer: It's personal as well.

Participant E: Ja. That's it! That's it! So, we try, but is not easy, it's very difficult.

Interviewer: Does everyone experience the same sort of thing?

Participant C (focus group 1): Yes...we do this HIV and AIDS counselling, but when it comes you lose... somebody, I remember, it's three weeks back, when the client came in our room, and then I talk to her, "I want to - give me your child." And that child, she was having a thrush inside. And that child she was [*inaudible*] of breath. [...] The way the HIV, the things he's doing on, in the person; I was feel so bad on that day. I was stressed I didn't cope, I'm just crying, because I was thinking back the time this child suffering, because that child she was suffering from the birth. Now she is nine month. How long that period, having the pains. Unfortunately she was died [...]

Participant E: that child was in my office, it looked like an old man. Just like a skeleton, if you check. It's not even, you can say is a human being, is just look like somebody who's passed away already, is dead. [...] if you deal with that people, you always have that dreams, or that vision, if you stay alone [...]

Participant E: So, that's why I say, really, is going further, and I don't know why there's no strong action really. I don't know. Because we as a counsellor- people, people they are now going to die. The infected ones, they going to die, but we are affected! No matter we are not infected, but we are affected. Because if the person die, there is that pain you get!

Participant A (focus group 1): and to add more, you end up... you feel that you are not doing your job, because when you lost one of your patient, you feel the pain -You ask you a question, "What can I do? What I'm doing wrong?"

As case study 2 demonstrates, the helplessness that the counsellor feels, and her inability to change things and to "save" the client, also arouses anxieties of ones capacity to do harm, and of having failed. This is felt more strongly, if there is a sense of there still being some 'unfinished business' with the client:

Respondent 3: it was a lady - she came to me. She was HIV positive- she diagnosed five years back, I think so, and then she said to me "Okay, I am HIV positive. So, what I would like to do, I would like to tell my daughter that I'm HIV positive. But the problem is I did tell her - my daughter and my husband but it's just that they don't want to accept that I'm HIV positive. And I can feel it - I'm weak now. And I'm dying, you know. So, please help me. I want you to do that for me. Please tell them." [...] It was Thursday the lady came to me. And then Monday...because I did make arrangement with the lady that, okay, fine, "Friday I'm gonna ask, next Friday I'm gonna ask my daughter to come to you." Okay. I told myself that I'm gonna educate her daughter. So, unfortunately, um... heard that she died, you know... I was worried, you know. I was worried as a result the head daughter didn't come... I was worried... Because she was weak, really. She was weak. She was weak... she was bad - I was assessing her - I think she was in stage four [...] For me, it was difficult, like - it haunts me! It haunts me as a result of - I did say this to my psychologist - It haunts me really, because I was waiting for her daughter to come to me. Like, it seem as if she died not knowing what happened to her mum. And if she did come to me, I think it was going to be better, because, I think - it's whereby that I was going to tell her that "Please do something about your mum - take your mum to Chapel Street to find

treatment", you know. Because it seems as if she didn't take her treatment anymore... It was bad, really. It was bad.

Countertransference and Boundaries:

Case Study 2 also demonstrates the difficulty of maintaining boundaries when HIV and AIDS have personally affected counsellors. There seems to be an awareness amongst the counsellors of the importance of dealing with issues of countertransference and maintaining boundaries in the therapeutic relationship.

Respondent 2: That to hear the peoples' problems. And you want to help them, but you can't... Some of them you wish to be nearer to them. To share your love with them. Most of the time. But you can't, because you must have a distance with the client. Like, you can help the client, but she must not be your friend. She must know that you are her counsellor, not a friend.

Respondent 12: I think counselling it is not affect my life, because when I'm doing counselling you, if you are a counsellor, you must have a wall between you and the problem of the people. Don't take the problem to add to you, because their problem is working to you, if you take it. Do the problem at that time, and you finish. Don't take to you. And then you must have a boundary there between you. Because if you do, you are going to burn out...

However, boundaries are not easy to maintain, and two counsellors talk about how they worry about some of their clients, after the counselling session is over. In addition, the counsellor's own ideas about what is "right" and "wrong", makes the client worry about the client who is doing or thinking something that is different to the counsellor's ideas

Respondent 3: especially when the client is HIV positive, and she is telling me about her background - like, let's say she said to me "I can't believe this. That I am HIV positive, because I've got this boyfriend for years", you know, it worries me! You know, because I do understand that don't - like, I've got something in my mind, like, don't trust a man. I always - Like, it's difficult really if you say to the people, "You should have used condom!"... I mean it's too late now, you know. [...] Ja, it worries me, because, she didn't think that this boyfriend, like, he's sleeping around you know... she thought she was, he was in love with her, and that's why I said to them... I mean... you must look around as a human being - don't just tell yourself "I've got this boyfriend, and I'm staying with this boyfriend." Tell yourself that you're gonna use a condom. At least if you use a condom, you know that "I'm safe".

Participant D (focus group 1): What is bad about all this, because I'm working at an STD clinic, and a lot of people go there, thinking that this clinic is unique. And, when they are there, when I give some education, they decide to have a test, and what happening is very bad for me, because you build a good relationship with a person, and you contain this person, and then you counsel this person, and then he accepts, and then he writes up a consent form, and then after being tested, you refer, because is

a STD clinic. So, after then, you missing this person, you know. You think, "No, I've given the results. Where is he going to now? Who is going to contain him, or, you know? You think about those things. That is where it is bad.

Countertransference and boundaries, are addressed in Lifeline's training courses, and is the purpose of the Personal Growth Course, where the counsellors' past issues and experiences are worked through. Unresolved issues in the counsellors' past can be present in the counselling relationship, when the clients' experiences arouse unresolved issues and anxieties in the counsellor. Ten counsellors expressed some awareness of this:

Respondent 6: Like some cases that you come across in the counselling field, can be the reflection of what happened to you. So, if you go, undergo the training, then... you know what to expect, and you know what to do, when you come across that... that aspect. So, you will be ready for whatever will come, even if it relates to what you've gone through or not, you will be ready for it.

Respondent 11: So, that's why before you go for counselling, you must actually know that you've dealt with your problem, so that if you meet someone with a same problem that you had, you should actually have to be able to counsel the person. Because, if you haven't dealt with that problem, by the time that person tells you about his or her problem, then you will start maybe crying, referring back to what you have in you

Respondent 13: Because you can never be a counsellor, if you don't deal with your burden. You must, because if you were raped, for instance, you will come across with someone who was raped. Then it, instead of counselling that person now, then it's gonna be another, it will remind you of your case, and then you are gonna cry with that person. Then you are not helpful. You need to deal with it.

However, sometimes past experiences can become involved in the counselling situation unconsciously, as demonstrated by Case Study 3:

CASE STUDY 3:

Respondent 2 provides an example of how past experiences can impact on the counselling situation psychodynamically. The respondents experiences of the past, shape how she finds certain counselling experiences difficult, which raises her anxiety, and result in anger and frustration.

The respondent relates how her childhood hardships and marital problems led her to come to Lifeline to become a counsellor:

Before I was at school I thought that maybe I would be a nurse or a social worker. It's the way I've grown up. My father was drinking a lot. He used to beat my mom, and then... we grow up in that situation. And then what I was thinking... that time I was so young... I was thinking that maybe this thing can be solved, but I was so young I didn't know anything about the organisation where to go. Then, I thought on the back of my mind "This thing can be solved" But I don't know how - because I was hating the way I was growing up [...] And then I got married... and my marriage situation, which was not fine - it was not okay - there were problems. [...] And then I decided that Let me take my goals - I aim to be a social worker or a nurse [...] and then - I had a friend, who passed to be a social worker, and then I went to her "man, I want to be something like social worker or a nurse, but I've got this standard nine", and she said " no, just go to this Lifeline then, I think there will be something".

Later, when describing what a difficult counselling session is, she explains:

Ja, when the marriage it's broken down... the marriage is splitting because of this HIV... and there are kids in between. Now these parents are fighting each other. The one is saying, "You brought me this HIV." And the one is saying: "You brought me this HIV." Just have a look - these kids are hearing those stories, because... it doesn't end in the bedroom, it goes out in the dining room, the kids are watching the TV and they are hearing this shouting of HIV... and then... it goes and goes, and then they split together or they fight each other in front of the kids. - how are these kids going to grow up? And what's going on with their lives? [...] in front of these kids. It hurts me a lot. And it's where I become very angry, because I felt as if I didn't do it well. [...] Ja. To see this family is splitting now because of this HIV [...] He feels as if "I am not having HIV", but he didn't go for a testing [...] he is treating her as if... he is not a wife any more. Ja, I don't like that at all. I don't like it. It makes me angry because... the guy maybe he was loving the partner, but for the sake now the partner is sick... he seems as if he don't want her anymore. Ja, and it's what I'm thinking I, I feel angry. I feel angry really...it's that I can do something! I can do something! Just to open that guys eyes. That "Whether you wife is positive, she is there and she is still your wife... You have said in front of the people, in front of the priest that "I will do"... in sickness, in health, and in everything: "I will do". But now it comes to the stage of sickness, and you reject her!... And she didn't mean to be HIV. She didn't go and buy HIV...And what make me more angry, is that this guy maybe haven't even tested... or he has tested and he has just keep quiet - not telling the wife that "I went for a test, and then I found out that I'm positive"... until it became, the wife became ill and she went for a test...

Maintaining boundaries becomes difficult when the counsellor knows the client:

Respondent 11: Sometimes it's strenuous. Cause I once had... someone came into the clinic that I know. We use to go to school together. But I couldn't recognise her at that time. She came with a TB case and HIV case. And then she called me, and then I, [*inaudible*] and also I could slightly recognise her. Fortunately she was with her brother, and then I saw the brother and then I say, "Oh okay, she -" and then we chat with her brother. And on her second visit, the brother came to the clinic, and asked me to organise a wheelchair for her, because her sister couldn't walk. So, when I saw her, I was, like... I was... scared. Because especially if you've been with, if you know a person, and then a person, after a year or two, it was after a year actually. And the now she's coming very, very sick and I was scared. We thought, it was because she's sick of this, so I'm also gonna be, just sick like her. And then I just told them at the

clinic, that "guys, if a client comes in now, I'm not ready to see that person. If you could just say to that person, 'you must come back at this time'". I was so depressed... So, I couldn't, like... I couldn't, like, be able to see anyone at that point in time. But, I just took a break, and then put myself together, then I went... I talked to her. Fortunately for me I hadn't any clients for that, at that time.

Respondent 11 above, did not clarify whether she counselled the client or not, but nevertheless she was personally affected by her presence that she was unable to counsel anyone after that. Another counsellor said how she does not counsel people that she knows, because of the problems this might cause.

Respondent 14: Or else you get to meet someone who knows you just because I stay here around Khayelitsha. So, I don't usually counsel people who I know. Usually I refer them to another counsellor, because they won't open up fully. And also they won't trust you just because they know you from school, or grew with you, and analyse what you know, what can you do. Ja, to somebody else, because I also won't feel comfortable, you know. And I know that person won't feel comfortable. [...] So, the people who really know me, I don't think I will be able to counsel, because each and every time they will look at me in the street and think that I will talk about them behind there back.

Clients, as well as the counsellors, come from Khayelitsha, and other impoverished areas. Many clients face other problems besides being HIV positive, such as unemployment, homelessness, and hunger. Six counsellors mentioned that clients come to the counsellor expecting material help from her. One counsellor spoke of the anxiety this causes for her, because she is unable to help them:

Respondent 2: I think some of them when they come to me they expect me to do something. But, you do give that support, but not very deep, deep, deep down. Like to give them financial - where am I going to get the money to support a person? Where am I going to get the shelter? To get that child - maybe she's eighteen years, she has been rejected by the family - where is she going to stay? And who is going to support her? She needs someone who is going to support her... when she came to me she thought that maybe I would do something... but I can't! Where am I going to get the shelter, where am I going to get the money to support that child? Maybe she has got - maybe she is thinking to go back to school - who is going to support her to go back to school? And maybe her CD4 count doesn't go that she must get a grant... even whether she can get the grant, she will wait for about three months before getting the grant, by that three months where is she living? You see? So it goes - it hurts me! Ja, it hurts me a lot. When it comes to those problems... When it's counselling, yes, it's okay, but when it comes to those problems, it stresses a lot.

Three counsellors mentioned instances of doing more than what their job as counsellors require, in an effort to help the client with his or her material problems:

Respondent 2: Then it's whereby I must contact to a NGO, other NGOs, that "I've got this person, she's so-and-so, and she is, she is HIV positive, and she was living in this family, now they are rejecting her. So, have you got a place for her?" - And then fortunately we are working hand-in-hand with missionary charity - there are school kids there, and they support them with the uniforms, with the books, with the school funds.

Respondent 13: There was someone who was in tears. Who came. She said to me, she has this insurance from 1998 from Old Mutual [...] They deducted the money till this year. So, this year [...] She wanted to increase the amount that she was going to get when she, the mother dies, this year. And also to register the child's name. [...] So, she phoned her broker. The broker said to her she must go to her doctor. So, when she goes to her doctor, she receives a letter that says, without being tested now [...] from that doctor, she received a letter that is from Old Mutual, a letter that states that she is HIV positive, so at this point in time - I read it. It says, there is a part that says there on the letter - at this point in time they are unable to - she's uninsurable [...] So, now what the doctor advised her to go to do another test now. [...] So, apparently the doctor told her that "You are HIV positive." [...] So she said to the doctor, "No, I don't believe this, this whole thing. I don't believe because ever since I applied for insurance, I had one person, and he's faithful to me. It's still the same person. So, I don't believe the whole thing. So, I was now satisfied myself by going to another place, of my own." Then that's how she got [to me...] So I counselled her, and we tested her. The results were positive. [...] Now, looking at that case, though it's an HIV thing, it needed to be referred somewhere. Because now there was going to be a law of her money. Remember, the money's been, has been deducted since 98. This is 2002. [...] I didn't take it, because she was in tears, and she was not okay to get out of the door, and I [*inaudible*] and everything, so. I said to her, "Once we get a break, I will go around the corner, there is a place that [...] is dealing with people's rights, those who are HIV positive. So, I went there. So, I talked to a lady there. I identified this issue, then she phoned another lady in East London, so I spoke to that one in East London, and telling about this issue. So, she said to me [...] "We need to get the contract [...] And find out if the policy is excluding the HIV thing [...] if it excludes that, they need to fight for her [...] and also they are going to assist her to get all the money, to be refunded." [...] I can say it was a difficult case, because... that's not my part to... to play that, to go about the insurance thing, but it is as - what I've just said, I cannot leave the person alone like that. I felt I can stand up for her.

One counsellor refers the client to someone that can help with material help:

Respondent 11: They expect, some of them if they don't have any places to stay. Like, they... the other guy came to me, and then he wanted to go and tell his family in Durbanville about his HIV status. So, he didn't have any money to go and tell them. So, he expected me to give him some money, organising place of shelter, because he's staying in another shelter, but during the day outside, he can only go there at night. So, also maybe food parcels. So, from there, I have to explain to the person, that "the social worker deals with this. And come on this day, the social worker will be here."

Giving 'bad news':

Nine counsellors spoke of how difficult it is of having tell a client that he or she is HIV positive. The counsellors say how they find it draining and stressful, especially when there are many HIV positive clients in one day. By contrast, telling someone that he or she is HIV negative is easier for the counsellor.

Respondent 1: No, it's not easy! Because, when you tell somebody that he or she is terminally ill, then it's not easy.

Respondent 1: it's not so easy when you have positive, like 2 or 3 clients in succession positive, then you feel... "What a day!" - I don't know how you feel like that, because you are not supposed to be emotionally involved, but you feel that this was a difficult day for me. Ja, you feel stressed out then.

Respondent 8: [*What is it like to give someone their results?*] Mm... positive results?... it's very, very devastating. Though we have to be direct. We have to be direct, and you don't have to, you... one shouldn't show any emotion. Like, sometimes they will cry. Sometimes they will rave and go on - you have to be cool. Cool, but accommodating

Respondent 13: Early this year, when I started to give results of people, to give positive results [...] I was not used in giving positive results. That was my first experience. That was the reason. It was my first experience, and I had people who were just cry, cry, and I had a lot of number of HIV positive. On my first day, I had five. So, one was just negative. I had five. So much I just needed a break, and I asked the sister to go home. At home I just slept. I did not eat. because it was really, it was starting to be a real thing to me. Because when you study about a things, it is a theory, but when it's practical then it's the real thing, because you can see it [...] my shoulders! Whew! It was like [laughs] I was carrying a big bag [laughs]. Heavy bag in my shoulders. And I was so stiff! And I was uptight, and I was tense! I was tense!

Respondent 16: sometimes, I just become exhausted, and sometimes I become stressful. Ja. If, say for instance, if the day I've got three clients, and they were all HIV positive, I do get exhausted and also stressful, because, ja, it stress me a lot, you know. When maybe the day you get three of them, HIV positive. Ja, sometimes is very difficult. I mean you reflect the feelings of the client and all those things.

Negative attitudes towards client:

Sometimes, the unconscious and conscious anxieties discussed above can result in the counsellor having negative feelings towards the client, as the counsellor projects her own negative affective state. Case Study 1 above, provides an example, where the clients refusal to disclose her HIV status to her husband, made the counsellor feel anger towards her, the client:

Respondent 8: I still feel that she shouldn't have done that...I mean, it was deliberate! ... I'm still not through with it. I'm still really angry with her.

Another counsellor talks of the anger she felt towards a mother who had refused to take anti-retroviral treatment, and her baby had died of AIDS:

Respondent 15: Again, it's very difficult. Because once, you can see easily that child, when, after the birth of the baby, when it's growing, when the mother come to the clinic for the first day. You can see straight away, this child, maybe there is something wrong, because you can ask the mother - "No, I didn't go and take the results. That means I didn't get the AZT" - "Did you get the AZT?" - "No." - "Did you get the Nevirapine?" - "No, I didn't get Nevirapine [*inaudible*]" But you won't say nothing, because you are a counsellor. You are not allowed to say, "Why!" Then you can keep quiet. But after nine months when you tell this child, when you find out this child is positive - which is not fair, it's positive, because you can see straight away her mother refused to take the results, and if she refused to take the results, she can't get the AZT or the Nevirapine, because she refused everything, you know.

Another counsellor speaks of feeling angry towards a client who continues to not use condoms:

Participant B (focus group 2): I think, to see the clients making the same mistake, like you told her that, you don't say she mustn't get pregnant again, you just telling her about the disadvantages of getting pregnant, you see. And you see that the client is pregnant again. So, sometimes you started to be angry, because you've told her

A young female counsellor recalls an older male client who treated her and spoke to her with disrespect because she was a younger woman. The counsellor judged the client negatively as a result.

Respondent 14: Okay, well I judged him, I must say. I just told myself "Ooh, this is a very typical black person. I'm sure he's not really use to talking to women, and I'm this young lady in front of him trying to telling him about life", you know. So, that's where the first impression - I told myself, "Okay, let me just relax, and try to give him the respect he wants me to give". Because if I'm this young, and he's that old, he expect me to be under him. So, I lowered myself a bit, trying to fit his shoes so that I can be able to give him what I wanted to do - at least the information, if he's not willing to talk about his life. [...] Maybe if I was a man, it would have been very different. I think so. That's why I said he's a very typical black man, because those people, the woman's place is in the kitchen. So, that's the impression I got really, the way he treated me, you know

Counsellor's HIV status:

The counsellors were not asked about their own HIV status, but one counsellor disclosed her HIV positive status during the interview. Her status and how it may impact in her job as counsellor was discussed in the interview. The counsellor felt that her own positive status was not a difficulty in her job as counsellor, but rather a help or an 'asset':

Respondent 16: Well, it helps a lot, it does, I'm - in the first, I'm a role model to the other people in the community. That this person is HIV positive, and she's living positively, and you know, she's a young, normal person, you know. There's nothing wrong with her. So, they do copy from me, you know, the style of living with HIV. Ja, it helps a lot.

The counsellor did recognise the potential for her own status to become an issue in terms of countertransference, but felt that it was an issue she had dealt with in her training to become a counsellor:

Respondent 16: Because sometimes you might find the client that have the same problem. Like, the serious problem to me, is to find out I'm HIV positive. Ja... but I took, I did cope with it up to now. But, when a client comes up and say a serious problem like that, that doesn't strike to me because I did share it here.

However, there may be unconscious processes that take place as a result of her positive status, as implied when she talks of how stressful it is to counsel clients who have tested positive:

Respondent 16: sometimes, I just become exhausted, and sometimes I become stressful. If, say for instance, if the day I've got three clients, and they were all HIV positive, I do get exhausted and also stressful, because, it stress me a lot, you know. When maybe the day you get three of them, HIV positive. Sometimes is very difficult. I mean you reflect the feelings of the client and all those things. Is the feelings, and how is she feeling.

Respondent 16: usually it happens because it is the way I reflect their feelings, you know, and some of them you find that they're crying, you know, and you need to talk to them properly, and all those things.[...] But, it does something to me, because, ja, sometimes I just become stressful.

However, the counsellors mainly come from Khayelitsha, an area with high rates of HIV infection. It is likely that people they know well have been infected with HIV, or have died of AIDS, as stated in Case Study 2:

Participant E (focus group 1): So, I mean is a pain, because you are a human being. A counsellor is a human being. Immediately ask you that - he have got that helpless, he feel downs. He don't know what's going on. And as a counsellor, before this client leave, you must give a hope, a strength. Some they touch you, because even our families, some of our sisters they passed away because of this. So, somehow you are a counsellor, but, the pain is always there.

Two counsellors mentioned that some people assume that they are HIV positive, because they are HIV counsellors:

Respondent 11: But other people that know me as an AIDS counsellor, they take it as, like, if I'm working with people living with AIDS, and then I must also be HIV positive. Because you can't be dealing with, if you are an, they take it as if you are an HIV and AIDS counsellor, then they believe that you are always counselling people, giving them hope, because you are also living with the virus.

Respondent 13: my father last year said to me...Now that I'm a HIV counsellor, or I'm starting about HIV, he said to me..." Did I ever test myself?" So, I felt, I didn't feel okay a few minutes, but I knew that was a lack of education also. So, I'm okay with that. No, because my father, I thought, he thought, he used to think that... with order for you to do presentation or to talk about HIV, you need to someone who's HIV negative [*positive*].

Concern for safety:

As already shown above, only two counsellors stated that their clients have threatened them.

This made them feel concerned for what might happen, and for their safety:

Participant B (focus group 3): I did last year counsel a man, and he threatened me, before I give him the results. And he said, "If I'm HIV positive, I don't know what I will do to you." I said, "No. I'm not the cause of that." But, unfortunately he was negative, so I don't know what will happened if he was positive. [...] And my colleague, the other - it was not a man, it was a woman. She said to me, "If I'm HIV positive, I will hurt you." But, she was positive. She didn't do anything.

Respondent 6: And when I met her in Site C, she told me that "I am going to arrest you! You said I'm positive! So, I am going to arrest you!" So I felt.... I wasn't sure how to respond to that [...] It was offending I suppose. It was offending because... I was, what I thought was I wonder what would other people think, because she was with one guy... but the guy was busy talking to someone else - but I was concerned, more concerned with other people which might be listening to her.

Respondent 6 later stated how the husbands of clients react negatively to their wife's positive diagnosis, and the counsellor fears that, if she should bump into that husband in the street, that his anger might lead him to do something:

Respondent 6: the behaviour from, because especially in the male partners, because when I was in the MTCT program, when the women gets tested and she test positive, then we would encourage them to bring over their male partners. Then the behaviour of the male partner when he finds out what is happening with his wife, started doing, like, some do accept their wife's status, and wanted to test. And some doesn't even want to listen! The only time which you will stop talking with that one you tell when maybe her partner told him that, or tell someone that "I'm HIV positive", then he will just rise up. So it will remain to be a difficult situation...in that situation. You don't know what he will think of you when he meets or she meets you in the township. [...] Nothing has been reported which has been done by - but I'm just thinking because of, because from the way which that person behaves. So, from that... ja, from his

behaviour you can tell that "Oh, maybe -", but nothing has been reported. But it's just that you cannot underestimate the person.

Another counsellor implied that she felt concerned for her safety, when counselling men on her own. The counsellor struggled somewhat with talking in English, so this is not clearly stated. She does however mention that the door is closed, and she is alone with a man, and he [the counsellor says "she", most probably meaning "he", as she is referring to men] can "put anything in front of you".

Respondent 12: is not like a mother, the man. Mm. Because you close the door, you are with this one, the [inaudible] is [inaudible], and she, she put anything in front of you. So there is that. Is not happening, but you think, you suppose to do this, please, must please, if the - they don't really reaction of this.

This was also, more explicitly mentioned by another counsellor in a focus group interview. A male client had in the past, threatened this counsellor, thus probably making her more cautious.

Participant B (focus group 3): sometimes when you counsel a man, you must be... aware. You mustn't lock the door. Especially when you give the man the results of positive. Then he can do anything to you. So, you must always be aware.

Another counsellor expresses her concern for her safety with regards to her health, and possible infection from infected blood samples, and close proximity to sick patients:

Respondent 13: I would say, the worst thing it is for you to be careful about the blood when you are giving the results. Not to touch the test, because you can be infected. It's just that you need to be forward, accurate, careful about yourself. Even with talking to them, you can be infected with TB. These people can be sick. These people can be sick. You can contract germs and everything. Other infections, because there are those who got mouth infections as well, and when you talking to them, you got to sit like this. You sit very close. You need - that's the law of counselling - you need to sit close. But check that, you need to check that, you need to be vigilant.

Not being appreciated or given due recognition:

One of the counsellors mentioned that one of the worse parts of counselling is that the counsellor feels that he or she is not always appreciated and thanked by their clients:

Respondent 6: And I think the worst part of being a counsellor, well ... is you don't always get.... appreciation. [...]Yes, not all of your clients can come back to you after they have solved their problems to be thankful to you.

By contrast, eight counsellors acknowledge how good it is to have their clients appreciate what the counsellors have done, and thank them for their help:

Respondent 5: *Nice counselling is, miskien as jy iemand kry, sy het eers gehuil wanneer jy saam met haar gekry het eerste keer. Dan gaan sy, en sy terug kom, en sy kom reg. En dan as sy vir jou sien, en waai, en vra hoe gaan dit, of so. Dan voel ek baie gelukkig. [Translation: Nice counselling is, maybe if you get someone, she cried when you were together for the first time. Then she goes, and she comes back, and she is fine. Then, if she sees you, she waves and asks you how you are, and so on. Then I feel very happy.]*

Respondent 10: is where I see the people, we are helping people, when they come back, with their partners. And sometimes the employer phone me that, "At least, (name), you have helped us." Sometimes they phone, but "Oh... at least my relationship is good now. It's better... Yes" And then I also feel good. Even when the schoolteachers phone us - some did give feedback, some they don't. So that makes us good.

Participant E (focus group 2): Noticing that you are being noticed by the client that you are working with, because even if you are in town, you find that, "(name)!" You know. That makes you happy. And that makes you proud of knowing that I've done something, even if I didn't notice. Sometimes when you are doing counselling, it's not easy for you to notice that I've done something to this person. But, as soon as you see this person saying "Hi, (name)!" then you know... That also makes work easier for you, and also makes you to want you to do more.

One counsellor stated very clearly in a focus group interview, that the only thing that mattered was the thanks from the clients and others, for the job that she does:

Participant E (focus group 1): there's little things can make us happy. We are not happy anymore, but we are working because we get the salary at the month end, but we facing the difficulties. So, to say really there's few things who can make you happy. Like, what make us happy, is the clients. Finish and *klaar* [translation: finished]. Otherwise when you go back to my salary, even my salary is far away from the job I'm doing. So, there's nothing can make us happy, without that thanks from that people. That's all!

Four other counsellors felt that they, as counsellors, are not given the due recognition and appreciation for their work, from others, particularly the government:

Respondent 16: Counsellors are working hard. Counsellors are doing a huge job in the clinic. Of giving the people the counselling. It's a huge thing. Ja, we need to be raised up, you know, about our job. It's a great job. To be raised up. That it's a great job. In fact, I need to go, I just need to go forward with it, you know. [...] Is a great thing. Especially to the department of health. It should be appreciated.

Interviewer: Do you find that your work is not appreciated?

Respondent 16: I mean - I don't mean that, but that should be recognised.

Interviewer: Do you find that it ever is appreciated and recognised?

Respondent 16: Er, at the moment, Ja, I can - I don't know what to say. But, in fact, I don't know really what to say. But, I just say that point. Ja. The job need to be recognised, because it's a great job.

Focus Group 1: Participant A: To our government, or else... we are not satisfied, because the government even the - we feel that we are just there as *amapopi* - toys, you know.

Participant B: They don't recognise/

Participant A: /Because if the government need us he can pay us at least a better salary/

Participant E: Do something better.

Participant A: You know. Encourage us.

There was much discussion in focus group 1 about the counsellors not being given due recognition, as already shown in two quotes above. One of the counsellors in this focus group (Participant E), seemed to be the leading voice in this regard, and expressed, somewhat angrily, her dislike of being called a "lay counsellor", which makes her feel like it's a job that is not highly regarded:

Focus Group 1: Participant E: They don't see as a lay counsellors. Ow! I don't like that name! I wonder when this can make us to go - 'lay'! Is look like I'm lazy! I don't like it, man! I don't like it!/

Participant D: /It looks like you are uneducated. You not doing it well as [...]

Participant E: The first time I go to my clinic, the sister they say, "Okay, I'm going to take a round with you. The people they must know - "This is so-and-so, a lay counsellor from -" - Oh my God! - my face just go down, "Oh no, what is a 'lay'?" As a result, what is 'lay' really, because most of us are educated. We are educated! What is the problem! I'm always thinking, "I'm educated, what is the problem." What I did they can't - what I can't do it, they did it!/

Participant D: /Without education, you know, because we are picking them from the ground./

Participant E:/Is true!

Participant E (focus group 1): the counsellors, they always say, "Oh, that lay counsellors" - I don't like that name -But I'm always saying [laughs] "Lay counsellors" - as a result if you focus on the counselling is not a 'lay' counselling is just a counselling. No, is not professional counselling, counsellor. Always the things they think, they can do the things on the way they want because they are 'professionals'! We are not 'professionals'. But we do that dirty work they can't do it! Because that broken people, we always give them up, you see. But they always say, "No, we are professional", but they don't do professional. I mean, I don't like, we are not recognised. They always think we are nothing from them, but we pick up piece by piece, and that client, as a result, you can see if you come to the clinic, they always ask from us, not from them!

3.2.3 Cultural Difficulties.

Acceptance of condoms:

Nine counsellors mentioned that clients do not accept the use of condoms:

Respondent 1: we advise safe sex, because if - we think that is very important although people are not used to this kind of thing - it's not easy for them to accept it. No! People just - they have got all kinds of excuses...sometimes you see excuses " Oh, condoms - I don't feel comfortable with condoms", or " I don't want to use plastic" and things like that, or "They break", and all that kind of thing.

Focus Group 3: Participant C: It's not easy at all for them to accept, because you will here a partner complaining "my husband don't want to use condom!", or "My wife don't want to use condom!" So, even if you are doing education to the whole group, you will find that one partner is not willing to use condoms.

Participant B: I think in hundred percent, er, ninety percent are not/

Participant A: /Are not using the condoms/

Participant C: And they are not willing at all.

Five of these counsellors stated that it is the men, in particular, that do not accept using condoms:

Respondent 3: especially guys, guys - I think that they are difficult. [...] I usually met guys that are difficult, you know, about this condom.

Respondent 6: in our culture, we are not - especially male partners, we are not used to condoms and all this stuff. So if the wife, or girlfriend comes to him, in front of him, telling him to use the condom, without knowing what is happening, might be difficult. Because we are not, we are not used to the condoms, and stuff.

Men are in positions of power in the relationship, and are the ones to decide whether condoms are used or not:

Respondent 13: introduce the condom? It is very difficult for them, because they are afraid of losing their partners. Even married people. Condom issue is, it's really the thing. It is really a big problem for them...because their partners are telling them they want flesh-to-flesh, and they are afraid of losing the relationships, because if you force them to condomize, they will go to another lady. We will not. In fact their partners, the majority their partners have dominion of, over them. I'm talking about men. Mm. All of them, the majority will tell you that, "I used to tell my partner to use a condom when he has a sexual encounter, but he refuses. It's a big thing. It's sad, it's sad, it's sad. And yet, when you ask them, "Do you think your partner is faithful to you?" They will tell you, especially the Africans, they will tell you, "No, you can't say a man is faithful to you. They will, there is no man who gets faithful!" They make it as if it's a law, or it's a tradition.

One of the counsellors also mentioned the female client's fear of violence from her partner, if she mentions the use of condoms to him:

Respondent 5: Toe die [*inaudible*], miskien nie die condom gebruik nie. Daan vra ek: "No, man. As die jongetjie nie hierdie condom wil gebruik nie, wat dink jy van jou liewe?" Daan se sy: "Ek hou van my liewe, maar, as ek miskien vir hom vra, dan wil hy vir my slaan." [**Translation:** *When the [inaudible] maybe does not use the condom. Then I ask, "No, man, if the youngster does not want to use the condom, what do you think of your life?" Then she says, "I like my life, but, if I maybe ask him, then he wants to hit me."*]

Three counsellors mentioned that condoms are not used because of the desire for the couple to have a baby. This is expressed as a cultural need by one of the counsellors. It becomes difficult to counsel safer sex in this instance:

Respondent 15: Sometimes, we are getting difficulties, because people are very young, they need their babies. They need the babies. Some people say, I mean, some people are HIV, you know. For example, a young couples, they can come to you and say, "Ooh, is so funny, we did go to the test. What are we going to do, because I'm HIV positive, and also my husband is HIV positive. Then we can't get - the doctor tell us straight away 'don't get-'. They can't get the child. Can't get a baby [...] You find it difficult, yes. You find it difficult. Some say, "No, I don't want to adopt. I need my own baby."

Participant E (focus group 1): is very difficult, for a married couple, like... women - from our culture, if you've got a wife, supposed to give you children. So, if we use condom - how? And even the man, if he's positive, he doesn't, most of the men, they don't worry about positive, they want to just, without condom, have sex. So, if you are a husband, how can I use from my wife a condom? If they do answer, "What is this wife for?"

One counsellor mentioned abortion as the only acceptable solution to an HIV positive pregnant woman. The counsellor implies that the women do not use condoms, and if they do fall pregnant, then they can have an abortion; they seem to be not interested in other options, including using condoms.

Participant A (focus group 3): And since the abortion is legal, [*inaudible*], and so they afraid to come and then they say to me, "No, I don't want any talk, or anything. I just want to do an abortion." If you gave options, if she's pregnant. She says, "No, I don't want anything. What am I going to do, because I'm HIV positive? So, how can I - I don't think I will have much power to look after my baby, because I'm sick myself, so I decided to do abortion." And then she will come next time, pregnant again. So, they don't use the condoms

Counselling older clients:

Six counsellors (ages 24 to 41) mentioned that there is a difficulty to counsel older clients. The counsellors attributed this to their cultural respect towards elders. It is disrespectful to talk about sex to someone that is much older than you are. Thus, if the client is much older than the counsellor is, it is difficult for the counsellor to discuss sex with the client, although it is necessary in HIV and AIDS counselling:

Respondent 2: these people you are talking about now, they are older than you. Let's say for instance we are talking with the mother and father, and sisters of this client of mine, maybe - mother and father they are my - I'm - my mother's age, and we've got to talk about sex, we've got to talk about condoms. I've got to educate them. Then - to my culture when you come to about talking about sex... to your parents, it is very hard and difficult, and it seems as if to them you are swearing to them when you are talking about sex.

Respondent 11: a difficulty on, like... talking to an older person, maybe an - especially African man. Like, if maybe a person is fifty something, and here I come in my twenties, coming to talk about sex with a person. [...] With us, in our culture, you don't discuss something like those sex with maybe your mother, your father, or even your older brother. So, having to say something to someone that I regard him as my father or my brother, so, it was, like - I was not feeling like, um... okay that talking about it. But, I say is part of my job, so I have to do this, because some of them are coming, maybe with an STD. So, that's where I have to enter. So, I have to talk about sex

Participant B (focus group 3): Ja, it's very difficult, but, you have to speak about that when you a counsellor. You must say what you want to say. Although you know that in my culture, I can't speak with sex to the older one. But, in counselling you have to speak about sex and everything.

One counsellors spoke of how older clients react negatively to a younger counsellor. Another counsellor perceived older clients to judge her in terms of age, because the counsellor experienced the client is more closed and unwilling to talk openly about sex.

Respondent 2: Sometimes it's very difficult because some of the elder, our elder people, they are so stiff. They don't want to hear anything about sex - they don't want to hear - "you are so young! You want to tell me about sex! What do you know about sex! Because I am your father, you can't talk to me like that!" Then it's whereby you have got to calm her down, and you explain everything... He will hear you, but here and there. Not everything. It's worse when you come to the part of condoms and sex. It's because he's feeling that you can't talk to him like that - you have got no respect! He will tell me "you have got no respect, my child! How can you talk to me about sex? Because I am your father's age!"

Respondent 14: I always feel comfortable when talking to my age group [...] And also to teenagers, because they always look at you and think, "Okay, she is at the same age. At least she understand what is happening", you know. And the older people, they will look at you, "No, this is just a young lady. What does she know about life? I can't open", like it's that group, that people, you know. It's different, we are different ages and different groups, and people will judge you about your age, and just look at you and think "No, I can tell this person up to this, you know. I can't tell more, because maybe this person hasn't been married, so what does this person know about marriage?" So, that can create some problems. Ja. I find it more difficult. They are more, like, are really difficult to counsel, because they are really not used to be open up about their sex lives. That's the main thing - sex life. They are not really open about their sex life; they are not used to that.

Two counsellors mention how they prepare older clients about having to talk openly about sex. The counsellors explain what they are going to talk about, and why they need to talk about sex. In a sense they almost apologise for having to talk about sex to them, and assure that they mean no disrespect.

Respondent 2: It's a matter of age... when it comes to the elderly people who are older than me, it's a bit scary and sensitive. Before I put the topic of sex and condoms, I've got to excuse myself that "I must talk about it, because it's there and our kids are using it, and it's a nature!" And then, I've got to excuse then and to apologise to them that "I'm going to be like this, I'm going to talk with this." Then it's - "Ja, you can talk my child, because it's happening, it's what our kids want: sex, sex, sex!" Then you can talk. It's whereby I'm feeling free to talk, because I have apologised the first time.

Respondent 7: But, I do that with the understanding that I might be offending my client about this, you know. So I have to be careful. To respect, you know, as much as I could. Because I understand I might offend you. Especially if it's an old woman, when you are going to speak about sex, or old man, you know. Things like that. So you need to be just very careful about this. Ja, age matters, very - Ja, age matters. In terms that there are things that you can't speak in my culture, and there are things that you can't share with old people. You can't ask an old woman about the relationship with her husband. Things like that. So, you can't... you know. They believe, that's a belief that nobody can tell her "No.", you know. So when you come to this things, and then you need just from the beginning to tell that, "Please feel free to answer me, because I will be asking you questions. Some of the questions will just include things like this", you know. To give just to... you know. "I'm not trying to maybe to disrespect you, but I'm trying to maybe assess the risk of getting HIV."

One older counsellor (age 48) stated that she found younger clients more difficult to counsel, because she finds them to be more immature:

Respondent 9: For example, I think we get difficulties maybe in the youth, youth people. There are difficulties in counselling, because, they don't want to... what can I say... they more, I think they more than the big people, because they, their minds are

still... they are still young, you know. They don't see why you saying these things to them. So, big people are easier.

One counsellor mentioned how, in the training courses, the trainees are trained in groups that contain people of different ages, so that the trainee counsellors can experience talking about sex with others who are older:

Respondent 10: We did look at that because, I remember I was the one who raised it when we are doing the training. I was also, already counselling that time. So... What we have done, with the groups, we did mix younger and older, we start that way. So that mixing, when we share in the small group, it, it did help. So that a younger person must not have fears to counsel a older women.

Male - Female communication:

Eight counsellors mentioned difficulties with regards to communication between men and women, particularly with regards to sex. Men and women do not talk openly about sex with each other.

Respondent 10: especially in our community we haven't got a chance at home to express our feeling, because we've got that... Er, that... the man is the head, so you can't say what you like. It is there to our community, you know.

Participant E (focus group 2): Sometimes it's difficult, because of the culture, you know. You are a woman, talking to a man. It's difficult sometimes. Because in our culture, you know, the man is always the head of the house, or the head of whoever. And now you, as a woman, talking to your head of your house.

This impacts on the counselling situation when the counsellor is female (as is mostly the case) and the client is male.

Respondent 10: Sometimes when the client enters, you will see that he or she is, especially when you are a woman, he's a little bit... shocked. And he will think you'll take the woman's side. Or maybe you won't help him.

Respondent 14: Well, what I really mean is like most men can, they don't even share things with their wife, because the woman's place is in the kitchen, you can't talk matters like this with the women. As now, I'm about to talk about his sex life, whereas he's very older than me, he's fifty - "who am I?" and I'm a woman on top of that, you know. So, there are some words he wouldn't like to use maybe. He rather talk to other men about that. Maybe if I was a man, it would have been very different

Respondent 15: what is difficult - the mans don't want to come. Is not easy to get the mans [...] because some mans are afraid to talk to the women. They like to talk to the man. So, then you can tell straight away, "No, there is a man. Tell your husband. Bring

your husband. There is a counsellor here. A man counsellor." Then they say, "Okay, yes." Then they will come at least one by one, because there is a man.

A male counsellor stated how he feels that it is difficult for female clients to be open to him to talk about sex, because he is male:

Male respondent: But on other hand we need to look the issue of gender in between, because when we deal with HIV, as we go along there are issues... the women will feel that, "No, I can share with this with him." And then you just feel that, you know. You feel that this person was good in the beginning, but now is changing, you know. And especially when it comes to the relationship issues and so forth, you know. You feel that is just changing. Then when you go - we change again, we go maybe... you are working on feelings, about HIV, and then again, that same person will change and become somebody else to you - alive and tell you everything, you know. So you feel that person is... I understand that's a issue of gender. Ja, I'm a man, and then she is a woman. And then if it was a woman, then that will be easy for them to just carry on. And some of them, they are telling you that, "No, I don't feel comfortable to be counselled by a man. So, I feel if I could just get a woman." So, I refer that person [...] And then some of them will tell you that, "No, I'm not comfortable. This part I'm not comfortable to share with you." And then some of them will just tell you, "No, I'm fine." [*inaudible*] but you feel that "No, this person is holding back", you know. And you also assume that maybe is because I'm a man.

One female counsellor mentioned that she finds some female clients to be reluctant to talk openly and honestly about their sexual relationships, for fear of being judged:

Respondent 14: but women they can hide some things. Especially if you are woman, they will think that maybe you are judging them about sleeping around. But men, it is okay for men. If you are black, it is very okay for men to sleep around. But for a woman is not okay.

The above respondent mentioned how it is considered acceptable for men to have many partners, which is something also referred to by another counsellor, who regards it as a difficulty when counselling men:

Participant A (focus group 1): And then you counsel her, you challenge the husband, and you find out the husband didn't understand what is HIV. And he don't want to listen. He say, "No. to - our culture - we know that you nurses, you always, everybody had AIDS." And then you counsel this, and then he went home. And then he get another girlfriends, because he deny that he is HIV positive. He used that culture; 'I'm a man, I'm supposed to have many partners.' You know. So, it's difficult.

Two counsellors mentioned that, in general, they find men to be more reserved than women in counselling:

Respondent 7: when you work with black Africans, it's not like working with Coloureds or [inaudible], because sometimes when you ask the question, you know. You expecting this person to give you an open-ended answer. Then he just give you a close answer, "Yes", "No", "Yes", "No", you know. Especially when, if it's a man. Because that guy - is what he was doing. I was trying to challenge him as much as I could, but... he was always, you know, pushing myself away [inaudible] "Whom are you going to tell?" - "My wife". "Tell me about the relationship between you and your wife" - "No, is good", you know. Things like that. You know. So it's... that is where I feel - actually this year, because for, for the first time I'm working with black Africans. So I feel this year that it's so difficult, it's not easy. [...] I'm not sure about the reason, but I assume that is because of the culture. That men will ask men about his social part. He doesn't give you everything, there all the story, about who is he, and so forth, you know... Especially when you go in-depth, you know. Looking about things like partners, "How many partners do you have?" Things like that, you know. He doesn't give, you know - Actually the whole issue about health, the man is always giving a short answers. One is taking time to go to the doctor if maybe sick. And two... is that short answers.

Respondent 12: most of the men are so... is not open, but he is not like a mother, the man. [...] Ja, a man is closed, is not open

One counsellor pointed out how, similarly with regards to age differences, the training courses address the issue of gender, by including both males and females in the training groups, so that they can be used to feeling comfortable about talking openly about sex to each other:

Respondent 10: And there, there is a sexuality part, because - that's why we include that, because in our community, I will always say that we don't talk about those things

Respondent 10: in our culture, when you look a man like this [directly], it's not easy. But now, we let that happen in the group. That member group, when he's young he need to talk to that man.

Bewitchment:

Two counsellors in focus group 2 and one counsellor in an individual interview stated that beliefs about bewitchment can cause problems in counselling, because the client believes that the HIV is a result of bewitchment, resulting them in denying the disease.

Respondent 11: Ja, it was difficult, because - saying, like... I couldn't actually believe that he could believe that he's been bewitched, although he knows that there's something like HIV. That's why I'm saying there are people out there who don't, like, really believe that there's something like HIV, or don't know anything about it.

Participant E (focus group 2): the ones that are in rural areas, will just tell you that "my father and my mother died, and they didn't have this. And your father, my wife died, and your mother died, and they didn't have this. Why are we having this? This is because of witchcraft. There's nothing like HIV, and we must go to the witchdoctors, and I've told you this; that I have dreamed about this, so is nothing of HIV. You know. Is a poison." So, it's difficult. You must do counselling, and at the same time, you must also let the person know that you are not discriminating him because of the culture, or because of the way he is feeling. Then, you must try to cater for the culture, and also for your counselling skills.

Focus Group 2: Interviewer: Okay, and beliefs about witchcraft and bewitchment, does that cause problems at all in the counselling?

Participant E: They do!

Participant D: Ja, especially if they are in the denial stage. They just feeling that it was the witchcraft, and you have to deal with that, and then if the person is very sick, as we are doing with people in [*inaudible*] before, is very sick, he believe that the neighbour is done this to him or her, so they have to go to the traditional healer to make this thing go away. But, the HIV is not going away. And he becomes sicker and sicker, especially the men, they come later in the clinic, because they are very sick

This influences the client's perception of the usefulness of counselling for healing him or her. As mentioned in the above two quotes, believing HIV to be caused by bewitchment, leads the client to think that help lies with traditional healers rather than the counsellor. A third counsellor also mentioned this:

Respondent 7: and most of the people they tell you that, "You're always refusing. [*inaudible*] to herbs." Things like that. "If I can just get the herbs, then things will be okay. If I can go to somewhere else, and then -" - they believe in, to the traditional healers, more than the doctors.

One counsellor made an interesting statement in an individual interview, that some clients believe that having the HIV test itself will "set of" the bewitchment:

Respondent 11: Because you do find those people who still believe on witchcraft, even if they're HIV positive. They say people make it in a form, like, if you go for a HIV test, then you will be HIV positive

Interviewer: So, they say if you go for test that will make you HIV positive?

Respondent: Ja. But, it will appear in the form of HIV, though it's witchcraft.

Interviewer: Okay. But going for a test will make that happen?

Respondent: Will make that happen, yes. But they will say then, "I don't believe this is HIV, this is witchcraft."

This was never mentioned by any of the other counsellors, and in an effort to validate this, the researcher specifically asked the participants of Focus Group 2, when they were discussing bewitchment. All five participants in the focus group refuted this.

3.2.4 Organisational Issues

Teamwork:

Counsellors at clinics work within a team of health care personnel, which includes nurses, sisters and doctors. Problems with relationships between team members in the workplace, can cause problems which impact on counselling. Only the ten counsellors in Focus Groups 1 and 2 discussed teamwork and lack of teamwork. Focus Group 1, in particular, seemed to have been experiencing workplace problems, with regard to working as a team. In this group, the counsellors expressed some anger towards those in higher job positions, for example the sisters, who they felt were not supportive of their needs and their jobs as counsellors. The counsellors' felt that the sister seems to be more concerned about the clinic's statistics (how many people were tested) rather than the nature and needs of the counsellor and the person being counselled:

Focus Group 1: Participant D: the sister is there, because what I've noticed what they need is the stats. They want stats.

Participant E: The stats. How many people/

Participant C: /were tested.

Participant D: Ja. They want the numbers. And when you told them about the quality of counselling, they don't understand. They will tell you, "Look, a pre-test counselling takes up to maybe for fifteen minutes, or ten minutes", you know. And you say to this person, "You don't know counselling, sister", because there are so many issue which arise within that pre-test counselling -You know. So, sometimes you take a long time. You know, when you busy counselling, this sister come and, you know-

Participant A: Open the door. Knocking/

Participant D: /Open the door, you know. Want's to - "there are some other people! Finish up! Finish up!" you know. And that thing really irritates me at times. [...]

Participant E: Because you can spend a lot of time reflecting the feelings of him, is it really want this? Is it ready for this? As a result, if you haven't got that chance, okay, you must get, you must finish the people, maybe ten. The counselling don't work like that. Even one client that's enough, if you feel is very hard time. But to them...ja, you must make maybe ten, or seven. You can't work. As a result, you feel like somebody who are lazy. As a result you are not lazy, you feel that you have got a load for that, you are - I don't know what can I say/

Participant D: / sometimes you do three, all this three is positive, and then after that you feel, "Oh, this is enough for the day! I can't take any more." But the nurses will come and say, "please test the other one", you know. And that is not good.

This group also discussed some experiences they had where the sister or doctor gave the results of the HIV test to the client, and then sent the client in distress to the counsellor, who had not yet sat and counselled the client:

Participant E (focus group 1): I remember, one of the doctor [...] she see that client, and then she told, "with this shingles, you think you are this 80% or 20% of HIV

people." And then the client didn't reply back. "I think you are this 80%. You have HIV. So, go to room 7, and then they are going to tell you, you have your, if, they finish draw your blood." And then she come to me and knock on the door, and I say, "Okay, have a seat." When she start sit, she cry, I can't do nothing. "What's going on? Why you crying?" About half an hour, just give that chance to cry here, and then after that I ask, "Do you know that you tested?" - "I'm HIV." - "Did the doctor draw your blood?" - "No." - "So, why?" - "No, the doctor said." And the doctor is more that a counsellor, is a doctor. The doctor can't lie. Really can't lie, but the way she put the things! They way she saying! Because on, on that space there's no need, you can't say. But is a doctor. As a result what I did. I just think: No. She gave me a hard time now! Because this person already crying, already broken heart already! So, the first time must go straight to the doctor, "Look, if you are going to say like this, I think you supposed to counsel, and do everything! And you must do everything to that person! Otherwise you give that broken people to me! Who's going to pick up all that?" And, I mean, in the way we work sometimes... I don't know, because I'm always thinking the counselling is there. The doctor has got a counselling. The nurses has got a counselling, but the way, is not look like! As a result, they give us a hard time.

Participant B: in my clinic, there was a client that was tested, without being referred to us as counsellors. Was tested by the sister, and then the sister take the client back to the doctor, and then the doctor gave the results to the client that, "You are HIV positive." Without counselling. Whereas they are the professionals. And at the end they did try to shift the blame to us. But, I did try myself to check to our register. Didn't see the stats. It was their fault, not us. Whereas they are professionals

These problems experienced by the counsellors, lead to feelings of inferiority and anger towards those in the higher job positions. Participant E in the focus group was more vocal about her anger:

Participant E (focus group 1): the counsellors, they always say, "Oh, that lay counsellors" - I don't like that name -But I'm always saying [laughs] "Lay counsellors" - as a result if you focus on the counselling is not a 'lay' counselling is just a counselling. No, is not professional counselling, counsellor. Always the things they think, they can do the things on the way they want because they are 'professionals'! We are not 'professionals'. But we have, we do that dirty work they can't do it! Because that broken people, we always give them up, you see. But they always say, "No, we are professional", but they don't do professional. I mean, I don't like, we are not recognised. They, they always think we are... nothing from them, but we pick up piece by piece, and that client, as a result, you can see if you come to the clinic, they always ask from us, not from them!

One of the counsellors in the focus group, however, had a different experience of working at a clinic, where she feels she is supported by others in the workplace:

Participant A (focus group 1): But, from the other clinic, but I don't ... I don't want to blame, like, when I'm working I'm recognised, because they know what is the counselling. I don't maybe is because is an NGO, and they are focusing for the HIV,

because they know if you've got a client, no person can supposed to knock. And even they, even if you forget to stick 'Do not disturb', they stick it, the doctor, because they know you got a client on that side. And then if, they also... after you see a patient, they call you, like, try to support you as a counsellor, "How do you feel? You need a break? If you feel you are tired you can do another job, not taking anymore the cou- the patient", you know. [...] So, they give that support. That is - we are working hand-in-hand with them, so - But, you see that other clinic

By contrast, focus group 2 discussed the importance of teamwork and how that makes the job easier:

Participant E (focus group 2): I think teamwork is the best. If you are working in the same clinic, I think teamwork is the best, because if you are working there as counsellors, and you are not together, then that will give a chance even to the staff, to look down, you know. So, I think teamwork is the best. And also to share the knowledge, or to share the experience of the other counsellors. That is what is the best. It makes the job easier.

Interviewer: you said 'staff will look down on you'; what do you mean by that?

Participant E: If, like, at our clinic we are four counsellors. There are four counsellors. So, if one of the counsellors, if they've got problems, and then they are not together, you know, they are looking down upon themselves, then it's going to be much more with the staff; with the sisters and the nurses. I think the best way is to - charity begins at home. So, if you are the counsellors from Lifeline, and you have a problem amongst yourselves, I think the best way is to solve that problems, not including anyone from outside. And to - if I've got more experience, then to share the experience with the other counsellors. So that if they've got problems, it's easy for them to come to me and say, "Look, (name), I've got this problem." And then we would have maybe a chance to solve the problem. Both of us, you know. And also it makes work easier, because even the clients will see that you are the same. So, they won't have a problem if I'm not there. They would just go to anyone, any counsellor that is there. But, if the teamwork is not there, then it's even difficult for the clients to go to, to whoever, if that particular counsellor is not there. So, I think teamwork is the best thing. And also teamwork with the other staff. Teamwork with the other staff. Working together. It's the best thing.

Capacity Problems:

Two counsellors mentioned how the "office hours" of the counselling service excludes a number of clients that are not available at this time. While some clients are able to attend one day of voluntary counselling and testing, those who are working are largely unavailable for ongoing counselling, or to attend support groups, which is found to be a great help to the clients.

Respondent 3: Some they don't... but I do understand to those who don't come for ongoing counselling, some people they are working then they don't have a chance to come for an ongoing counselling.

Respondent 7: the services of counselling, are between office hours only. And there are people who are not available at that time, you see. I think, I don't know what we can do, but I think there's a need, because nobody is supporting them. Nobody is telling them anything, because they are not available at all. We talk about the support groups, we talk about the follow-up sessions, and so forth, and then, for them, we don't accommodate at all. I don't know what can we do about that, you know. But I think there's a need for them also to know. Because some of the things, you might just sit down and think, "is because of these people - they don't understand", but the information is for the certain people not everybody.

One counsellor mentioned how latecomers to the clinic cannot be seen to, because there is a cut-off time.

Participant A (focus group 3): it's easier for us to work, easier if the clients came earlier in the clinic. Because others, they used to come late at the clinic, and they don't understand you if you say "No, it's late now, and the sister in charge says, said this and this about the latecomers." So... they don't understand. So, if they come earlier, the work is easier.

One counsellor in focus group 1 mentioned a lack of designated counselling space as being a problem.

Focus Group 1: Participant C: Yesterday I have a client a 32 years old man. This client he is suffering from polio, TB, and he also fits. We do the pre-test counselling. While we do pre-test counselling, he was an active guy, he was a talkative. Yes, he agreed to do an HIV test... Unfortunately the results was positive... I do the post-test counselling, while... he was shocked. And he, while he was shocked he just, there was the silence between me and her maybe for five to ten minutes. While we on the silence, there is a person outside. She want to come here on this room, because this room I used is the family planning room. So, now they want to do the family planning. Now, I suppose to reflect the feelings of this client, but I don't have a chance, because there is a person outside.

Participant B: Mm. Also that means that we don't have-

Participant B+C: enough space.

Participant D: Enough time

Participant B: And the doctors, they've got their places of working. We as counsellors, we don't have nice places. We don't have our rooms. That is unfair for us

Two counsellors in Focus group 2 talked about a problem, of finding a staff member to perform the HIV test, after the counsellor has pre-test counselled the client. This "shortage" of staff causes a hold-up for the counselling services, as the counsellor has to wait for someone to come and perform the test.

Participant A (focus group 2): And also when you are counselling a person, when you finish counselling and then you want somebody to prick this person. You must

look around for people who must prick, and then the people are busy with other jobs. And then you stuck to that person, and the others are waiting outside. And that clinic makes you stressed, because when you go outside you see these people are waiting for you, and you still sitting there for one people

Participant B (focus group 2): And they are going to put the blame on you, because you are the one who are responsible for them. So they are not going to look for the sisters, they are going to put the blame on you - the clients. They won't understand that you can't do this, because you've already started, then you must do it, because you've already started. So, that is the reason that he can't do the test, you see.

Participant A (focus group 2): Sometimes it is a lack of staff. Sometimes they are doing the babies, and then just say to you, "I'm coming", and then you waiting. And then look, when you are looking at the time, you see, hey, five minutes is gone already. And then go back and ask her - "Okay, I'm coming, I'm coming!" And then, go again to look out for another person, and that one say, "I'm busy. I'm coming."... maybe you are going to sit there for an hour for one person.

3.3 What helps the counsellor to cope

Supervision / Debriefing:

Eleven counsellors, and five counsellors in the focus group discussion, mentioned debriefing to the Lifeline counsellor supervisor, or work-colleagues as an important means of coping with their difficulties. Counsellor supervision is provided every fortnight by Lifeline, and counsellors have a chance to discuss their problems in small groups with the supervisor.

Respondent 2: Ja, it helps me a lot. A lot. Because if you are not going to the supervision you will be overloaded really. Overload of work - you feel tired. You feel depressed. Ja!... and you feel that "Yo! this is a lot of job!"...

Respondent 6: in the supervision it's where you see the psychologist, it's where you can offload... whatever things, stressful things which you have encountered during the working hours, and the problems which you did get. So, in that way you will be offloading, and if you are telling things like that it's that way you get offloaded [inaudible]... That's the supervision.. Yes. It really does [help]... It does, because you expressed that - the way you feel. You've expressed how you feel

Respondent 16: sometimes, I come here at Lifeline for supervision. So, I do expel the cases like that. Ja, it helps because I come relieved after that. Problems that I, the serious cases that I deal with it in my work. Then, I just become relieved after that.

Participant C (focus group 2): also is very hard as a counsellor to work when you got the problems, the personal problems. That is why we got this supervision on [inaudible]. It is important, because is where we offload problems and other problems in our job, so there are those, because if I got a problem is not easy for me to go or to look through the client's problems.

Supervision occurs only every fortnight, so in between these times, the counsellors debrief with their work-colleagues, and amongst themselves:

Respondent 9: What helps me to cope? What helps me is, as I'm working with my colleague. So, after we finish working, we always in a place like this. And we are four, we are five. Yes. So now, it's easy for us, to say, "Oh, my problem was this," you see, "my problem was this." So now, when you cough up, out what was difficult to you - They were there for you to explain, you see. "Were you - No, you're right now. You do right. Okay, you suppose to do this like this", you see. So, every day, after we finish in the work, we are in a room like this, so that we can [inaudible]. So, that helps us, you see, to cough.

Respondent 16: and also there's a guy here in my, in fact is a male nurse. Ja, sometimes he calls me that we need to talk. Then we need to have one session that if you say you make maybe for the 10th, today you had a difficult case, we need to talk about that, so you can be able to be relieved. So, it also helps, to sit with him, and just explain to him, what problems did I met for the day.

Participant C (focus group 2): And also we are four in the clinic, so in terms of this hard working, like we didn't come to the supervision, we do not come to the supervision, so what we are doing, used to do every morning, it just happen, we feel as if it makes things easier. We just share our problems as counsellors that we received from our clients. We just share things, discuss things, and then at least - then also if you have got a problem, you come to the job early in the morning when you are greeting each other. Tell how you feel about the day, those things. It also make easy. Then we are feel free, and relaxed at least

Participant E (focus group 2): what we are doing in our clinic, we would, when we are finished working, and then we would sit down, and then we would ask if there's anyone who had a, an unsolved problem today. And then we would discuss that, and then we would say "If you can tackle it this way", and giving help to each other.

One counsellor mentions that she talks to a close friend when she feels she needs to talk to someone about a problem:

Respondent 3: I'm coping with that, like I do have a psychologist, so if I have a problem I'm telling the psychologist, or... a close friend, because I... we meet with our psychologist every two weeks time, so sometimes it's too far for me. If I got a problem today I just told that "No, I must tell a close friend this problem, otherwise if I am going to wait for next Friday, no I think I'm going to burnout. I must talk about this. I need someone to talk to", so that's why I use to talk with my close friend

Relaxation:

Six counsellors mentioned that they find ways in which to relax after a day's work, which helps them to de-stress. Even during the day, they find a time to get out of the workplace and

have a short break. Counsellors also make use of the weekends and holidays to relax and refresh.

Respondent 1: Relax! Relax myself afterwards! 'Cause that day and- it's gone, and it's done with, and I've got to relax finally, with some means to relax myself, so that I am not all that stressed out. there's quite a number of things to relax - you do a little bit of stretching, or you do a little bit of praying, or you do a little bit of sitting down and meditating, and this kind of thing

Respondent 7: Another thing that I do, every morning I just take, just exercise at home for fifteen minutes, just exercise, before I can go and wash myself. [inaudible] it helps, and to [inaudible] again, you know. As you carry on just [inaudible], it helps.... And the last thing is to give yourself a break in between the clients, you know. About fifteen minutes, ten to fifteen minutes, you know. To give yourself that break.

Participant C (focus group 3): I think counselling is very stress, counselling is stressful. But, I used to deal with stress - I love, I like gospel music - when I'm stress, I just take out this gospel music. But, it helps me a lot. [...] It helps me a lot. I'm getting a lot of strength. Even before I went to work, I just listen to gospel music, and then I also sing with the cassette, you know. And then I feel okay. The whole day I feel okay. And even the morning at work, I'm also attend a short prayer

Setting limits on workload:

Four counsellors stated that they had set a limit on the amount of clients they see in one day, or the amount of work the counsellor has to do.

Respondent 3: I think I was working too much before, you know. [...] Work too much, so I told myself: No, I'm not going to take more than five clients a day. Otherwise I'm going to burnout

Respondent 7: What I do... if on Monday I saw many people, then Tuesday I will be dealing with, doing educations, you know, around the clinic. It helps than - you know education helps than listening, counselling. Because when you are counselling, you give the whole attention, you know. You are there. But when you do education, the people are just listening, you know.

Respondent 7: On Thursdays in the afternoon, I just relax. I don't take anybody for counselling, you know. From 2 o'clock to 4 o'clock, I don't take anybody for counselling. Because I also think about my life at the end of the day, that I might burnout, affected mentally and, you know, socially, and otherwise, you see.

Being prepared, having skills and experience:

Fifteen counsellors stated that they felt that their training that they received helps them in their work. They feel that the skills that they have learnt has prepared them to cope with their jobs.

Respondent 6: It's not more difficult to counsel, because they can listen to you, they can - Now that we have that skills to built a trust with the patient, to build that, um... that friendship, it makes easier for one to talk to your - to the patient or to the client.

Respondent 10: it's better when you are a counsellor you got those skills. First of all. As I said the Lifeline counsellors got those skills. Then, with the clients it's easy for us, because by those open questions, by talking to that, with that sex, sexual problem, you will let that clients the - obviously the client will talk about the problem. If maybe I was a counsellor... I was maybe shy to talk with that problem, that client can't talk. But as I'm ready, I talk with the problem of maybe sex or what is happening.

Respondent 11: At first I thought I couldn't do it. But, with the help of the training that we get - because mostly, before you go and work in the clinic, you first go and... what you call it?... you go and see how people deal with it, because you get into the field, you first go and observe in the clinic, and then I was sent to ATICC, for a three week course. For the first week you do it on AIDS awareness, and then the second one advanced counselling. So during the time, you get to do role-plays. You actually practising what you gonna do at the clinic. So that helps much.

Respondent 13: Well, at the beginning, to tell you the honest truth, I use to be frustrated myself. Yes, I use to be frustrated, but now I'm very matured, because I've gone to ATICC as well, to do intensive counselling, so I'm okay now. [...] But, I promise you, I don't struggle much, because I know what to do in when situations like this, I know what to do.

One counsellor mentioned how it helps to be informed about what is happening around the clinic, and about related topics. In this way, the counsellor can be helpful to the client when he or she asks questions, and is able to refer appropriately.

Participant E (focus group 2): it's also important for the counsellor to know her job, but also it would be helpful for the counsellor to even know the other things that are happening inside the vicinity that she working. Because if the client is asking me, for instance, about family planning, and I'm working with a family planning advisor in the building, then I would say, "I don't know." You know. It doesn't mean I must know everything, but I must also know where to refer this patient. "You want to know about family planning? Okay, go to that door. Go to that room." You know. Otherwise if I would only concentrate on counselling, and ignore the other things that are happening inside the building, then it will be difficult even for me.

Three counsellors felt that their work got easier over time, the more experienced they became.

Respondent 3: Before it was difficult, you know. It was difficult...Ja, when I was just working there as a AIDS counsellor, it was difficult, but at least now I'm coping... at least - it's been a long time

As mentioned above, the training received, in particular the Personal Growth Course, has helped the client become aware of their own issues, and this has helped them in their work

Respondent 1: It has affected my counselling, because I know how to handle myself when I meet people, who have been through what I have been through... If I didn't have that personal growth, I could never talk about, or be able to understand other people's problems, but the personal growth made me stronger, so that I can be able to talk to people.

Respondent 12: I like the counselling, because when I was doing a Personal Growth, I share everything about my life. When I'm going to work, I'm fine. I don't have a, if I got a problem at my home, I deal with that problem. When I'm going to work, I'm fine, I'm ready for my work. I don't put my problem to work. So, I like it, because of the personal growth first thing.

The development of skills has not only helped the counsellors in their work, but also in their own lives. Eight counsellors mentioned how they felt that what they have learnt from counselling has helped them in their own lives.

Respondent 2: I can handle the problems, even mine now - I can handle my problems too

Respondent 13: I love counselling because it makes you mature. A matured person. It, and also it makes you... it makes you broad. In, in many - you learn to know how to talk to a per-, to a mother. You learn how to deal with a marriage

Respondent 15: I mean, what is nice to the counselling, you learn a lot. You learn a lot experience to the people, to the different people. You can learn a lot of things to the counselling. They can make you clear. Sometimes, even at home, use the skills at home, don't stay, don't use the skills only at the clinic, and somewhere else. At home also. To your friends also.

Three counsellors felt that the relationship of trust that is built with the client, makes the counselling easier:

Respondent 7: you need to try to develop a strong relationship with that client as time goes, especially if is positive. Try to be always, you know to make that person feel at home, you know, when is coming in your room. Even when you see the person standing in the street, just - not about talking about HIV, just... yes, you know, just pass each other, you know, about some of the things around. And then try and be a friend with them, as much as you could. So that a person can see that "there's somebody who's care for me, there's somebody who's closer to me. Even if is difficult to share with that, with anyone, I know there's a person that is closer to me, you know, if I need some help I'll go". And indeed they come.

Participant C (focus group 2): is not easy to take the client, if (name) is dealing with the client in the pre-test counselling, and then I take over in the post-test counselling. At least it is much easier if I did pre-test to the same person, and post-test to the same person, because I was there when I was doing [inaudible]. Ja, I know. When she come back now for the post-test, I know her much better. I know at least how to deal with her

Value of helping people and the community:

Twenty-two of the counsellors stated that the fact that they are helping people, and helping the community makes their jobs worthwhile, and it gives them the strength to continue doing it.

Respondent 3: the reason why I said "I like this job" is because, I think I'm helping the community... Ja, I know it's difficult. It's a difficult job. It's a difficult job, really. But, I am helping the community, I can say at the moment

Respondent 6: doing it inspires me a lot. It inspires me. And knowing that I am serving the community which I come from [inaudible] I think alone inspires me also. Yes, that I think it is an inspiration for me. Because I know that there were no people like me before. Now I am there, I have to serve as much as I can.

Respondent 7: I think is love, because what I'm doing I do with love, you know. I love my job. I love when I feel that... is what I'm called for. So I - that's the only thing I can say is love - something that is driving me, it's my driving force, all the time, you know. When this person is in need, I try to attend the person with love. To give that ear, and see what I can do. And that motivates me.

Participant E (focus group 2): Knowing that you are doing something for your community. And when somebody comes in, and she tested positive, and she bring the partner in, and then after that you go home, and you call them, or they call you and say, "You know, (name), thank you...because I've been drinking, but now because there's this HIV thing happening, you have sat down with us. I've stopped drinking. Now I'm concentrating on my family." For you as a counsellor, you feel proud, because you have changed someone's life, knowing that I've done something good for someone in my community. So, also that makes you to go again to help more, you know.

Fifteen counsellors mentioned knowing that they have helped a client, and seeing the client cope, as being one of the nicest aspect of their jobs.

Respondent 8: The better aspects of counselling is when people know their status, and then they, sort of, make use of it. Like, start support groups...Go open with their status's, do educational talks, because they know if they experienced it, they know, they are in that situation. Then it's so much, er... nice - nice, ja.

Respondent 9: The nicest thing is, like, since we are doing a lot of - we are, I've got a lot of clients. So, what happens in my counselling - to see them coming to me every day, every time, I see them. Every time. And I notice that they don't have any difficulties anymore, since I've been seeing them, you see.

Respondent 16: It's a big job. If you see that all my clients are able to cope with their HIV status, especially the people who are involved with the support group. They are able to cope with it. They are no longer feeling the pain. That's what I like, you know, because this is not the end of the road. And HIV is not a death sentence.

Three counsellors mentioned an HIV positive couple, who got engaged when they found out their diagnoses, as an example of a nice experience of seeing clients cope and dealing with their problems.

Participant E (focus group 2): when I started my counselling I had a young lady. She was eighteen years, and she tested positive, and she said "Name" - I ask her "Why you crying?" and she said "I'm worried about my partner, because I told him that, if he can find out that he's positive, he will kill himself." I said to her, "Bring your partner in." And so they come in, both of them, and you know it was a positive thing, because after I done this session, the man just sit down in front of this lady, and he said, you know, "Can you please marry me? And I want to marry you. And I don't want you to go and tell your family about HIV, and I'm not going to tell my family. Just, can we marry, please?" And then the lady said, "Yes." And for me it was, like, (sigh) Oh good! [Laughs] So, that experience gave me, you know, power to go on, because even now they are still married. They are calling me saying "(name), we are still together, and life is good for us, and for our babies. So, we are still fine." So, that makes us to go on with the job that we are doing.

3.4 Impact of their work on the counsellors' lives

The counsellors that were interviewed individually were asked what impact their work has had on their lives. Only two counsellors mentioned a negative impact in that, in times of stress, the counsellors have little time and energy for their families and friends:

Respondent 3: Ja, it was affecting the relationship with my child before, and especially the clinic, if there was a [inaudible] we are two counsellors [...] if one of the counsellors is on leave, and the right [inaudible] I didn't have a chance even for my boyfriend - Oh no! I feel like Oh no! I don't want to spend time with my boyfriend and with my child, you know. Such things like - it was difficult, really, you know

Respondent 7: Well, sometimes counselling can distance you from friends, because sometimes after work you feel tired. You don't feel like speaking to anybody. Also the family. You don't feel like speaking to anyone, you feel like sleeping today. And then, the children maybe are there; they want to speak to you. Things like that, you know. Sometimes it does that.

Although the focus groups were not asked about the impact on their lives, 4 counsellors in the focus groups also mentioned how, when they feel stressed, their work impacts negatively on their relationships.

Focus Group 1: Participant E: Because to be there we lose a lot. Even the relationships. I mean, when I'm talking about relationships/

Participant A: /our boyfriends/

Participant E: /The boyfriends

Participant All: [laughs]

Participant E: The counsellors, most of the counsellors. Even me. I'm not married. As a result I got four years I don't have a boyfriend, because of this frustrated. I've no feelings/

Participant C: /We don't have feelings/

Participant E: /Nothing! You see/

Participant C: /Me too. I don't have a boyfriend./

Participant E: /So, is very, very difficult [...]

Participant A: /We got a boyfriend, but -/

Participant E: /We nearly burn out now./

Participant A: /most the time you keep a distance [...] And then they, even your boyfriend can always blame you. "Look. You are working with people are HIV. So, now you are changed." You feel that, "Okay. You need to focus to you? You can go to hell, because I focus to my client." So, you feel that your happiness/

Participant E: /Ja. It's destroyed a little bit./

Participant A: /It's limited.

However, in general, for fifteen of the counsellors, there has been a positive impact on their lives. The counsellors speak of the positive change in their lives as a result of the skills they have learnt from counselling, and from the training courses, in particular the Personal Growth Course. What they have learnt has changed them as people, and empowered them. The skills that they have learnt from counselling have helped them in their relations with others.

Respondent 1: I think counselling has changed my life in a way that, er... I'm more relaxed... I'm more taking things not as serious as I used to take. Ja, I say 'serious' - things that I am not supposed to take - are not all that serious. I'm more relaxed. I'm more patient with people. I'm more understanding of people. I'm more understanding with my children, with my family. This has definitely changed me I think for the better

Respondent 2: And it helps me a lot to be a counsellor, because I was that somebody who was very quiet. Ja! Before I was very quiet. But now ...I can open my mouth. Now. It helped me a lot. Ja, it empowered me a lot, a lot really

Respondent 3: I'm changed, really! I'm no longer that (name), all secretive now, you know... It helps me, counselling. This Personal Growth, especially Personal Growth, it helps me a lot. Because I was secretive, really, because I... most of the things I didn't talk. I used not to talk to anyone. I told myself, "okay, fine. I'm not going to say

this to anyone." But, when I joined that training, I changed. I changed... it helps me a lot

Respondent 4: change a lot to me because I know how to, to talk with people, because... because at first I was not... a talkative person... I was just sort of... I just sit at home, and not even visit the others. I just stay at home, because if I don't feel like, I don't feel like to talk with other peoples, I don't feel like. At first. But now... counselling has, doing changes a lot to me... because now I know to - I, I can go to the community to participate to something in the community, but before I never do that.

Respondent 9: I can say, I'm very, very, very good, happy and healthier... to my counselling in - it did something to my life. Because, I had the problems, like, I grew up my children myself, and my husband died long time. So, I was in a bad situation at that time, you see. Because I had to look for my children, and they were very small at the time she died. So, all those things they were in my mind all the time, you see. But, when I came here, and cough out everything, so I noticed that my life now, I see that there is life to me, and my children. [...] there is a light in front of me...since I been under Lifeline. There is life, there is life, in front of me. I can see it. I can feel, there is life.

4. DISCUSSION AND CONCLUSION

4.1 Counselling activity

Although this study did not aim to be an evaluation of the counselling activity, some data on the counsellors' description of their activity was collected. From the counsellors' description, counselling seems to involve a mixture of non-directive (client-centred) and directive (education- and advice-giving) counselling. This was found generally to be the case in South Africa by Richter et al. (1999). Although many counsellors talk of two separate tasks when talking of education and counselling, the two are not so clear-cut when it comes to counselling around testing for HIV, where a lot of education is given during pre- and post-test counselling.

The results have revealed some possible limitations to a client-centred method of counselling. Firstly, HIV prevention strategies, of which counselling forms a crucial part, have definite goals with regards to reducing sexual risk behaviour. HIV prevention strategies have focused on the individual's sex behaviour, emphasising monogamy and faithfulness, and the use of condoms. It is difficult to follow the client's lead, when there are specific behaviours that you want to encourage the client to do. Some counsellors speak of advising their clients about these activities.

Secondly, with HIV counselling, it is important that the client has an understanding of the disease, its transmission, and methods of prevention. Counselling in a non-directive way requires that the client is knowledgeable about HIV transmission and prevention, so that he or she can make decisions with regards to treatment and coping. It is difficult to counsel in a non-directive way when the client is not aware of the consequences of his or her actions and choices. Counsellors spoke of the lack of awareness and understanding around HIV that they encountered from their clients. This results in the counsellor needing to give education around the facts of HIV/AIDS, its transmission and prevention.

Thirdly, in a client-centred system, mostly the infected individual is counselled, although HIV and AIDS impact on social, familial, and sexual relationships. While counselling the individual may help him or her to come to terms with the disease, and its consequences, the individual may still remain powerless to make any effective changes, especially with regards to sexual behaviour, when he or she is disempowered to do so. Particularly for women, who may be dependent on their husbands for economic support, they may be powerless to

challenge the 'rules' of their husbands with regards to sex. Stigma also factors into this, in that the individual may arrive at a point where he or she has accepted his or her status, but feels unable to disclose for fear of possible negative consequences. If we look again at the UNAIDS (1997b) definition of HIV counselling as "a confidential dialogue between a client and a counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS" (p.3), an individualistic client-centred approach may not necessarily be the best approach, given that many of the issues influencing a person making the decisions exist in social and sexual relationships, and not with the individual alone.

Lastly, HIV is distressing and has serious implications not only for the infected individual, but also for those affected by the HIV-positive individual. Clients are encouraged to disclose to their partner or a member of their family, and this is in some cases a requirement for entering a treatment programme. However, the individual discloses to the partner or family member on their own, and often to a person with limited understanding of, and strong feelings regarding, the disease. Disclosing can result in much distress for the person hearing the news, and that person is often not receiving counselling for his or her distress. Some counsellors did mention that they counsel couples together, once they have disclosed to each other. Six counsellors also mentioned providing counselling for the family when the client requests it, but this seems to be an 'extra' service provided upon request.

4.2 The client-counsellor relationship

The consequences of being HIV-positive are enormous for the infected individual, resulting in a number of difficulties that the client has to face, and which are brought into the counselling situation. Perhaps most important is how the strong stigma attached to HIV and AIDS results in the client's struggle to disclose his or her status to significant others, who have the potential to support him or her. In some cases, the clients may even deny their status.

However, what is particularly important and relevant to the purpose of this study is the impact that counselling the client has on the psychology of the counsellor. HIV/AIDS counselling is stressful and emotionally demanding work. Counsellors and clients are involved in a confidential and intimate relationship where emotionally loaded topics, such as sex, death, and dying, are discussed. For the counsellor, the intensity of the client's emotions and the distressing aspect of the illness may arouse anxieties in the counsellor, resulting in problematic countertransferences, and the breakdown of client-counsellor boundaries.

Having to tell a client that he or she is HIV-positive is perhaps the beginning of a distressing, emotionally intense, and uncertain time for the client. Counsellors find giving the "bad news" of a positive test result to be a difficult and stressful experience. The distress of the client, and the counsellor's fear of the client's unpredictable reaction, arouse anxieties and even fear in the counsellor. Having to witness the distress the diagnosis has caused for clients arouses anxieties in the counsellor about their own capacity for harm and reparation. Many counsellors differentiated between having to tell the client of a positive diagnosis, which they found stressful, draining, and devastating; and a negative diagnosis, which they found easy and happy. One counsellor overtly referred to splitting the experiences of telling "bad news" (positive diagnosis) and "good news" (negative diagnosis) into a job badly done and a job well done: "If people are HIV positive, I don't do my job. Then if people are negative I say, 'I know, I'm happy, I do my job.'" (Respondent 3) This splitting may function as a defence against anxiety, and works in the same way as the infant's splitting of the "good" and "bad" mother in the paranoid schizoid position.

The very fact that there is currently no cure for HIV/AIDS makes counselling a client with HIV or AIDS difficult for the counsellor. Counsellors are unable to change the fact that the client is ultimately going to suffer and most likely die as a result of the disease. This arouses feelings of helplessness and hopelessness in the counsellor, who faces counselling a person who cannot be saved. This frustrates the counsellor's unconscious drive towards reparation, and creates anxiety for the counsellor. Case Study 2 explicitly portrays this hopelessness and anxiety in the counsellor when she says, "What I did is just to talk; nothing else." (Participant E, Focus Group 1) It is interesting to note how the counsellor uses the will of God as a strategy of explanation with the client. The power of God, the creator, is used as a metaphor for the powerlessness and helplessness of the counsellor. It is only God, the creator, who can "save" or "destroy", not the counsellor.

The drive for reparation is reflected in the importance placed by the counsellors on knowing that they are helping people, and helping the community. The majority of the counsellors (76%) stated that the fact that they are helping people who are in need, and the community, alone inspires them to continue counselling. Most of the counsellors mentioned knowing that counselling has in some way helped the client, and witnessing the client cope, as the nicest aspects of their jobs. When a counsellor witnesses a client cope, this diminishes the counsellor's anxiety in that the counsellor was in some way able to 'repair' the damaged client.

Implied in this value of helping the community is the strong sense of identification with the community, and thus the clients who come from the community. Counsellors come from largely impoverished backgrounds themselves, as do the clients; and some counsellors spoke of clients coming to them with material problems of poverty, homelessness, and hunger. This may cause the counsellor to identify with the needs and deprivation of the client, and may arouse anxiety in the counsellor with regards to his or her own needs and deprivation. Four counsellors gave examples of where they ended up doing more than just counselling for the client, and helped them with their material problems.

Given the high estimated rates of HIV infection in the country, it is likely that HIV and AIDS have affected the counsellors themselves. This provides a further area, where counsellors can identify with the distress of the infected individual. This was strongly indicated in Case Study 2, where the counsellors in Focus Group 1 talk of the loss that the counsellor faces when the client, with whom the counsellor has had an intimate relationship, dies. This affects the counsellor, who is faced with the distressing aspects of disease, dying, and death. This in turn arouses the counsellor's own anxieties and fears about death. For counsellors who have been personally affected in their own lives with friends and family who have died of HIV, past experiences are relived. One counsellor stressed: "The infected ones, they going to die, but we are affected!" (Participant C, Focus Group 1) At the time that this study was entering its completion stage, I learnt of the AIDS-related death of one of the counsellors (who was not interviewed). This brought the fact that HIV is a personal experience closer to home. Only one counsellor disclosed her own HIV-positive status. While she considered her own status to be an 'asset' in that she acts as a role model to others, she recognises the potential for difficulty, and also states how she becomes "exhausted" when counselling HIV-positive clients with regards to their own feelings around the positive diagnosis.

The death and loss of the client can create feelings of there being unfinished business between the counsellor and the client, further fuelling the counsellor's anxiety of her capacity for harm and desire for reparation. Respondent 3 talks of a case where the client died: "It haunts me really, because I was waiting for her daughter to come to me. Like, it seem as if she died not knowing what happened to her mum. And if she did come to me, I think it was going to be better". The counsellor thinks about how things could have been better if she had done things differently. This indicates the unconscious desire to 'save' the client, and the anxiety caused when that is not possible. This situation may also be a countertransference of unfinished business that the counsellor may feel she has with lost ones.

Case Study 1 also provides a powerful example of the anxieties that are aroused in the counsellor as a result of the circumstances of the client-counsellor relationship. This case study provides an example of the implications that confidentiality, the cornerstone of counselling, may have on the psychology of the counsellor. It is useful to review the case quickly here. Case Study 1 provides a moving account of a counsellor's struggle with an HIV-positive woman who was refusing to disclose to her HIV-negative husband, and was not using condoms. The counsellor counselled the wife on an ongoing basis, and the husband during periodic HIV testing. Over a period of approximately two years, the counsellor had to witness the husband becoming infected as a result of the wife's refusal to disclose her status and use condoms. This caused great anxiety for the counsellor, who was concerned for the health of the husband. However, the counsellor was unable to break confidentiality, and this made the counsellor feel helpless, and guilty. The anxiety and negative feelings of the counsellor were projected onto the wife, the client, with the result that the counsellor felt very angry towards the client, whom she blamed for the husband being positive. This case left a great impression on the counsellor, who had to deal with feelings of guilt, helplessness, blame, and anger. The counsellor received help from her superior, as well as supervision, which helped her to deal with some of these feelings. However, the anger still remains. At the end of the quoted case study, the counsellor responds to the question of whether she is still angry, by saying: "Ja! Though I know now she's helpless, because I mean, shame, she's very ill now, but I still feel that she shouldn't have done that". This implies guilt for feeling anger towards the client, who is suffering and dying. Kiemle (1994) speaks of counsellors' guilt for having negative feelings about a client who has to cope with the distress of a potentially deadly disease.

Case Studies 1 and 2 may also be examples of how the boundary between client and counsellor can diminish, and the counsellor becomes affected by the distressing emotions. It is possible that some of the helplessness and hopelessness that the counsellor experiences are a projection of the client's own sense of helplessness and hopelessness in living and dealing with a deadly disease. The guilt and blame felt by the counsellor in Case Study 1 may also be partly a projective identification of the client's own possible feelings of guilt and blame for having infected her husband with HIV as a result of her own behaviour. There is also the example of a counsellor (Respondent 11) who came across a client, of the same age, whom she knew, and who was very sick with AIDS. This resulted in the counsellor identifying strongly with the client, and raised anxieties in the counsellor about her own mortality.

The counsellors seem to be aware of how countertransference impacts on counselling, and the importance of maintaining boundaries in the counselling relationship. Aspects of Lifeline's training are designed to address these very issues. However, much of this takes place unconsciously, as shown with Case Studies 1 and 2, where the counsellor is contaminated by the feelings of the client. Counsellors also speak of "worrying" about a client, when the client is doing something counter to what the counsellor regards as being the right thing to do. In this case the counsellors take on responsibility for the client.

In addition, the counsellors' own past lives can play a role in the counselling work. Case Study 2 shows how the counsellor's own past experiences with regards to HIV and AIDS make aspects of the counselling task difficult for the counsellor. Case Study 3 provides a clear example of how a counsellor's unhappy childhood experiences with her parents play a role in how she finds counselling couples and families in trouble difficult. In this case, the counsellor speaks of her father, who is abusive towards her mother. Although the counsellor does not state that she felt anger towards her father, she does mention that she "was hating the way I was growing up". Her anger is projected onto the husband of her client, towards whom the counsellor feels anger. Her own experiences in childhood also cause her to identify strongly with the imagined pain of the children. The counsellor's unconscious drive to make reparation is reflected in her statement "it's that I can do something! I can do something!"

As sex is a subject that is not normally discussed openly between the sexes and between the generations, talking openly with someone older and of the opposite gender becomes difficult. Counsellors spoke of how it can be difficult to counsel clients who are older than they are, particularly when talking about sex and safe sex. Counsellors found that they had to prepare the older clients beforehand, and in a sense apologise for having to discuss sex with them. This places the counsellor in a somewhat subordinate position to the client, and one counsellor spoke of how she felt inferior when counselling a much older man. Her sense of inferiority caused her to have negative judgements towards the older client, whom she felt was patronising her. Similarly, counsellors find it difficult to counsel clients of the opposite gender.

A counsellor pointed out how Lifeline's training programme helps to address these cultural issues involving age and gender. Lifeline training occurs in small experiential groups, where trainees of different ages and gender are mixed in a small group, and they have to talk to each

other about intimate subjects, like sexuality. In this way, the trainee counsellors prepare themselves for the experience of talking with clients of a different age and gender.

4.3 Counsellors and the workplace

Work-related problems also cause stress for the counsellor, which then impacts on counselling. Some counsellors felt that there was a lack of appreciation for the work done by counsellors and a lack of understanding about the needs of clients and counsellors, from senior staff members in health clinics as well as by government. In Focus Group 1, there was much discussion about how a lack of appreciation and lack of teamwork make the counsellor's job difficult. In contrast, Focus Group 2 discussed the importance of working together as a team with senior staff members, and how this makes the counsellor's work easier.

The counsellors in Focus Group 1 felt that counselling is at times a long process, particularly if the client tests positive. In addition, it is tiring for the counsellor, and counsellors feel they need to control the amount of time spent with each client, and limit the number of clients they see. This can be in conflict with the senior nurses, who are concerned about the number of people who need to be tested. Counsellors in Focus Group 1 speak of being rushed to finish off counselling sessions. The counsellors also talk about how some patients are sent to them for counselling, already in distress after having been told that they are HIV-positive. These issues make the counsellor's job stressful, and much anger is felt towards the senior staff members, whom they feel are not supportive of their needs. There seems to be a conflict with regards to the perceived primary task of the clinic. For the nursing staff, the primary task is to get people tested, and educate them about HIV transmission and prevention. For the counsellor, the primary task is to provide emotional support for the client. Petersen and Swartz (2002), have highlighted how South Africa's health care system has had a biomedical orientation, and needs to be reformed to provide a comprehensive and empowering approach to care. For HIV/AIDS counsellors, trained in an empowering and client-centred approach, there is a clash with the biomedical and technicist approach of primary health care. Van der Walt and Swartz (1999; 2002), have shown how nursing in TB clinics in South Africa is task-orientated, where care is provided in the performance of specific tasks, rather than caring for the patient as a whole. Van der Walt and Swartz (2002) highlight that task orientation is the routine practice in public health service, and stands in the way of "patient-centred engagement." (p. 1008). Results of this study indicate the clashing interface between counsellors, trained in a client-centred approach, and nurses, trained in a task-orientated approach.

The position of the counsellors within a task-orientated clinic, is an interesting one. A task-orientated approach to health care has been shown to act as a defence against the anxiety aroused in the health care worker, from working with 'damaged' patients (Menzies, 1960; Van der Walt & Swartz, 1999; 2002). Counsellors provide patient-centred care in that the counsellor works with the patient as a whole person, within a task-orientated health care system (Van der Walt & Swartz, 2002). It can be argued then, that counsellors may function as an unconscious container for the anxieties of the staff, as they are the staff members who work with and contain the patient as a whole person. This can be illustrated by the example of the patient who was tested positive by one of the nurses, and told of the results, and then sent for counselling when the patient was in distress:

Participant E (focus group 1): I remember, one of the doctor [...] she see that client, and then she told, "with this shingles, you think you are this 80% or 20% of HIV people." And then the client didn't reply back. "I think you are this 80%. You have HIV. So, go to room 7, and then they are going to tell you, you have your, if, they finish draw your blood." And then she come to me and knock on the door, and I say, "Okay, have a seat." When she start sit, she cry, I can't do nothing. "What's going on? Why you crying?" About half an hour, just give that chance to cry here, and then after that I ask, "Do you know that you tested?" - "I'm HIV." - "Did the doctor draw your blood?" - "No." - "So, why?" - "No, the doctor said." And the doctor is more that a counsellor, is a doctor. The doctor can't lie. Really can't lie, but the way she put the things! They way she saying! Because on, on that space there's no need, you can't say. But is a doctor. As a result what I did. I just think: No. She gave me a hard time now! Because this person already crying, already broken heart already! So, the first time must go straight to the doctor, "Look, if you are going to say like this, I think you supposed to counsel, and do everything! And you must do everything to that person! Otherwise you give that broken people to me! Who's going to pick up all that?" And, I mean, in the way we work sometimes... I don't know, because I'm always thinking the counselling is there. The doctor has got a counselling. The nurses has got a counselling, but the way, is not look like! As a result, they give us a hard time.

In this quote, the counsellor clearly states her function as a container for the nurses and doctors' anxiety when she says: "Look, if you are going to say like this, I think you supposed to counsel, and do everything! And you must do everything to that person! Otherwise you give that broken people to me! Who's going to pick up all that?"

There were also strong feelings of inferiority among the five counsellors in Focus Group 1, who spoke about being labelled "lay counsellors", and emphasised this as an inferior label, highlighting their lower rank in the professional hierarchy. Much of the narrative that took place in this focus group was split into an 'us' (counsellors) and 'them' (professionals) discourse, with an expression of 'us' as doing 'good' work, and 'them' as doing 'bad' work. This

splitting may function partly as a defence against the anxieties and inferiority felt by the counsellors.

These feelings of inferiority and ranking relatively low in a professional hierarchy must be seen in the context of discrimination and race in South Africa. All of the counsellors in this study are black South Africans. During Apartheid, black South Africans were assigned the lowest socio-economic jobs, while white South Africans enjoyed the higher, more prestigious positions. Black South Africans lived under an oppressive state that regarded them as racially inferior, and controlled every aspect of their lives. Thus, in this case, a black woman, who has historically been regarded as inferior, continues to feel as if she is regarded as inferior because she is called "lay" counsellor, and continues to be in the lower hierarchical position, despite her capability and education. Furthermore, the employer is the Department of Health, and thus the State. During Apartheid, the State was the oppressor and an institution that was feared and not to be trusted. This experience of authority has "resulted in a deep mistrust of power" (Gibson, 2002; p. 18), and may result in an ambivalence towards those in authority in the clinic.

Counsellors also spoke about capacity problems within the workplace, such as lack of counselling space, which makes the task of counselling difficult as counselling sessions are interrupted when shared space is needed. In addition, lack of staff causes problems, when the counsellor is unable to find a staff member who can perform an HIV test on the client, and the counsellor is then "stuck" with the one client, while others are waiting. Furthermore, counsellors also expressed the fact that counselling services taking place during daytime working hours exclude a large number of people, who are unable to come because of work.

4.4 What helps the counsellor to cope

This study has shown how HIV/AIDS counselling can be distressing, emotionally stressful, and anxiety-provoking work. Difficulties can be dealt with to help the counsellor cope with these potential problems and issues. Many of the Lifeline counsellors have been doing this work for long periods of time. At the time that details were collected from the 43 counsellors in March 2002, two counsellors had been with Lifeline Khayelitsha since its inception six years ago (1996). A third of the counsellors had been with Lifeline for three years or more. The average length of time that the counsellors had been with Lifeline was two years (this includes recently recruited counsellors). This indicates that counsellors have been sufficiently

able to find ways of coping with the demands of their work to continue counselling. Of course, for many this is their full-time job and only source of income.

The two most frequently mentioned processes that help the counsellors in their work are the preparedness and the training received, as well as supervision and debriefing. The counsellors felt adequately prepared and trained for the task of counselling. They also felt that they have been equipped with skills that have helped them in building a therapeutic relationship with the clients. As mentioned already, the training has also given them an awareness of the importance of maintaining boundaries and dealing with countertransferences. Not only have the skills learnt helped them in their work, but also, for many, what they have learnt has helped them in their own lives with their own relationships, and empowered them as individuals.

Over half of the counsellors mentioned debriefing, to the Lifeline counselling supervisor or to colleagues, as an important way of helping them with their problems and issues. Supervision was a space where counsellors could "offload" their problems, and discuss their issues with the supervisor and other counsellors in the supervision group. Sharing problems is an important way of coping with difficulties, with many counsellors mentioning sharing problems with colleagues in the workplace. This occurs through informal chats with other counsellors, and through formal periodical meetings with staff members, where problems are discussed and shared.

4.5 Limitations of the study

There are some limitations to this study. Firstly, the sample is taken only from Lifeline Khayelitsha, and is thus a very homogenous sample. The findings cannot be generalised for the experiences of counsellors in other parts of the country. However, the information collected will provide useful indications of some of the possible difficulties and strengths facing HIV/AIDS counsellors in South Africa. In addition, the findings show how transference and countertransference can create difficulties for the counsellor.

Secondly, I, as the researcher, am a white male, interviewing predominantly black women from an impoverished background. As a result of South Africa's Apartheid past, race and class are loaded with issues of privilege and power. Sensitivity must be given to the way things are communicated, because of this difference between the researcher and the researched, which may contribute to a bias in the findings. I found some interviews to be 'a bit too positive', in

that the counsellor talked about having or experiencing very few difficulties in her work. This was the case for Respondent 5, who mentioned having no difficulties. After the interview was over, she asked me whether I could comment on how she is doing her work. This left me with the feeling that she was trying to make a good impression, and thus was reluctant to talk about any difficulties. A similar thing happened with Respondent 9, although she did discuss some difficulties that she has experienced.

Thirdly, due to time constraints, and the issue of confidentiality, no direct observations of the counselling process or interaction was made. It must be acknowledged that differences may exist between the counsellors' descriptions and interpretations of the counselling activity, and their actual counselling interactions. Furthermore, as no observations were made of the work environment, a similar caution must be made with regards to the counsellors' experiences in the workplace.

4.6 Conclusion

This study provides an insight into the reported relationship between counsellors and clients, as well as counsellors and the health care system. This is an area of research, which has been largely lacking. Much research has been conducted on HIV/AIDS from the point of view of the patient or client. Counselling services have been designed with the needs of patients in mind, but not the needs of the counsellors themselves, both with regards to their interaction with clients, as well as their position within the health care system.

The results of the study identify three main areas of concern with regards to HIV counselling. Firstly, some indication is given of the possible limitations to a client-centred system. It is clear that HIV counselling must include a mixture of non-directive counselling as well as directive counselling around health education. Given the persisting lack of awareness and misconceptions around HIV and AIDS, clients first need to be educated about HIV and AIDS before there can be any effective non-directive counselling. Furthermore, an individual client-centred system is perhaps not the most appropriate, given that many of the issues and problems relating to HIV prevention and care occur in social, familial, and sexual relationships. The findings of this research can be combined with other studies to gain a better understanding of the strengths and weaknesses of different counselling models. Richter and her colleagues (1999), have highlighted the "need to develop diverse and flexible ways of delivering counselling services" (p.141) in South Africa. Findings from this study provide a valuable contribution of knowledge towards developing such counselling services.

Secondly, the nature of HIV/AIDS, and the issues it creates for the patient, can arouse a number of anxieties in counsellors, related to their own past; their capacity for harm and reparation; feelings of helplessness and hopelessness; strong affective states such as guilt and anger; and feelings of inferiority. Counsellors may defend against these anxieties in dysfunctional and problematic ways, for example by projecting negative states onto the clients, and by the use of splitting. In light of this, a programme for training HIV/AIDS counsellors should ideally include psychodynamic issues, so that the counsellors gain an awareness of how transference and countertransference can become problematic in the counselling relationship. A training programme should also include a module similar to Lifeline's Personal Growth Course, where trainee counsellors can explore some of their unresolved issues, and patterns of thinking about and reacting to things. This would create an awareness of how their own feelings are influenced by their past. Of course lay counsellors will not benefit from the extensive training received by professionals, like psychologists, for example. Such extensive training equips the professional to work effectively with transference and countertransference in a therapeutic relationship. For this reason it is essential that counselling programmes provide supervision and support for counsellors on a regular basis, where such psychodynamic issues can be worked through. This need for ongoing supervision is similar to what is needed for professionals. Given the very distressing nature of HIV and AIDS, and how easily anxieties can be aroused in the counsellor, supervision should be provided on a weekly basis.

Thirdly, the results provide some indication of how anxieties can be played out in the workplace and among staff. It must be acknowledged once again that no observations were made of the workplace, so the findings of this study need to be substantiated by further research. Similar to how supervision can help the counsellor manage their psychodynamic issues, regular staff workgroups, facilitated by a consultant, can provide a space for staff members to explore workplace issues and anxieties, and develop solutions to cope with them. Furthermore, the study indicates a clash with regards to the orientation of counsellors and nurses, who are trained in opposing approaches to health care. These differing approaches results in a difference with regards to the perceived primary task of HIV testing and care, and may cause tensions between the counsellors and nurses.

Future research can make observations of the working relationship between the counsellors and the other staff of health care institutions. Such research can highlight the difference in orientation with regards to the delivery of health care, and how this creates tensions between

different staff members, and arouses anxieties, which are played out in the workplace. Research can also make comparisons with other HIV counsellors who differ in terms of the training received, and who do not receive supervision. Results can compare the levels of coping between the counsellors, and identify what helps counsellors who do not receive supervision, cope. This would provide a more comprehensive understanding of the needs of the counsellors, and identify different ways in which counsellors cope. It could also lead to recommendations about how best to tackle structural issues regarding the position of counsellors in the health system.

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ADDENDUM A: PLACES WHERE LIFELINE LAY COUNSELLORS WORK**CO-ORDINATORS:**

LifeLine Centre, Khayelitsha

Uluntu Centre, Guguletu

LAY COUNSELLORS:**CITY (CAPE TOWN):**

- Chapel Street Clinic, District Six
- Green Point
- Groote Schuur Hospital, Observatory
- Spencer Road, Salt River
- Woodstock

GUGULETU/MANENBERG:

- Jooste Hospital

KHAYELITSHA:

- Empilisweni
- Luvuyo
- Matthew Goniwe
- Michael Mapongwana
- Nolungile, Site C
- Site B day hospital
- Site C day hospital
- Zakhele
- Zibonele Mobile Clinic

MITCHELLS PLEIN:

- Weltevreden Clinic

NYANGA:

- Nyanga Clinic

ADDENDUM B: OUTLINE OF LIFELINE TRAINING COURSES.

(Compiled from the Lifeline training manuals (Lifeline, 1988; Lifeline, n.d.)

A. PERSONAL GROWTH COURSE:

The Personal Growth Course is offered over ten weeks (3-hour sessions a week). It is designed to enable the trainee's to discover and understand themselves, and to accept themselves and others. It is aimed at creating self-insight and awareness of personal strengths and weaknesses. It is an experiential course, where trainees are assigned a small group, where each member participates in discussions and exercises within the group. Each group has a Lifeline counsellor acting as facilitator. After completion of the course, each member of the group give feedback to each other as to their suitability to be trained as a counsellor, and to go forward with the Communication and Counselling Skills Course.

Module 1:	Introduction to the training course
Module 2 & 3:	Listening and communication
Module 4:	Sexuality
Module 5:	Spirituality, Death, Grief and Loss
Module 6:	Values and Prejudice
Module 7:	Conflict
Module 8:	Anger and Trust
Module 9:	Stress and Addictions
Module 10:	Where to from here?

B: COMMUNICATION AND COUNSELLING SKILLS COURSE:

The Communication and Counselling Skills Course is offered over nine weeks (3-hour sessions a week). The course teaches the skills required of a counsellor. Trainees are assigned to small groups, where learning takes place experientially. Trainees practice the skills learnt through role-plays and skills are practised through arranged telephone calls and face-to-face counselling with other trainees and Lifeline counsellors. Skills are assessed regularly throughout the course.

Module 1:	Introduction & Observation Skills
Module 2:	Attending Behaviour
Module 3:	Self-awareness
Module 4:	Questioning
Module 5:	Reflection of Feelings
Module 6:	Reflection of Content
Module 7:	Information Giving
Module 8:	Reframing and Interpretation
Module 9:	Confrontation
Module 10:	Integration

ADDENDUM C: COUNSELLOR QUESTIONNAIRE AND CONSENT FORM

PLEASE SUPPLY THE FOLLOWING INFORMATION.
THIS IS NEEDED TO HELP ME SELECT PEOPLE TO BE INTERVIEWED.

NAME:_____.

AGE: _____.

HOME LANGUAGE:_____.

GENDER: please tick: ☐ female ☐ male

HOW LONG HAVE YOU BEEN AT LIFE LINE?_____.

WHAT ACTIVITIES ARE YOU INVOLVED IN AT LIFE LINE?:

Please tick all activities that you are involved in:

- ☐ Management
- ☐ Administration
- ☐ Counselling: ☐ at lifeline centre
- ☐ with TB and HIV patients at clinics
- ☐ VCT
- ☐ MSF
- ☐ MTCT
- ☐ Support groups with mothers of the MTCT program
- ☐ Other: please specify:_____.

CONSENT: Are you prepared to be interviewed, on the condition that what you say to me will be kept confidential?

- ☐ Yes signature:_____.
- ☐ No

Are you comfortable in being interviewed in English? ☐ Yes ☐ No

Which telephone number may I use to contact you?_____.

What is the best time(s) to phone?_____.

THANK YOU FOR THE INFORMATION.
I LOOK FORWARD TO SPEAKING WITH YOU!

ADDENDUM D

NOTE: Counsellors in this list are in no particular order, and do not correspond with the order of the respondents in the rest of the thesis. In other words, "Respondent 1" in the thesis does not correspond to counsellor 1 on the table under counsellors interviewed.

TABLE 1: Details of Lifeline counsellors as at March 2002

	Gender F=female M=male	Age	Months working with Lifeline	<u>Activities:</u> Manage- ment	Admin	Counselling at Lifeline offices	Counselling TB and HIV patients	pre- and post-test counselling	Counselling patients at MSF clinics	Counselling mothers of the MTCT program	Facilitating Support group of mothers
Counsellors interviewed individually:											
1	F	41	60	*		*					
2	F	28	24				*	*			*
3	F	48	9					*		*	*
4	M	25	24	*				*		*	*
5	F	48	6					*		*	*
6	F	30	2				*			*	
7	F	38	5				*	*			
8	M	25	5					*			
9	F	58	5			*	*	*		*	*
10	F	24	5		*	*			*		
11	F	28	12				*	*			
12	F	54	27				*	*			
13	F	37	36						*		
14	F	33	18				*	*			
15	F	33	48								*
16	M	32	18			*	*	*			*
Counsellors interviewed in focus groups:											
Group 1	F	39	48				*				
	F	26	7				*				
	F	49	27				*	*			
	F	40	36					*		*	*
	F	28	14						*		
Group 2	F	42	36					*		*	*
	F	48	5			*	*	*			*
	F	36	36							*	
	F	28	24					*			*
	F	27	3					*			
Group 3	F	29	5						*		
	F	24	5					*			*
	F	35	12							*	*
Counsellors not interviewed:											
1	F	44	48		*	*					
2	F	43	48								
3	F	38	24					*			
4	F	53	3						*		
5	F	24	1							*	*
6	F	25	6				*				
7	F	39	12				*			*	*
8	F	35	54				*				
9	F	47	18					*		*	*
Counsellors who did not want to be interviewed:											
1	F	42	48			*	*	*		*	*
2	F	39	72							*	*
3	F	52	72	*							
4	F	46	60				*				
5	F	45	17			*	*	*		*	*

AVERAGES: (number of counsellors in brackets)

Total (43)	37	24	3	2	8	18	22	5	15	19
Interviews (16)	36	19	2	1	4	8	11	2	5	7
Groups (13)	30	17	0	0	1	4	7	2	4	6

ADDENDUM E: INTERVIEW SCHEDULE**A. BRIEFING - purpose of interview**

- use of recorder
- confidentiality

B. POSSIBLE QUESTIONS:

To be investigated further through use of probes,

1. Perhaps we can start of with you telling me about what your job is.

- Where do you work as a counsellor?
- What does the (above) organisation do?
- Where does counselling take place?
- Can you tell me about Lifeline as an organisation?
- Can you tell me about the other (eg. Health clinic) organisation?
- What is the relationship between the two organisations?
- Is there a relationship between Lifeline and other organisations?

Probes: eg. Can you tell me more?

Can you explain that further?

How does that work?

Who is involved?

What is it like?

2. How did you come to be a counsellor?

- What made you get involved in counselling?
- What training did you go through?
- What is your opinion of the training that you received?
- Is there anything that you would add to the training program?
- Is there anything you would change in the training program, or anything you would leave out?

Probes: eg. Can you explain that further?

What happened in that situation?

What about it don't you like? / Do you like?

3. What is your role as a counsellor?

- What are the aims/goals of counselling?
- Who comes to you for counselling?
- What do they expect of you?

Probes: eg. What do you think of that?

How do you feel about it?

4. What are the best and worst aspects about being a counsellor?

- What are some of the difficulties of being a counsellor?
- How do you cope with these difficulties?
- How do problems get resolved?
- What would you change about the way problems are resolved?

Probes: eg. What happened then?

What made it difficult?

How did you feel?

5. Can you tell me, in detail, about one of the most difficult counselling sessions you had?

Can you tell me about the nicest counselling session?

Probes: eg. How did it make you feel?

What did you do?

What happened then?

6. Does counselling have an impact on your own life?

- How does it impact in your family life?
- How does it impact in your relationships?
- How has it affected you as a person?

Probes: eg. What do they say?

How do you react?

What do you do?

7. What makes you continue doing this work?

- How do you see your future?
- What do you see yourself doing in 5 years time?
- If you had your time over, would you do this again? Why/ Why not?

C. DEBRIEFING:

- Thank you very much for sharing with me. I have no further questions of you. Is there anything else you would like to share, or any questions you would like to ask?

ADDENDUM F: LIST OF CODES USED IN THEMATIC ANALYSIS**CM** Counselling Model:

- P: Person Centred
- E: Education
- A: Advice-giving
- L: Limitations of client-centred system

CT Type of Counselling:

- I: Individual
- G: Group
- F: Family
- O: Ongoing counselling

Diff Difficulties:

-CI: Client difficulties: difficulties that are experience as a result of the clients' attitudes, status, knowledge, and circumstance.

- 1: disclosure
- 2: denial
- 3: lack of awareness / understanding
- 4: clients' negative attitude towards counsellor. Eg: client blaming counsellor for HIV status
- 5: negative reaction of client, eg. Bad reaction to diagnosis; not returning for follow-up counselling
- 6: couples that are sero-discordant
- 7: Stigma and discrimination
- 8: Poverty and dependence
- 9: Clients not prepared for testing
- 10: Clients not being open/truthful

-Cs: Counsellor Difficulties: difficulties that are experienced as a result of the counsellors feelings, attitudes, professional constraints, and status.

- 1: Psychodynamic issues:
 - boundaries Eg: worry over client
 - Past experiences
 - Anxiety of "failure"/"harming" eg. "didn't do my job" when client is HIV positive.
 - helplessness: eg. Cannot save patient.
 - inferiority: eg. "lay" counsellor; not being recognised/appreciated.
- 2: Giving "bad news"
- 3: Confidentiality: eg. When partner is at risk
- 4: Negative attitudes toward client: eg. Anger, frustration.
- 5: HIV counsellor status: ie: others think you are HIV.
- 6: doing more than counselling
- 7: Large workload
- 8: No chance to debrief - containing problems
- 9: Not being appreciated / recognised
- 10: Concern for safety
- 11: Knowing the client

-12: Not able to deal with the problem

-Ct: Cultural Difficulties: difficulties experienced as a result of cultural beliefs, traditions and attitudes.

- 1:** Unacceptance of condoms
- 2:** Counselling older clients
- 3:** Male - Female communication
- 4:** Bewitchment
- 5:** Beliefs about counselling

-Or: Organisational issues: difficulties that are experienced as a result of organisational problems at the workplace

- 1:** Lack of teamwork
- 2:** Relationship with hierarchy
- 3:** Lack of counselling space
- 4:** Limiting office hours. Ie. Clients unavailable during work hours

Cope Coping "mechanisms": What helps the client to cope with difficulties.

- D:** Debriefing to supervisor/ colleagues/ friends
- R:** Relaxation techniques
- L:** Setting limits on caseloads/workload
- V:** Value of helping the community
- P:** Preparedness/Adequate skills/training
- T:** working as a team
- O:** Support from others
- E:** Experience in counselling
- B:** Building a strong relationship with the client

Net Network of care - referrals

Nice Nice aspect of counselling work:

- G:** Giving "good news"
- A:** Appreciation from clients and others
- D:** Making a difference/ helping people
- C:** Seeing clients cope/ being pro-active
- P:** Personal growth/ the learning of skills
- R:** Forming relationships with clients/others

Train Training:

- PG:** Personal Growth Course
- CS:** Counselling skills course
- On:** ongoing training.

Imp Impact that counselling has had on counsellors life:

- P:** positive
- N:** negative