THE EFFECTS AND NATURE OF VOLUNTARY COUNSELLING AND TESTING FOR HIV AND AIDS IN SOUTH AFRICA AS EXPERIENCED BY THE COUNSELLOR

A research report submitted to the Faculty of Humanities, School of Human and Community Development, in partial fulfilment of the requirements for the degree of M.A. Research Psychology

Deanne Goldberg

0417553D

Supervisor: Mrs. Lynlee Howard-Payne

Department of Psychology
School of Human and Community Development
University of the Witwatersrand

DECLARATION

I declare that this thesis is my own unaided work. It is submitted in partial fulfilment of the requirements for the degree Master of Arts in Psychology (by Coursework and Research Report) in the Department of Psychology, School of Human and Community Development, University of the Witwatersrand. It has not been submitted for any other degree or examination at any other university or institution.

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Deanne Goldberg

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Date

Abstract

This research represents the culmination of approximately two years of investigation into the nature and experience of counselling for HIV and Aids in South Africa. Over this time, the researcher engaged with Voluntary Counselling and Testing (VCT) counsellors across Gauteng province, South Africa, to gain insight into the practical as well as the psychological aspects of their counselling experiences. Numerous facets of the counselling experience are explored. The demographic descriptors of the responding sample were used to elicit a profile of the typical VCT counsellor. Additionally, counsellors' personal motivations for entry into the field, as well as training experiences and the procedures they adopt when counselling were investigated. An essential strand of the research involves the subsequent exploration of counsellors' perceptions regarding the work that they do. Finally, the research presents reflections on one of the emergent issues raised in the results- power dynamics and their influence on the experience of counselling for HIV and Aids. A reflexive review was included in the findings of this study in order to provide the reader with an insight into the researcher's emotional and cognitive experience of conducting this study. The study represents a valuable endeavour in refining current understandings of VCT counselling practice and experience.

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Chapter 1: Introduction and Overview

The research described within this document aimed to explore and document the experiences of the counsellors who provide Voluntary Counselling and Testing (VCT) for HIV and Aids to members of the South African population. There exists a growing awareness that psychological counselling has the capacity to significantly affect both the physical and mental health of the counsellor, and VCT may certainly be conceived of as a form of psychological counselling (Dunkley & Whelan, 2006). VCT has been consistently promoted as a critical and effective intervention in the prevention of HIV and Aids both within academic literature, as well as governmental and health care policies. Despite this, however, there is comparatively little information addressing the counsellor's perceptions and experience. In order for the success and quality of this intervention to be optimised, an account of the nature and experience of the VCT process would be valuable. The individuals responsible for its implementation may be seen as influential in maintaining adequate and effective standards of care. The research study described here, therefore sought to examine counsellors' experiences of providing VCT in South Africa.

The Joint United Nations Programme on HIV and Aids' (UNAIDS) update on the Aids epidemic states that South Africa currently maintains, internationally, the highest number of individuals living with HIV and Aids in the world (2007). The most recent estimates have suggested that this number may be approximately 5 500 000 (Global Health Facts, 2008).

With the epidemic incidence of HIV and Aids, particularly in developing countries, the need and moreover, the demand for HIV and Aids counselling has been shown to be increasing (Grinstead, Van Der Straten & The Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000). Further, Green (1989, as cited in Coyle & Soodin, 1992) has emphasised that, world-over, the provision of counselling has come to be regarded as an indispensable component of the services available to those people who are either concerned with, or have been diagnosed and are living with HIV and Aids. Bond (1995)

also emphasises that the same official bodies have recommended that each individual who undergoes an HIV test should be given the opportunity to receive counselling. It is at this point where an intervention such as Voluntary Counselling and Testing (VCT) is seen to be critical in combating the HIV and Aids epidemic.

South Africa's *HIV & AIDS and STI National Strategic Plan: 2007- 2011* states, among its key priorities of treatment, care and support that it aims to "reduce HIV infection and Aids morbidity and mortality as well as its socio-economic impacts by providing appropriate packages of treatment, care and support to 80% of HIV positive people and their families by 2011" (South African National AIDS Council (SANAC), 2007; p.11) The document continues by stating that one of the ways to do this would be ensuring an increased access to VCT services and promoting regular HIV tests. They seek to enhance the accessibility of VCT services, which should recognise the diversity of the needs of those making use of this service as well as to increase its uptake.

It is intuitive thus, that with the increased incidence of HIV and Aids in developing countries, as well as of those living successfully with Aids in developed countries, the need for volunteer services is great (Held & Brann, 2007). Effective counselling may enhance the quality of life and coping resources of the client, as well as improve familial and social support systems (Coyle & Soodin, 1992). In addition, the counselling forum has a significant role to play in assessing risk behaviour and preventing further potential infections (Meursing & Sibindi, 2000).

Rachier and colleagues (2004) have stated that the services provided by VCT sites are playing an increasingly important role in the prevention of HIV and Aids and it is therefore critical that the services provided should be optimum. The importance of this fact was highlighted by Solomon and colleagues (2004) who note that although VCT has repeatedly been touted as a critical form of intervention, the focus has recently begun to shift from merely taking action, to ensuring that preventative measures adopted are, in fact, efficacious.

It is also essential to note that there are significant stresses implicit in the counselling role, which may affect the mental and physical health of the counsellor (Dunkley & Whelan, 2006; Ross & Seeger, 1988, as cited in Ross, Greenfield & Bennet, 1999). Ross *et al.* (1999) highlight how burnout (and dropout) among HIV and Aids volunteers and caregivers, who play such a critical role, results in considerable strain on the HIV and Aids care system, and also disrupts the care and treatment of patients.

In acknowledging the considerable stresses to which VCT counsellors are exposed, this study sought to investigate the coping mechanisms employed by counsellors. These may be either adaptive, maladaptive or avoidant (Dunkley & Whelan, 2006). The coping style of the counsellor has the capacity to affect profoundly his/her ability to counsel productively, and an understanding of these would surely be helpful in providing counsellors with the appropriate resources in order to optimise the efficacy of the counselling service they provide.

Despite the touted importance of VCT both nationally and internationally, there is surprisingly little information surrounding the counsellor's perceptions and experience. In a review of the VCT literature published (until 2001) that pertains specifically to South African context, conducted by Solomon and colleagues (2004), only 385 published articles met the criteria for inclusion in the study. This fact remains at odds with the well-publicised importance of VCT, making it clear that there is certainly a need for further research in this field.

As a final note, the research described here sought to extend and refine a research report conducted by the author at an Honours level (Goldberg, 2007). The results obtained within the report provide compelling evidence in support of the above statements. Currently, VCT counsellors within South Africa appear to be under significant pressure and would relish the chance to have their voices heard.

With the pandemic levels of HIV and Aids in South Africa, it is clear that there is an increased need for effective interventions. A thorough understanding of the counsellor's

roles and responsibilities, as well as typical stresses and coping styles would be invaluable. Ultimately the rationale behind the study is that a more detailed knowledge of this topic may be useful in creating and maintaining a supportive infrastructure. Thus, the research described here sought to extend and enhance the prior investigation. It attempts to document the nature of the counselling experience and its effects on the counsellor, thereby giving voice to the concerns of the counsellors. It is the hope of the researcher that the study's results will be useful in enhancing the counsellor's experience of their work and thus optimising the effectiveness of this important intervention.

This chapter has provided an overview of, and introduction to, the study represented in this dissertation. Chapter 2 presents a review of the literature which formed the theoretical foundation of the research. VCT is explored technically, and the nature, requirements and risks of the counselling process are described. Chapter 3 describes the methodological underpinnings of the study. Included in this chapter are descriptions of the study's design, procedure, instrumentation, data analysis, and ethics. Chapter 4 provides an integrated representation of the findings of the study. In addition to the emergent thematic results, broader reflections- those of the researcher and participants alike- are noted, and recommendations and avenues for future research are highlighted.

Chapter 2: Literature Review

2.1 Introduction

There are numerous factors that may inform the counsellors' experiences of providing VCT. The literature review presented here seeks to critically address some of these, and in so doing, to provide a working knowledge of useful theoretical concepts, and descriptions of issues that are of critical relevance to this project. To begin, a discussion of the nature of the counselling role is provided below.

2.2 Counselling and the Counsellor

Colman (2003) defines counselling as "the practice or profession of applying psychological theories and communication skills to clients' personal problems, concerns or aspirations. Some forms of counselling also include advice-giving, but the dominant ethos is one of providing facilitation without directive guidance" (p.172). Thorne (2005) also noted that many therapists and counsellors, in Rogerian tradition particularly, regard empathy, genuineness and positive regard for the client as core conditions in *any* healing, counselling relationship. Counselling, thus, refers to the process of utilising an understanding of psychological theories, and integrated communications skills, in a facilitative manner, in an attempt to assist individuals with their equally unique problems.

It is important to note, however, that some disparities exist in definitions of counselling. Further, there is some debate whether a discernible difference between psychotherapy and counselling exists. McLeod (2003) suggests that the main differences between the two lie in the amount of training each of the relevant practitioners receives.

It may be noted that regardless of the debates surrounding their differences, at a fundamental level, both counselling and psychotherapy rely on psychological theories and specific guiding principles. It is for this reason that this research draws on literature derived from both psychotherapeutic- and counselling-oriented texts, and regards certain fundamental issues as consistent between the two. The counsellor is assumed to draw on similar fundamental resources as the psychotherapist. Therefore, this text engages with

certain concepts that are relevant to both fields, in order to enhance its richness and the depth of understanding.

2.2.1 Voluntary Counselling and Testing (VCT)

According to the World Health Organisation (WHO) (2006): "Voluntary counselling and testing is when an individual chooses to undergo HIV counselling so that they can make an informed decision whether to be tested for HIV" (p.1). WHO provides a visual representation of the process of VCT, referred to as "The Gold-Standard Model" (WHO, 2004, p.106), which describes the relationship of pre- and post test counselling (see Appendix 1). Also, in an earlier UNAIDS (2005) definition, it was stipulated that the decision must be entirely the client's own and that assurance of confidentiality is paramount.

The main aim of pre- and post-test counselling is to empower the client to make productive use of the test results. For those who are diagnosed as HIV- positive, the role and aim of counselling is to minimize the emotional distress, as well as medical and social impact of diagnosis on their own and others' lives. For those who are given a negative result, counselling hopes to encourage these individuals to remain uninfected (Meursing & Sibindi, 2000).

2.2.1.1 Pre-test counselling

Pre-test Counselling represents the first stage of the VCT process. Before the counselling process begins, the VCT counsellor will assure the client of his/her information being confidential, and that anonymity will be ensured wherever possible. Further, it is essential that informed consent be obtained. The counsellor will assess the client's current level of knowledge about HIV and Aids. Lifestyle and risk behaviours that lead to an increased risk of HIV infection are also important factors that will be addressed. Further he or she will explain what is meant by an HIV test and the different types of tests used in testing an individual's serostatus, as well as what is meant by the 'window period'. The counsellor will address the client's coping resources with particular regard for the

implications of a positive or negative result, and will attempt to strengthen these in preparation for a result (Mindset Network Health Division, 2008).

2.2.1.2 The HIV test

Thereafter, the HIV test would be conducted. There are a number of different tests which may be utilised, including the commonly used rapid tests, as well oral, more advanced blood and genetic tests. The rapid test determines whether specific antibodies are present in the blood; the presence of these antibodies in the blood would be indicative of the presence of the HI virus. (AVERT, 2008) This rapid antibody test appears to be the most commonly used tests at VCT clinics.

2.2.1.3 Post-test counselling

Post-test counselling represents the final stage in the VCT process. It is a critical part of the intervention as it has the capacity to either positively or negatively influence the outcomes and impact of the result of the HIV and Aids test. Mindset Network Health Division (2008) describes the following important aspects of Post-test counselling:

For the patient who receives a negative test result the counsellor should provide client with information on safe sex practices and other mechanisms to ensure that he or she remains safe. Once more, the patient will be reminded of the window period and advised to be tested again after three months. The client will be advised to be tested regularly, particularly if he or she is currently engaging in risky behaviour. Examples of such behaviours may include: engaging in sexual activities with multiple partners, or while infected with a sexually transmitted infection, low condom use, partaking in transactional sex, excessive alcohol consumption, migration, an early sexual debut or the sharing of needles amongst those who partake of intravenous drug use (Simbayi *et al.*, 2006)

Research has shown that the diagnostic testing procedure and receiving the test results are associated with moderate to intense levels of anxiety and distress for the client (Worthington & Myers, 2003). Should the test return a positive result it is essential that the counsellor be sensitive to the emotional state of the client on receiving this diagnosis.

The counsellor must assess whether the necessary resources are available to ensure that the client will be able to cope with the diagnosis. It is the counsellor's role to reassure the patient, and to provide emotional support. It is critical that the counsellor explain the difference between being infected with HIV and having Aids. The counsellor will assess the need for psychosocial support, and attempt, in conjunction with the client, to assure an adequate support system, as well as draw up a follow-up plan explaining the implications of becoming infected with HIV. The importance of disclosure to partners will be highlighted and explored, the availability of anti-retroviral treatments will be discussed, and the risks, including an increased susceptibility to tuberculosis to which individuals infected with HIV are exposed, will be mentioned. The counsellor should also emphasise the concept of "positive living", and highlight lifestyle changes that will prolong the client's life to the greatest extent possible.

2.2.1.4 Types of VCT

Particularly within resource constrained settings, the need for knowledge of serostatus is imperative for scaling up HIV and Aids prevention and care (Strode, van Rooyen, Heywood & Abdool Karrim, 2005). Closely intertwined is the drive to increase the number of people being tested and who know their HIV status. Stemming from this, an interesting debate exists in the literature and practice surrounding the process of testing for HIV and Aids. A distinction must be made between *voluntary* or *client-initiated testing* and *routine* or *provider-initiated testing*. A Cochrane review of the relationship between voluntary and routine HIV testing further makes use of the terms *opt-in* and *opt-out testing* (Smith, Kevany, Doolan, Horvath & Kennedy, 2007). *Voluntary* or *opt-in testing*, which represents the main focus of this dissertation, was highlighted in the earlier sections of this chapter and described as the process whereby "an individual chooses to undergo HIV counselling so that they can make an informed decision whether to be tested for HIV" (WHO, 2006; p.1). Important here is the client's right to *choose* to undergo testing and receive a diagnosis of their serostatus. This type of testing requires that the patient take the *initiative* to request and consent to testing (Smith et al, 2007). This fact represents a core limitation of this type of testing in that it assumes a specific

level of knowledge, impetus and initiative that would drive an individual to present for testing and also relies on the health care provider or worker's willingness to actively promote, explain and endorse the testing (Smith et al, 2007).

Routine testing, in turn refers, to cases in which presenting patients or clients are notified that testing is a routine part of the clinic visit; no formalised counselling or written informed consent is required in this case. The term *opt-out* refers to the criterion that patients would have to specifically refuse testing to be exempt (Smith et al, 2007). This form of testing is seen as potentially beneficial in increasing the rates of testing because it forces the patient to make an active decision to refuse to be tested, rather than to remain with an unknown serostatus by default (Smith et al, 2007). Where voluntary testing relies on the client to initiate the testing procedure, the adoption of a routine approach to testing would serve to further the public health agenda of increasing the portion of the population aware of their HIV status. In so doing, the potential for prevention of the further spread of HIV would be enhanced. The problem which thus arises is an ethical one. While the broader public good may be served by the outcomes of routine testing practice, it may be seen to conflict with the individual's right to choose the nature and course of their medical health seeking behaviours highlighted in the constitution (Strode *et al.,* 2005).

Within the context of the study described here, this debate finds relevance in the fact that in the pre-test counselling session, VCT counsellors are charged with the responsibility of encouraging their presenting clients to go through with their tests. It is only through this increased awareness that prevention practice can be enhanced and enforced. This creates an extra dimension in the initial session which may be associated with a significant pressure for the counsellors to perform their roles in an exemplary manner. With VCT representing one of the primary contexts for testing (and HIV and Aids counselling) throughout the country (SANAC, 2007), this study undertakes an important task in its desire to assess the experiences of the counselors who provide this service Through its attempt to document these experiences, this dissertation may be seen to represent an initial step in assessing the areas of the counselling experience which may benefit from improvement and ideally lead to performance enhanced efficacy.

2.2.1.5. The current state of VCT

Solomon, Van Rooyen, Griesel, Gray, Stein and Nott (2004) testify that:

> "As stated by Richter, Durrheim, Griesel, Solomon and van Rooyen (1999): "Despite the level of service provision and proportion of people reached by VCT, both in developed and developing countries, the focus of attention is definitely shifting from the urgency of 'doing something' to the questions 'is it working?' and 'how can it be improved?'" (p. 1).

This statement highlights the current and critical need to assess the efficacy of such a potentially powerful intervention. It seems logical to assume that the state of the service provider is directly related to the efficacy and success of the service. The review which follows provides a review of some of the core concepts that influence a counsellor's experience of providing VCT.

2.3 Counsellors' Experiences

As may be gleaned from the above discussions, the VCT counsellor plays a complex role with both unique nuances, and complex difficulties. There are numerous issues that inform their experiences of the counselling process. Included among these are mounting stress, vicarious responses to the often traumatic experiences of their clients, the development of sufficient coping abilities, and finally, navigating and holding out against the constant threat of burnout and compassion fatigue.

2.3.1 Stress

The term "stress" has become an integral part of daily conversation. This ever-present phenomenon filters into every aspect of both private and professional life, and the VCT counsellor is certainly not immune. Colman (2003) defines stress as: "psychological or physical strain or tension generated by physical, emotional, social, economic, or occupational circumstances, events, or experiences that are difficult to manage or endure" (p.711).

In 1966, Lazarus (as cited in Carver, Weintraub & Scheier, 1989) proposed a basic way in which to conceptualise stress. He viewed stress as an interrelated cycle of primary appraisal (stressor perception), secondary appraisal (cognitive response selection) and coping (response execution and return to equilibrium) underpins most stress models (Carver *et al*., 1989). One of the most comprehensive current models of stress is the Biopsychosocial Model (Bernard & Krupat, 1994, as cited in Cordon, 1997). This model is aligned with the prominent paradigm in health psychology that highlights the critical importance of affording equal importance to the biological, psychological and social aspects of human experience and the ability of each of these to contribute to health. Cordon (1997) further suggests that according to the Biopsychosocial Model of Stress there are three components to stress: an external component, an internal component, and the interaction between the external and internal components. "Mason (1975) implied ... that the psychological, behavioural and physiological responses to stressors were inextricable, that is they were organismic" (Weiner, 1992, as cited in Nel, 2003, p.21). The external component of stress refers to the environmental events that precede the recognition of and response to stress. This concept relates to the comprehension of the nature of certain psychosocial stimuli that result in a perceived threat to homeostasis mentioned earlier (Cordon, 1997). Examples relevant to the counsellor's role include career conflict, living status, studies, communication as well as spousal/familial support (Ross & Deverell, 2004).

Poor self-concept, impatience, and over-dependence are examples of factors which, on a personal and individual level may not only induce, but heighten, the experience of stress. Also, poor consequential thinking, an inability to set realistic goals, poor health habits, an inability to prioritise, inflexibility, inadequate resource management, as well as reduced communication and interpersonal skills are associated with a high degree of personal stress (Bryce, 2001). These examples relate to the psychological component of the Biopsychosocial Model.

Interestingly, Ross and Deverell (2004) indicate that the moderation of all the above-mentioned stressors may be related to gender, age and experience. Personality factors have also been shown to moderate stress (locus of control, personality type, hardiness). Counsellor's experience and socio-cultural context may also be seen to influence levels of stress. Collectively, these aspects may play a significant role in the counsellor's assessment of relevant situations as stressful or not. The existence of these moderating factors is consistent with Colman's definition cited previously (2003).

The factors mentioned in the preceding paragraphs may influence counsellors' experience of stress, and may well have an effect on the mental, as well as physical, health of the counsellor (Dunkley & Whelan, 2006). As mentioned previously, the 'cost to caring' highlighted by many authors is a particularly prevalent issue, particularly in the counselling forum. Maslach and Jackson (1981) suggested that "for the helping professional, who works continuously with people under such circumstances, the chronic stress can be emotionally draining and poses the risk of burnout" (p.99). Burnout is closely associated with the phenomenon of compassion fatigue, and these two concepts are reviewed and discussed in the section that follows.

2.3.2 Burnout and Compassion Fatigue

Maslach and Jackson (1981) have described burnout is a consequence of emotional exhaustion and cynicism which occurs often amongst individuals who are engaged in what they term "people-work" of some kind. Counselling, and VCT particularly, may rightly be seen as subsumed within this category.

Pines and Aronson (1988) further define burnout as "a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations" (as cited in Collins & Long, 2003, p.420). Burnout has been conceptualised by Rushton as the final stage of stress (1987, as cited in Ross & Deverell, 2004). In his review of research on the symptoms of burnout, Kahill (1988, as cited in Collins & Long, 2003) identified five main categories of symptoms and these included emotional, behavioural, physical, inter-personal and work-related symptoms.

Citing Maslach and Jackson (1989), Kiemle (1994) states that the therapeutic actions of engagement and containment, that is, being attentive to, and adequately containing the concerns of the client, may lead to 'burnout' in the counsellor, particularly if the counsellor fails to attend supervision. An intimate awareness of his/her internal emotional and cognitive dynamics is central to a counsellor's ability to counsel successfully; the development of such insight may be fostered by regular supervision.

Burnout is frequently associated with compassion fatigue. Compassion fatigue refers to a pre-occupation with the individual's trauma, and including numbing and avoidant aspects, as well as hyper-arousal (Martin, 2006). Essentially, what this suggests is a deeply emotive response to the client's traumatic material manifested in the counsellor.

In a study by Gachuta (2006) on the relationship between supervision and counsellor burnout, the author reflects on her own experiences of counselling: She stated:

> "As a counsellor, there have been moments when counselling has been a dreary occupation. Reflection on those times brings into memory vivid feelings of being spent, weary deadbeat. There was lack of creativity and innovative energy. There were also deep feelings of wanting to avoid emotionally draining client work. There are lucid memories of an intense fear of inadequacy and inner instability. Engaging in client work during those times resulted in feelings of regret, guilt and self-doubt, as well as failure to respect internal messages of the counsellor" (p.2-3).

This extract highlights a number of important factors relative to both burnout and compassion fatigue. It is likely that over a prolonged period, the constant demands on emotional availability and accessibility made by the counselling role on the counsellor

may have negative effects on his or her internal state. This may in turn jeopardise the quality and effectiveness of the counselling intervention. The attention to the feelings of "regret, guilt and self-doubt" highlights the need to monitor and navigate the counsellor's own 'terms of engagement' and the manner in which these may affect the counselling process.

Particularly in the context of the HIV and Aids pandemic, the efficacy of such an intervention is crucial to successfully enabling the positive psychosocial and behavioural changes which are its goals. In light of the material highlighted here, it is clear that the value of the counselling intervention depends intimately on the state of its facilitator. By examining the counsellors' experiences in the counselling context, this study aims to better understand the factors that may affect the counsellor, and resultantly, improve the potential quality and outcomes of this intervention.

The experiences of the counsellor, as well as his or her current level of stress, influence the manner in which they respond to certain situations. These responses are also influenced by the coping skills of the counsellor.

2.3.3 Coping

Matheny, Aycock, Pugh, Curlette, and Silva-Cannella describe coping as any effort- adaptive or maladaptive, unconscious or conscious- that attempts to counter the effects of stressors or enable the individual to deal with the effects of the stressor in the least hurtful way possible (1986, as cited in Rice, 1999). As mentioned previously, Lazarus (1966, as cited in Carver *et al.*, 1989) conceptualises coping as the third stage in the stress response- that is, the process of enacting the chosen response to the presenting stressor.

The coping mechanisms employed by counsellors are of interest to this study. As highlighted these may be adaptive (for example, active coping, emotional- and social support) or maladaptive or avoidant (alcohol/drug use, denial) in nature (Dunkley & Whelan, 2006). Consistent with these principles, Aldwin and Yancura (2004) note that there is a relatively consistent consensus regarding the coping strategies that exist; there

are five general types which include emotion- and problem-focused coping strategies, social support, religious coping and making meaning. The utilisation of religion, and the seeking out of social support, may be said to complain elements of emotion- as well as problem-focused coping strategies. These strategies are not mutually exclusive; rather, they may be used cohesively or cyclically.

Additionally, Ross and Deverell (2004) mention physical (for example, exercise), social, recreational, spiritual and cognitive (*for example*, seminar attendance and problem solving) as stress-coping strategies utilised by South African social workers. It is likely that similarities may exist in the coping mechanisms employed by VCT counsellors; this was investigated in the current study.

It is the contention of the researcher that the coping styles employed by the counsellors may have the capacity to affect his or her ability to counsel productively- it follows that, for example, engaging in risky behaviours like substance abuse, may corrupt the counsellor's functioning, for example, at a cognitive level, which would in turn vastly impair the quality of the counselling service provided. It is, therefore, important to assess the coping strategies employed by counsellors. A more detailed understanding of the types of strategies employed may yield valuable information regarding counsellor behaviour and potentially, the need for intervention by supervisory bodies.

2.4 Psychological Consequences of Counselling to the Counsellor

Having attended to the issues of both stress mechanisms and coping, it is useful to consider some of the more complex ways in which these may manifest in the counsellor. The sections which follow therefore provide an examination of some of the psychological consequences of adopting a counselling role on the counsellor.

2.4.1 Responding to the presentation of diagnosis

Worthington and Myers (2003) have noted that the diagnostic procedure and receiving the results of an HIV test can be associated with increased levels of concern, distress and anxiety. Furthermore, Olley, Zeier, Seedat and Stein (2005; p.551) have described how

recently diagnosed patients may present with symptoms indicative of Post Traumatic Stress Disorder (PTSD): "On receiving a diagnosis of HIV and Aids, infected individuals may experience recurrent, intrusive thoughts or dreams of illness and death and may try and avoid people, activities and places that serve as reminders of the illness (Acierno *et al.*, 1997; Breslau *et al.*, 1991)."

The above statement highlights the acutely traumatic event of being diagnosed as HIV positive. Stevens and Doerr (1997), exploring the narratives of women who had been diagnosed with HIV and Aids, state that each participant in turn acknowledged the traumatic nature of the diagnosis. They highlight the sense of 'imminent demise' as well as helplessness with which these individuals reported being faced.

The unique nature of the treatment process undertaken by, and the relationship developed between counsellor and client allows for a broad range of empathetic strain to occur (Wilson, Lindy, & Raphael, 1994). While the HIV diagnosis is not a 'typical' trauma, it remains an emotionally charged event for the client, and exposure to this may elicit a vicarious response in the counsellor.

2.4.2 Vicarious trauma responses and Constructivist Self Development Theory

The diagnosis of a patient as HIV positive has been shown, as highlighted previously, to be related to the potential manifestation of vicarious trauma responses in HIV and Aids counsellors (Martin, 2006). Two main types of vicarious trauma responses have been identified; these are vicarious traumatisation and vicarious resilience.

McCann and Pearlman (1990, as cited in Collins & Long, 2003) first introduced the concept of vicarious traumatisation (VT), that is "the transformation in the inner experience of the therapist that comes about as a result of the empathetic engagement with the clients' trauma material" (p.417). VT suggests that engagement with clients who have been exposed to trauma may in fact alter or interfere with the therapist's own self-esteem, cognitive schemas, memories and emotions. Pearlman and MacIan (1995, as

cited in Hernandez Gangsei & Engstrom, 2007) state that VT does not reflect psychopathology on the part of the counsellor; rather it is an inevitable response to trauma work.

Recently, Hernandez and colleagues (2007) proposed an extension of current understandings of vicarious responses to trauma by examining the potential for a Vicarious Resilience (VR) response to emerge. VR refers to a process with a unique and positive effect that arises in therapists as a result of their working in traumatic contexts, and learning about coping with adversity from their clients. Their work may have a positive effect on the therapists, one which may be strengthened by drawing conscious attention to it (Hernandez *et al.*, 2007).

The processes of VT and VR exist concurrently; they highlight the complex nature and profound capacity of therapeutic engagement both to heal and to fatigue (Hernandez *et al.*, 2007). Further, they locate these phenomena within the framework of Constructivist Self-Development Theory (CSDT). CSDT was developed by McCann and Pearlman (1990) and presents a highly interactive conceptualization of self-development, including the multifaceted relationship between the development of self (including personal schemata, psychological needs as well as ego resources) and the ascription of meaning and encoding of traumatic events in memory. It acknowledges and highlights the complex interactions between person and environment- this is consistent with the tenets of the Biopsychosocial Model cited previously.

CSDT suggests that exposure to trauma may disrupt the counsellor's cognitive schemata, with particular regard for perceived safety, control, intimacy (both within oneself and with others), dependency/ trust and esteem (Sexton, 1999). CSDT would suggest that HCWs will associate and attribute meaning to events based on their personal experience of that event. This may be related to the coping mechanism described above whereby the counsellor would seek to 'make meaning' in order to cope. Ribeiro (2004) also addressed this concept, and noted that there is evidence for change in interpersonal contact as well as emotional expression in individuals exhibiting VT.

2.4.3 Counter-transference and rescue fantasies

Despite their differences, the roles of the VCT counsellor and the psychotherapist share the fact that both are engaged in acts of caring, focussing on the psychological wellbeing the individual. It is true in both cases that the counselling process has the capacity to affect the counsellor, both mentally and physically (Dunkley & Whelan, 2006). For this reason, the literature reviewed here has drawn on concepts woven through both the therapy and counselling fields.

A concept of particular interest to this study, drawn from psychotherapeutic literature, is the phenomenon of counter-transference. Colman (2003) describes counter-transference as the emotional reaction of the therapist or counsellor toward the client, particularly toward the client's transference, and further highlights that the reactions mentioned may arise from the unconscious conflicts as well as needs of the analyst. The implicit dynamics of the therapeutic relationship; and counter-transference particularly, contribute to the efficacy of the counsellor and the ultimate success of the intervention. Consistent with this, Figley (1995) has highlighted the 'cost of caring' and states that often the counsellor absorbs part of the suffering of the client, which they aim to alleviate.

An interesting aspect of the counter-transference phenomenon is the presence, among therapists, and possibly counsellors alike, of a rescue-fantasy. It seems that in some cases, therapists attempt to 'rescue' their patients from their distressing situations (Masterson, 1983; Greenacre, 1971, as cited in Berman, 2004). It is imperative, accordingly, that therapists and counsellors be critically aware of this aspect of their personas, and their counter-transferential interactions with patients. Notably, this issue is raised as it emerged particularly strongly in the author's previously conducted study, where one counsellor stated specifically that she wanted to "save more students from contracting HIV and Aids by teaching them how to become responsible" (Goldberg, 2007; p.56), thus highlighting her adoption of the role of saviour to the clients. The emergence of this phenomenon may suggest that a commonality amongst counsellors in this field would be their desire to 'save' their clients.

2.5 Conclusion

This chapter has sought to provide a review of the literature which informed the initiation and construction of this dissertation. VCT counselling represents a core resource in the fight against HIV and Aids in South Africa. It is informed by a host of influences- in addition to the biomedical facts which form its basis; it relies on the ability of the counsellor to disseminate this information in an effective and empathetic way. As a result counsellors are required to be increasingly well-informed, as well as able to adapt to and cope with the multifaceted nature of their sessions.

Additionally, with the pandemic rates of infection, and the higher rates of risk perpetuating behaviours, counsellors are required to attend to ever increasing numbers of presenting clients. This literature review sought to highlight the fact that despite the high numbers of potential clients requiring and presenting for VCT, as well as its touted importance in literature and policy-planning it remains an under-explored area which warrants further investigation and investment.

Counsellors are charged with the dual responsibilities of successfully encouraging clients to go through with the test, as well as of ensuring that the testing clients receive their results in a manner which facilitates the most productive approach to self-care and further exposure to risky situations. The success of the intervention-centred nature of this process hinges on the ability of the counsellor to coax a productive outcome from the session. As such it seems likely that they are subject to a significant degree of empathetic strain. Not unlike a traditional therapeutic relationship, counsellors are often prone to stress as a result of the content of the counselling sessions, and are at risk of compassion fatigue, and burnout as a consequence. They may draw on a number of different coping mechanisms, both intrinsically and extrinsically, and may exhibit vicarious trauma responses as a result. Particularly, it seems, the prolonged and repeated exposure to what is arguably a difficult and traumatic event to witness may have a significant effect on the counsellors. A gap in the literature has thus emerged- counsellors' constructed experiences and understandings of their roles present an important area which warrants further and necessary exploration. The healing dyad which emerges from the aspects

attended to in this review appears to be a complex one, and therefore requires a nuanced understanding of the numerous factors, both public and personal, which inform its development and efficacy. Before presenting the findings of this study, a discussion of the methods utilised is presented.

Chapter 3: Methods

3.1 Introduction

The previous sections of this document have detailed the rationale and theoretical motivation for conducting the research described here. In the sections which follow, the operationalisation of this study is discussed. Important aspects that are attended to include: the methodological orientation and design of the research, the sample and sampling techniques utilised. The instrumentation, the procedures which were followed and also the analysis which was conducted are also discussed. Additionally, matters of ethical considerations are also addressed.

3.2 Research Questions

In any research enterprise it is of great importance that the method of enquiry suits the aims of the investigation. Thus to begin, the aims of the research must be reemphasised. The study aimed to explore, and document, the experiences of the counsellors who provide voluntary counselling and testing (VCT) for HIV and Aids to members of the South African population. The study presented here sought to investigate the research questions below:

1. What is the profile of the typical VCT counsellor in South Africa?
2. What is the nature of VCT practice and procedure in South Africa as reported by counsellors?
3. What are the experiences of VCT counsellors in South Africa?
4. What are the effects of counselling for HIV and Aids on counsellors?
5. How do VCT counsellors relate emotively to the work that they do?

In its focus on the counsellors' reported experiences the study immediately privileges the subjective reality of the counsellor. It is important to understand the paradigmatic underpinnings of such an endeavour. Therefore, consistent with this aim and orientation, this study is located within the interpretive paradigm, a discussion of which follows here.

3.3 The Interpretive Paradigm

Unlike traditional positivist research, which focuses on the measurement and description of, and statistical inference and prediction about a particular phenomenon under study, interpretive research seeks to understand the social world, as it is created and understood through the eyes and thoughts of its social inhabitants (Wildemuth, 1993, as cited in Higgs & McAllister, 2001; Neuman, 1994; Schuut, 2006). This shift in focus merits the use of a different logic of enquiry (Blaikie, 2009). In contrast to the stance of the positivist paradigm, which focuses on experimentation and mathematical treatment of data, the interpretive paradigm places its focus on exploration and insight (Cryer, 2006).

Researchers who choose to locate their studies within interpretive paradigm adopt a specific set of assumptions, and 'view' of the world when doing so. Blaikie (2009; p.99) reiterates how "interpretivist researchers regard social reality as the product of its inhabitants; it is a world that is interpreted by the meanings participants produce and reproduce as a necessary part of their everyday activities together". Considering this construction of reality, Neuman (1994; p.62) has eloquently described the interpretive approach as "the systematic analysis of socially meaningful action...to arrive at understandings and interpretations of how people create and maintain their social worlds".

The roots of interpretivist theory can be traced to Max Weber's emphasis on social action that is purposeful and meaningful; Weber's concept of *verstehen* - that is empathetic or deep understanding- reflects his focus on the emotions of the individual, as well as the processes employed to create meaning (Neuman, 1994; Schutt, 2006). The term social action refers to those actions or activities to which people attach subjective meaning, intent or purpose (Neuman, 1994). Essentially, the picture which emerges is this: by

focussing attention on the nature of such meaningful social actions, and their role in understanding patterns in social life, interpretivist scholars seeks to engage meaning, particularly addressing how and why certain meanings are made, and the purposes they, in turn, serve.

Terre Blanche, Kelly and Durrheim (2006) explain that a commitment to understanding human phenomena 'in context', in the ways in which they are lived, thought and felt lies at the heart of interpretive research. This 'in context' understanding of socially meaningful action was identified as a core component of the current study which sought to investigate the nature and meaning of VCT counsellors' experiences of their roles. The coherence of the tenets of the interpretive paradigm with the aims and scope of this study make interpretivism a secure and logical anchor from which to proceed.

Terre Blanche *et al*. (2006) further note that qualitative methodology represents a 'central achievement' (p.276) in the interpretive researcher's ability to engage this 'in context' understanding. Following this, and with a clear focus on the experiential nature of the counsellors' work, qualitative research was deemed to most appropriate.

3.4 Qualitative research

Qualitative researchers may be said to seek answers to questions about the phenomena which they are investigating in the real world; they privilege the subjective and immediate sensory, cognitive and emotional world of humans (Rossman & Rallis, 2003). Elliot (1999, as cited in Elliot & Timulak, 2005; p.147) has highlighted some of the most important features of qualitative research. He notes the importance of an

> "emphasis on understanding phenomena in their own right (rather than from some outside perspective); open exploratory research questions (vs. closed-ended hypotheses); unlimited, emergent description options (vs. predetermined choices or rating scales); use of a special strategies for enhancing the

> credibility of design and analyses (see Elliot, Fischer & Rennie, 1999); and definition of success conditions in terms of discovering something new (vs. confirming what was hypothesised)."

Qualitative research is naturalistic and interpretive in nature, and also makes room for emergent findings rather than being bound by a preconfigured scope of investigation (Rossman & Rallis, 2003). Terre Blanche *et al.* (2006) have highlighted that qualitative research focuses on understanding how expression allows us to construct and understand the social world in which we live.

3.5 Research Design

A well formulated research design also allows the researcher to enhance both the quality and relevance of the data collected. Durrheim (2006) notes that the research design of any study forms the bridge between the rationale for the study and its execution. Marshall and Rossman (2006) highlight that particularly in the case of a qualitative study, a research design should be flexible, but should also remain thorough, concise, and sound in its logic.

The study may be designated as having a *descriptive-explanatory* agenda in its design. Following Kelly (2006) as well as Marshall and Rossman (2006) descriptive research aims to accurately describe phenomena in the context of their occurrence. *Explanatory* research in turn seeks to identify patterns emerging in, or possible causal relationships which inform the phenomenon under study (Kelly, 2006; Marshall & Rossman, 2006). This is certainly in line with the study's aim to document the manner in which the focal areas described here influence the counsellors' understandings and constructions of meaning regarding the nature of and experiences surrounding VCT counselling in the Southern African context.

Additionally, the study may be said to adopt a non-experimental, cross-sectional research design. Polgar and Thomas (2000) further highlight the fact that within a *non-*

experimental research endeavour there is no active intervention by the researcher. This is an important aspect of the current study as it aims to describe the current experience of VCT counsellors, rather than to actively intervene in and affect it. *Cross-sectional research* is characterised by the description of sample at the particular time of observation (Babbie, 2005). This type of research is not retrospectively oriented, rather, it gives a description of the circumstances that exist at the time of the research being conducted (Flick, 2004). Together these aspects of the research design are in line with the intent to conduct a single in-depth, descriptive analysis of the survey results as a means of investigating the counsellor's individual experience of his or her role.

3.6 Sample

In order to identify an appropriate sample for the current study, a number of sources were consulted. It is important to note that the sample identification process undertaken involved a number of stages. It required flexibility on the part of the researcher in terms of sites' willingness to become involved, as well as the individual counsellors' desire to participate. This process is detailed below.

In the initial stages of the sample-identification process, a list of all available VCT sites in the Gauteng province was obtained (This list is accessible to the reader online from: http://www.healthinsite.net/health/HealthProfile.dll/eCareArticlePop?tp=1&artid=2N1600). The generation of this list represents the first stage in data collection. From this list, sites utilised in the previous Honours-level study were excluded, as that investigation is regarded as a functional pilot of the present study. Thereafter, the researcher entered into consultation with a Johannesburg based non-governmental organisation (NGO) with National Department of Health ties which assisted with providing details for certain sites.

The information gleaned from the aforementioned sources was utilised in an integrated manner to identify potential participant sites. To acknowledge the research process in its entirety, it is important to note that not all sites approached were included in the current study- this due to their lack of responsiveness beyond the initial stages of communication. However, ultimately, this paper draws on results from four main sites, and one counsellor

group. The final geographical catchment area from which the sample was obtained is indicated in the map, which appears in Appendix 2.

The descriptions provided here have been adapted (unless otherwise stated) from information gathered from the AIDSbuzz General Directory, which provides a useful resource guide listing a number of organisations and facilities active in the HIV and Aids arena (It is easily accessible at http://www.aidsbuzz.org/directory.html).

The descriptions of the included sites follow below; however the reader should note that the names of the facilities are withheld for ethical reasons. The respondents' returned questionnaires were similarly coded during analysis. Also, the abbreviations cited in the table should be understood as follows: voluntary counselling and testing (VCT), prevention of mother-to-child transmission (PMTCT), anti-retroviral therapy (ART), and post-exposure prophylaxis (PEP). Included in the table is the number of responses received from each site.

Table 1: Site descriptions

Site	Number of Respondents	Area	VCT	PMTCT	ART	PEP	Other services
A	17	Kagiso	✓	✓	✓	✓	Counselling and support groups, medical staff
B	13	Sebokeng	✓	✓	✓	✓	N/A
C	2	Gauteng (chain store based)	✓	×	×	×	Sugar, blood pressure and cholesterol testing
D	3	Alexandra	✓	✓	✓	✓	Counselling and support groups, home-based care
E	13	Braamfontein	✓	✓	×	×	Counselling and support groups, mobile-testing units, youth-driven HIV awareness and prevention programmes, (individual and corporate services)

In addition to the sample described previously, telephonic interviews were conducted where logistically possible with the supervisors at the participating sites. Two such interviews were further included in the study. These provided a useful opportunity to seek clarity and further explication of some of the issues raised by counsellors in their responses. The reader should note that the demographics of the responding sample are presented in the results and discussion section. This was deemed appropriate as a characterisation of the South African VCT counsellor forms a core aspect of the focus of the study.

3.7 Sampling Techniques

As this study seeks to adopt a multi-method approach in its investigation, in that it employs both qualitative and quantitative techniques (this concept shall be explicated upon shortly), it requires that a relatively large sample be taken for the quantitative measures, and a smaller sub-sample would be used for qualitative analysis. Although the originally planned sample sizes were larger, there was a significant rate of attrition with only 49 responses being returned. Due to the lengthy nature of the qualitative questionnaire participants were informed that they were not obligated to fill in all questions; noting this it is likely that the length of the questionnaire may have influenced the completeness of the responses received.

A non-probability approach to sampling was employed in this study. Specifically, a convenience sampling strategy was adopted, that is, the selection of participants will be subjective and rely on the ready availability of subjects (Henry, 1990). This approach is consistent with the scope of the research, with respect to the availability of accessible potential respondents.

3.8 Procedure

The earliest stages of this study comprise the researcher's preliminary engagement with the topic, and a review of the relevant literature; this process culminated in a research proposal that was thereafter submitted to the University's Committee for Research on Human Subjects. Ethics approval was thus obtained (Protocol #: MPSYC08/003 IH, See

Appendix 3). Concurrently, under the auspices of the NGO mentioned previously permission was granted to make contact with and access the VCT sites.

The period over which data was collected was initially proposed to take approximately three months. However, due to logistical issues and difficulty in obtaining consent from certain sites, the process of data collection in its entirety took approximately ten months.

The administration of the test measures was thereafter arranged at a time that best suited the counsellors, and all questionnaire dissemination was conducted on site. Prior to the administration and completion of the instruments participants were briefed as to the nature of the study, and confidentiality was assured. The introductory letter which prefaces the questionnaire explains that *choosing* to fill in the questionnaire would be regarded as the participant's giving their informed consent to participate. This was re-emphasised in the researcher's spoken introduction to the study. Also adequate space- to ensure counsellors' privacy whilst answering their questionnaires- was provided in all possible instances. Time was allocated for addressing any questions and concerns that the counsellors may have had both prior to and after their completing their surveys. In cases where this was not an option, counsellors were provided with the researcher's contact details should any questions arise.

Participants who consented to participate were requested to fill out the questionnaire in as much detail as they felt comfortable to provide. In its entirety, the survey generally takes approximately an hour to complete; counsellors found this satisfactory. The researcher was, whenever possible, present at all times during the course of the administration. In the case of the telephonic interviews mentioned previously, informed consent was obtained from these individuals prior to recording and transcribing these interviews.

The sections that follow detail the nature of the test instruments employed, and the manner in which these were analysed. The responses returned by the participants were coded according to their sites (as per the descriptions provided earlier) and each response was given a number. The responses were transcribed verbatim so as not to compromise

the meaning and structure of the participants' answers. These steps, in conjunction with the final write-up represent the final stages of the research procedure.

3.9 Measures

3.9.1 The counsellor's experiences questionnaire

The previous study conducted by the author (Goldberg, 2007) sought to create a qualitative measure that was contextually specific and at the same time also engaged with the theoretical concepts under study in a manner that was relevant to the South African context. In this way a new instrument was developed (See Appendix 4). The creation of this instrument was informed by a thorough search of the literature as well as consultation with relevant advisory parties. This questionnaire has been based on questions highlighted in the literature and existing research instruments. Two of the main sources consulted include the work of Coyle and Soodin (1992) as well as Grinstead *et al.* (2000). These sources were strongly aligned with the aims of the current study and thus informed the construction of the counsellor's experiences questionnaire. For a more explicit review of these sources the reader is referred to the author's previous study (Goldberg, 2007).

The previous incarnation of this study (Goldberg, 2007) is regarded as a pilot of the questionnaire. The respondents in the pilot were able to provide answers that were both descriptive and informative, and that eloquently addressed the questions asked. This speaks to the validity of both the elicited, as well as the sought-after content. Also, the fact that counsellors who participated in the pilot study did not express any difficulty in understanding the instructions or items in the instrument served to assure that no inconsistency would arise as a result of misunderstanding.

The instrument, as in the pilot study, was presented to and examined by the site supervisors, who were invited to make amendments and request any additional questions based on their specific needs and concerns for their programmes. This effort to emphasise collaboration sought not only to heighten validity but also endeavoured to maximise the

usefulness of the results of the research. In this study, none of the facilities requested that any items be changed. Additionally, in its current adjusted formulation, the questionnaire has been peer-reviewed, and refined, approximately three times, both by a departmental review and ethics board, as well as by the Perinatal HIV Research Unit's Peer Review Committee. This provides further support for the relevance and usefulness of the instrument in the context within which this research would be located.

The questionnaire is initiated by an introductory letter to the participants, (See Appendix 4A), and instructions and a demographic survey (See Appendix 4B), which seeks to establish the key population descriptors. Thereafter the counsellor's experiences questionnaire follows and includes a series of both closed- and open-ended questions regarding the nature of the counsellor's job/role, a description of training and experience, the nature of the stresses perceived by the counsellors, and finally, an exploration of the coping styles used by, and the coping mechanisms of the counsellor (See Appendix 4C).

Utilising this questionnaire format is advantageous in that it provides a written form of a semi-structured interview. In this way the respondents were- able to express themselves using their own words, within their own time and space. The written response format had an inherent additional advantage, in that the researcher was able not only to analyse the content represented, but also the manner in which counsellors chose to represent certain content. An examination of punctuation, underlining and textual styles allowed for a greater degree of insight into the thinking processes and beliefs held by the counsellors.

This method might also be said to be beneficial in terms of ethical considerations, in that there is no face-to-face interview; this eliminates issues of interviewer adequacy, as well as fear of judgement in the respondent. Having described the procedure as well as the instruments utilised, the section which follows details the analytic methods employed.

3.10 Data Analysis

The questionnaires, interviews and checklists utilised in this study required the selection of an analytic that was able to best represent the information obtained from the data

collected. Thematic analysis (Braun & Clarke, 2006) was thus elected. Cryer (2006) has noted that data collected for interpretive studies is often descriptive in nature, and for this reason, descriptive statistics are provided in certain cases.

3.10.1 Thematic Analysis

Thematic analysis is a qualitative technique similar to content analysis; it differs from other techniques in its enhanced emphasis on the qualitative aspects of the data (Boyatzis, 1998; Joffe & Yardley, 2003). Boyatzis conceptualised thematic analysis as "a process for encoding qualitative information" (1998, p.vi), that is, a means to identify, analyse and report patterns within data (Braun & Clarke, 2006). While some have described thematic analysis as a core skill utilised throughout the qualitative methodological 'family' (Boyatzis, 1998; Holloway & Todres, 2003; Ryan & Bernard, 2000 as cited in Braun & Clarke), Braun and Clarke have argued that it should be recognised as a legitimate and independent technique in its own right (2006).

Thematic analysis can be seen as distinctly advantageous; it offers the systematic elements which are characteristic of content analysis, but still allows the researcher to use the theme or code frequency together with an analysis of its meaning in its particular context (Joffe & Yardley, 2003). This serves to enhance the results by adding the subtlety and complexity of a truly qualitative analysis. Further, it is certainly consistent with the intent to explore and describe the nature and intimate experience of VCT counsellors.

This process of identifying and assessing themes as they are drawn from the data using 'explicit codes' represents a core technical component of the analysis to be conducted here. A point to note is that different types of themes have been identified. Theorists have described *manifest* or *semantic* (in Braun & Clarke's (2006) conceptualisation) and *latent* themes. Semantic thematic analysis focuses on the surface level data, while latent thematic analysis affords greater importance to themes that reflect underlying assumptions and ideologies (Boyatzis, 1998; Braun & Clarke, 2006; Joffe & Yardley, 2003). Considering these aspects, Braun and Clarke (2006) have outlined a series of steps for conducting thematic analysis. These are briefly outlined in the table which follows.

Table 2: Steps for conducting thematic analysis (adapted from Braun & Clarke, 2006, p.87)

PHASE	DESCRIPTION OF THE PROCESS
1. Familiarising oneself with one's data:	Transcription of data where necessary, reading and re-reading the data. Initial ideas should be noted at this stage.
2. Generating initial codes:	The researcher will systematically code the data set, highlighting interesting features of the data and collate all data relevant to each developed code.
3. Searching for themes:	Codes are collated into potential themes, and all relevant data to each of the potential themes are gathered and organized accordingly.
4. Reviewing themes:	At this phase, it is necessary to assess if the themes work in conjunction with the coded extracts (Level 1) and the entire data set (Level 2). This process will include the development of a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

A final point to remember is the fact that the researcher brings to the process his or her own pre-dispositions and assumptions to each undertaking. For this reason, it is important the researcher engage in an ongoing reflexive dialogue throughout the research process in order to maintain a critical and analytical stance on the emergence and relevance of themes (Braun & Clarke, 2006). Transparency in this regard represents a critical aspect of the study, and for this reason, the researcher offers a reflexive review at the close of the discussion chapter.

3.11 Ethical Considerations

Any research conducted with human subjects implies a commitment on the part of the researcher to protect the rights of the participants. The Health Professionals Council of South Africa (HPCSA) states that "Responsible health research not only makes a *scientific* contribution for the good of humans or animals, but is also conducted in an *ethical* manner" (2008; p.2).

Confidentiality and anonymity of the participants was assured and monitored rigorously and participants were informed of all measures taken to protect them in this regard. This was achieved by sealing the responses received until they were opened for analysis. Additionally, participants were requested not to write their names on the form so that no identifying information was accessible to the researcher. Notably, the comparison of respondents on a facility basis was disallowed at the reporting stage, both as an ethics related concern, and at the request of facility managers. Additionally, in an endeavour to protect the confidentiality and anonymity of the participants, the formulation and administration of the test instrument may actually be seen as ethically advantageous. This is as a result of the participants' capacity to commit their answers directly to paper- ideally this would eliminate issues of interviewer inadequacy, miscommunication and also a fear of judgement within the participant.

Counsellors were informed at the outset that they were under no obligation to participate in the study. Their return of the questionnaires, and implied consent therein were taken as voluntary submission. There were no foreseeable risks to the participants on the part of the researcher with regard to consenting to participate in the study. The respondents were repeatedly assured that there would be no consequences if they chose not to respond.

Some of the issues dealt with in the study are potentially sensitive and may be associated with a sense of anxiety. The ability to write, rather than having to directly verbalise one's thoughts and emotions may be experienced as less confrontational than perhaps an interpersonal interview format. In this way, counsellors were able to express themselves fully, but in a more confidential setting. Notably, proving this point, one counsellor commented in the 'additional comments' section that "A2: This was like supervision where you actually expressed yourself without anyone judging you". The respondents were notified that if, at any time, they were to require further debriefing or counselling, if possible, they should contact their supervisor. If that option was not available, or additionally, counsellors were informed that the researcher would make the necessary information or details available, in order to provide the assistance necessary to them.

3.12 Conclusion

This section has sought to provide the reader with a deeper understanding of the theoretical and methodological underpinnings of the procedures and analytic techniques adopted in the current study. With this understanding in place, the chapter which follows discusses the findings which emerged from participants' responses.

Chapter 4: Results and Discussion

4.1 Introduction

Although the traditional formulation of the latter part of a dissertation divides the results and discussion sections, for the purposes of the current study it was deemed logical to provide an integrated presentation of the two. This is consistent with the nature of the investigation which seeks to promote the combination of directly quantifiable and descriptive results and their implications with the more exploratory, phenomenologically-oriented aspects of a qualitative investigation. It is the contention of the author that the union of these two elements will greatly enhance the reader's experience and understanding of the outcomes of this study.

And so to recall, 49 respondents (counsellors) were interviewed for this study and shared their insights and opinions and also offered written recollections of their personal experiences regarding HIV counselling. The sections which follow attend to the manifest-semantic and latent content (following Braun and Clarke's conceptualisation as noted in the *Methods* section) derived from the participants' responses.

This section begins by detailing the demographic characteristics as well motivations for counselling described by the respondents. Thereafter, VCT training, practice and procedure are discussed. Counsellors' feelings about counselling as well as reflections on the nature of VCT counselling in South Africa follow. Additionally, the researcher offers a reflexive review of the research process. The counsellors' perspectives on participation are provided, as well as recommendations and avenues for further research. The chapter closes with a summation of the central motivations and findings of the study.

4.2 Meet the counsellor: Demographics and personal motivations.

When addressing the nature and experience of *being* a VCT counsellor in South Africa, it is useful to establish, before proceeding further, exactly who is counselling, and why exactly they are doing so. This section aims to characterise the sample and examine the factors which catalysed counsellors' entry into the field.

4.2.1 Demographics

By characterising this population it is possible to create a useful picture of whether demographic trends exist in the counsellor-population. Perhaps in this way, one might consider predominant factors that might influence such a group; trends such as these may also provide useful guidelines in tailoring the development of future VCT training protocol. Notably, the sample is not large enough to make broad inferential claims. It is, however, of significant enough size to offer some descriptive statistics and to allow for some reflections on counsellors' characteristics to be made. The table which follows presents a summary of the demographics of the responding sample.

The picture which is painted from the results of this study presents the 'typical' VCT counsellor in South Africa as a young single black female between the ages of 25 and 34. The results further suggest that this individual would be of the Christian faith, with one or two children, and a full-time counsellor with either a secondary or tertiary level of education.

Table 3: Sample Demographics

Demographic Variable		*Frequency*	*%*
Age (in years)	Unknown	3	6.2
	20-24	4	8.3
	25-29	13	27.1
	30-34	12	25.0
	35-39	5	10.4
	40-44	8	16.7
	45-49	1	2.1
	50<	2	4.2
Gender	Unknown	5	10.4
	Male	4	8.3
	Female	39	81.2
Race	Unknown	4	8.3
	Black	42	87.5
	White	2	4.2
Marital Status	Unknown	5	10.4
	Single	26	54.2
	In a relationship	8	16.7
	Married	9	18.8
Children	Unknown	12	25.0
	1 child	10	20.8
	2 children	16	33.3
	3 children	6	12.5
	4 children	3	6.2
	6 children	1	2.1
Occupation	Unknown	6	12.5
	Full-time counsellor	36	72.9
	Part-time counsellor	7	14.6
Religious/ Spiritual Orientation	Unknown	4	8.3
	Christian	43	89.6
	Jewish	1	2.1
Highest Level of Education	Unknown	3	6.2
	Primary	2	4.2
	Secondary	23	47.9
	Tertiary	20	41.7

The table which follows illustrates counsellors' use of each of the national languages within their home and work contexts. In their home contexts counsellors most frequently speak in Sesotho (35.4%) and isiZulu (35.4%), while in the counselling context English appears to be the most frequently employed language (83.3%).

Table 4: Home and counselling languages used by counsellors

Language	Home Language (%)	Language of Counselling (%)
Afrikaans	2.1	12.5
English	20.8	83.3
Ndebele	0	4.2
Sepedi	8.3	29.2
Sesotho	35.4	66.7
Swati	2.1	6.2
Tsonga	2.1	4.2
Tswana	31.2	52.1
Venda	0	6.2
Xhosa	16.7	56.2
isiZulu	35.4	70.8
Other (unspecified):	2.1	2.1

The figures which emerge here suggest that over half the counsellors who responded in the current study were able to actively counsel in six of the eleven nationally recognised languages. This clearly highlights both the relevance of and need for multilingual counsellors within the South African context.

4.2.2 Respondents' motivations for becoming VCT counsellors

VCT counsellors represent a valuable resource in preventing or reducing the spread of HIV and Aids. It emerged within this study that counsellors had been drawn to their roles for different reasons, and the researcher therefore endeavoured to develop a greater understanding of participants' motivations for entering this field. It is hypothesised that if future training programme designs could be constructed so as to reinforce initial motivations it would allow for the establishment of a more cohesive, and longer lasting counselling identity.

The results of the pilot study suggested that there were two main imperatives that initiated counsellors' entry into the field. These were the diagnosis as positive or loss of a loved one due to HIV and Aids, and a feeling of personal sense of satisfaction, leadership and honour inherent in the role-model nature of the counselling role (Goldberg, 2007). These results were confirmed and expanded upon in the current study.

4.2.2.1 Loss of a loved one

The extract quoted below is drawn from a telephonic interview conducted with one of the managers at a facility that participated in this study:

Researcher: "What drew you to counselling in the first place, what part of you or what experiences in your life made you decide to be a counsellor?

Counsellor: "Counselling, in a speaking concept is a taboo, and African person doesn't need to go for a counselling, so me I find it fascinating that each and every person has emotions and you need a space to deal with that, so I find as a career path for me to adventure it, and because... it so much and to be specific in the field of HIV. I lost a dear friend, like I lost my father, because of HIV and AIDS and it was difficult for my family to understand to go through that and so for me personally I had to go and learn so that I can teach them and make them understand the whole process of HIV, how it worked and to tell them that he has not been witched. You know as Africans you believe that a person has been bewitched and all that..."

In this excerpt, the counsellor notes how when he lost his own father to HIV and Aids, his intimate encounter with the virus and its devastating consequences catalysed his entry into this counselling field. He reflects how, despite the existence of cultural taboos surrounding the counselling profession, he believes it to be an important and critical

endeavour. This process, for him, seems to hold the dual advantage of being an excellent forum for information dissemination, as well as providing presenting clients with often much-needed emotional support.

The results which emerged in the current study provide significant support to the contention that the knowledge of a loved one who had been diagnosed with or passed away as a result of HIV and Aids provides a strong source of motivation for entry into the counselling field. One counsellor stated: "A3: I felt I needed to make a change in people's life, and some of my family members are infected", and another described how "B5: I decide to become a counsellor because most of school friends they tested positive". Still another mentioned, "D3: Some of my friends and family were HIV infected so I wanted to know more about HIV and Aids and how to behave around them." Together, these responses lend clear support to the notion that exposure to an individual diagnosed as HIV and Aids positive with whom the counsellor shares/shared an intimate relationship often serves as a significant catalyst for their entry into the counselling profession.

The extract cited below highlights this. The reader should not that the quote is verbatim, and has not been altered from the counsellor's submitted response. As highlighted previously, attention to the parentheses, diction and punctuation employed allows the reader insight into the counsellor's emotional world. For example consider the tension between referring directly to HIV or, as phrased below, "the whole (HIV) issue"- by parenthesising the HIV there seems to be an almost unconscious avoidance of referring directly to the virus and its consequences. This counsellor stated,

> "E12: I had a chance to work as a hospital in a medical ward. My colleagues and superiors (some) had the virus and (some) were in denial. One of my family member that I was extremely close to was infected. I felt obliged to change a few thing, a few ways that people think and view the whole (HIV) issue. I felt not enough awareness was

> done I felt the real, the core of the issue wasn't [tackled?] and maybe if I do it personally I might or will win. So here I am!!"

This response is rich in detail in that it sheds light on just how extensive the impact of HIV and Aids on the life and immediate environment of this counsellor had been. In her life, both family members and colleagues had been diagnosed as HIV-positive. She was faced with the realities of the service and quality of care received by these individuals in every sphere of her life, and has, as a result, chosen to empower herself and others through education and counselling. This counsellor appears to have taken it upon herself to try to bring about change.

This proactive stance may be understood in relation to the concepts of coping through meaning making, vicarious resilience and CSDT highlighted in the literature review (Aldwin & Yancura, 2004; Hernandez *et al.*, 2007; McCann & Pearlman, 1990). What these concepts have in common is they support the notion that individuals who experience difficult events (such as the diagnosis of a loved one with HIV and Aids) may seek to resolve the traumatic nature of these events by pursuing activities they imbue with relevant meaning. In the case of VCT counsellors, the loss of a loved one may motivate some individuals to take on counselling roles initially- personal experiences of trauma may yield a desire to use their own experiences to help others who face similar circumstances. VCT and its inherent focus on education and empowerment would be correspondingly held as core components of the constructed meaning-based coping mechanisms.

It is the assertion of the researcher that many counsellors do enter the field in order to fulfil their otherwise unobtainable desire to save these beloved individuals. Indeed, one counsellor stated "E3: Because I was once saved by VCT. So I've decided that I should do the same to others. Cause really people need more information about VCT." It seems that in her mind, the old adage of knowledge as power implies the power to save through education. An extended discussion of saviour identities follows later in this document.

4.2.2.2 Community Involvement

As highlighted, it further emerged that counsellors appear to feel a sense of pride in their work. They appear to see themselves as role models for their communities, and seek to utilise the power inherent in their positions to guide community members to lead healthier, safer lives. If one returns to the statements made previously about counsellors being drawn to the work in order to combat the harsh realities of HIV and Aids when they have been faced with these in their own lives, it seems likely that by adopting the position of a role model, and a leader- by exemplary behaviour- counsellors strive to free their communities from the danger of the pandemic. As in the pilot study, youth were identified as a vulnerable group, and one counsellor notes her entry into the field was particularly driven by this group. She remarked, "B3: In order to help our youth, as we see them taking drugs/alcohol and ending up having unprotected sex. And again to encourage them to test for HIV/AIDS".

The need and desire to make a difference in the lives of others was further highlighted by one participant, who noted: "A11: I wanted to make a difference to my country and other people's life". Importantly, intrinsic to this statement is the implication that VCT is perceived as an important and effective channel for intervention and generating change. A number of respondents highlighted how they were drawn to the work in order help facilitate this change. One participant responded "E9: I love working with people/ clients, and I think that it is important to work in VCT counsellor because you make a big role in changing their lives and their behaviour."

As in the previous statement, counsellors repeatedly emphasised their love of working with people. One stated, "A5: ... the reason why I'm here is because I like helping other people and my aim is to open an orphanage home for homeless and infected children". Another counsellor noted, "A10: I like working with people // I think it was the best decision I made, to make people aware of this HIV virus". This form of community engagement represented a significant source of motivation for counsellors.

4.2.2.3 Education

The importance of the ability of the pre- and post- test counselling process to educate presenting clients about the facts of HIV and Aids cannot be underemphasised. This represents another core source of motivation for entrance into the field of VCT. Counsellors acknowledged being drawn to this aspect; for example, one participant responded:

> "A14: I saw that many people are talking about myths not facts and they do not know their HIV/AIDS status and they are very ignorant. I thereby decided that it was best for me to do VCT so that people can know where they stand with their health."

The points raised by this counsellor around the critical importance of having the correct information, as well as the knowledge of one's HIV status are central, and among the core aims and outcomes of the VCT process. The appeal of this educator's position was highlighted by one counsellor, who noted "A10: I feel great being the one teaching people about HIV & AIDS. // It was the best opportunity as me, myself also gain knowledge." Another counsellor stated,

> "A15: I started as a health promoter it has become so easy for me (to) become a counsellor, having passion working with community educating them and made them to understand. And to learn more about HIV virus and themselves educating others, at the end of the day I have achieved a lot from the community also learned to more about characters of people."

In this she highlights how the ability to educate others is a primary benefit of becoming a VCT provider. However, this narrative also highlights how the different motivational factors cited in the previous sections can unite with the counsellor's attitudes and experiences, to produce a driven and proactive counsellor.

4.2.2.4 Career choices

Interestingly, some counsellors contextualised their motivation for counselling directly within their career paths. In one instance, a participant describes, E9: I love this job a lot and I want to grow further in this job & career" Another counsellor described how she became a VCT counsellor due to a "B4: scarcity of jobs", while another noted how " E5: ... when I was young I wanted to be are nurse or social worker but financially it couldn't happen. And I found out about HIV & AIDS counselling and I want the information." Both of these counsellors describe how they became VCT counsellors as a result of socio-economic circumstances- one due to an inability to find a job, and the other as a result of being unable to afford to study further.

4.2.2.5 Other personal experiences

Two experientially-based motivations stood out. In the first case a counsellor reported,

> "B13: I am also an activist. I did not know before 2004 but after being a volunteer caregiver I saw how people felt and have more passion and attend workshop. I volunteer to test 2004 (I was diagnose?) HIV positive attended course at Alpha Trauma Centre & Treatment Action Campaign"

It is certainly a notable response in that the counsellor elected to divulge his/her HIV status (gender was unspecified in the response). It seems that while this individual was already becoming active in working towards preventing the spread of HIV and Aids, it was a positive diagnosis that truly spurred this counsellor's engagement in the field.

In another extremely interesting response, one participant noted: "C1: As part of nursing it was important that I became involved. I also had a needle-stick injury. This made me very aware how people feel with regards to VCT. // It made me very patient and sympathetic with people". This counsellor highlights how when she sustained a needle-stick injury, she was faced with the reality of becoming infected with HIV. As highlighted previously, such a diagnosis is associated with significant distress, and potential traumatisation (Stevens & Doerr, 1997; Worthington & Myers, 2003). This counsellor chose to respond in the most proactive manner she was able- that is, to assist others in similar positions by becoming a counsellor.

What is common between these two responses is that each highlights how when particular individuals were forced to face the realities of HI virus on its most intimate and invasive level, it was their desire to not be beaten by the virus that motivated them to become VCT counsellors. Certainly, if the reader returns to the concept of vicarious resilience, as well as the Constructivist Self-Development Theory mentioned earlier in this document, these cases provides clear examples of how the counsellors made meaning of their experiences, transforming the traumatic events related to diagnosis into a positive capacity for empathy with clients faced with the prospect of a positive diagnosis.

4.2.2.6 A problematic response

One counsellor's response was particularly problematic, and is presented here for consideration. She states her motivation for becoming a VCT counsellor as follows:

> "A17: To teach people about HIV // To teach that after being HIV+ there is life but not death // Because in my family there are people with HIV and some of them died without the knowledge of HIV that HIV is curable, because of the treatment that is given to people who are HIV+"

The fact that this counsellor states that "HIV is *curable"* (emphasis added), is extremely problematic. The consequences of her potentially making such a statement to a presenting client have vast ramifications. The educational components of the counselling process are central, and represent a crucial part of its power as an intervention technique. It is essential that counsellors and clients alike understand the difference between cure and management of the virus.

However, to accurately assess this response, it is important to consider that the responses were written, and the researcher was unable to consult the respondent for clarity as a result of the ethical procedures adopted to ensure anonymity. If one recalls the description of counsellors' home languages, English is not always used as a first language and therefore it is important to consider that language capabilities may have limited counsellors' responses. With this in mind, contrast the previously cited response with this statement made by another counsellor about her motivation: "B14: To help people knowing their status. To show there is a life after knowing your status". Perhaps it is necessary to consider that when the counsellor spoke of cure due to treatment she may have intended to convey that when the virus is managed properly, "there is a life after knowing your status".

In either instance, however, it remains an issue of some concern that if the counsellor in question, despite receiving training, incorrectly phrases the information with which she provided her client. There remains the possibility that as a result the client may him- or her-self provide others with incorrect information. This certainly has implications for risk-taking and preventative behaviours for the client, as well as his or her sexual partners and peers.

4.3 VCT Counselling: Training, Practice and Procedures

4.3.1 Counsellors' training and level of experience

In the sections which follow counsellors' respective training histories and levels of experience are described. It is useful to attend to the scope, content and consistency of the training received by counsellors, particularly in the context of an assessment of their

competencies, capacities and experiences. A discussion of training levels is important as it effectively allows one to assess and compare the counsellors' respective levels of qualification and rank in the hierarchy of active health care professionals.

4.3.1.1 Involvement in general counselling

Counsellors were asked to specify whether they had received general counselling- that is to imply non-HIV and Aids specific counselling- training. Of those who responded, three did not specify their training histories. Four counsellors noted that they had received no general counselling training at all, while the remaining 41 counsellors had received some form of general counselling training. Important to note is the fact that the counsellors who stated that they did not have general counselling training all did have HIV and Aids-specific counselling training.

Counsellors were also requested to note the duration of their involvement in general counselling. There was considerable variability in counsellors' responses in this instance. These ranged from a number of counsellors having had less than a years' experience (in fact this ranged from 0.04-0.75 years) to one counsellor who had approximately 12 years experience. It appears that the majority of counsellors who participated in this study had not been involved in general counselling for an extended period of time. This is clearly illustrated by the fact that a majority have had less than three years experience in this field while more than three quarters of the sample had less than five years experience.

Table 5: Length of counsellors' involvement in general counselling

Number of years experience	Frequency
No response	2
Less than 1 year	12
1-5	24
>5-10	9
More than 10 years	1
Total	48

When asked to provide an indication of the number of courses they had taken, counsellors varied in their responses- this ranged from having taken no courses at all, to having taken ten, and as one counsellor stated, "As many as I can". Most counsellors (83.3%) reported having taken between one and four courses. The highest frequency was achieved where eleven counsellors had each taken at least two courses in general counselling.

Counsellors were also required to provide details as to the length of the general training courses they had taken. These ranged from less than a day's training to in excess of a year's. In fact the range, more explicitly, extended from just two hours to two years. This sheds light on the discrepancies that exist between the levels of training amongst counsellors. The lengths of these general counselling courses are reflected in the table which follows.

Table 6: Length of general counselling training courses taken by counsellors

Length of counselling course	Frequency
Unknown	4
< 1 Day	1
< 1 Week	2
< 1 Month	30
< 1 Year	5
1 Year <	6
Total	48

It is important to interpret these results with caution. The length of the training received is not to be understood as a direct reflection of their capacity as counsellors. However, it is certainly a matter of some concern that there are counsellors practicing with only a two hour training session to guide them. The process of counselling requires the counsellor be equipped with and proficient in the practice of a particular skills-set. It is the contention of the researcher that it is important from an ethical perspective for the counselling group

under study to be aware of some of the fundamental tenets of counselling practice- such as the Rogerian principles of empathy, genuineness and positive regard mentioned earlier. Without having the actual course contents for the purposes of comparison however, it is beyond the scope of this study to make absolute claims as to the completeness or appropriateness of training procedures. Additionally, acknowledging this, it is necessary to remember that a counsellor's personalities, commitment to their work and expertise, as well as experience, are invaluable assets to the efficacy of the counselling session.

4.3.1.2 Involvement in HIV and Aids-specific counselling

At this point it is essential to note that a problem emerged at this point in the questionnaire. In a number of instances, when asked to detail the content of the different training courses they had attended, counsellors often either failed to provide the details or descriptions of either type of training course attended, or would fail to separate their general and HIV and Aids-specific training courses. With this in mind, the *reported* results are presented below.

When asked whether they had received HIV and Aids-specific counselling training, 42 of the 48 counsellors reported having received such instruction. Two counsellors failed to provide answers to this question, while the remaining four participants explicitly reported having received no HIV and Aids-specific training. The fact that these four participants had not received HIV and Aids-specific training is an issue of some concern. They had all received general counselling training; however, one of the critical factors ensuring the efficacy of VCT is that counsellors are able to provide presenting clients with the correct information about diagnosis, risk factors and behaviours, and their serostatus during both the pre- and post- test sessions. Supplying clients with incorrect information has severe potential future consequences. In this, training serves a central and critical role in ensuring that counsellors are equipped with a complete and accurate knowledge base from which to work.

Counsellors were once more asked to reflect the length of their involvement in HIV and Aids-specific counselling practice. Most frequently, counsellors had between one and five year's training. The concerns raised previously about the accuracy of counsellors' reporting remain; however, once more the results are presented for consideration.

Table 7: Length of counsellors' involvement in HIV and Aids-specific counselling

Number of years experience	Frequency
No response	3
Less than 1 year	10
1-5	31
>5-10	4
Total	48

In the table which follows, the length of the HIV and Aids-specific training courses attended by counsellors are presented. Once again, the range of training experience was considerable. In this instance, training lengths extended between three hours' and one year's training.

Table 8: Length of HIV and Aids-specific counselling training courses taken by counsellors

Length of counselling course	Frequency
Unknown	6
< 1 Day	1
< 1 Week	8
< 1 Month	29
< 1 Year	2
1 Year <	2
Total	48

4.3.1.3 Types of counselling courses attended

As highlighted previously a problem did occur in counsellors' responses with regard consistency in reporting the details of their counselling training. For this reason, it was deemed appropriate to assess the content of their training courses collectively. The table which follows presents the courses- by content- which counsellors had confirmed attending.

The results suggest that equal numbers of counsellors had attended courses related to information on HIV and Aids, and VCT procedure (30). This was followed closely by counsellors having attended general training courses. Counsellors also reported having received training in the PMTCT, adherence, tuberculosis (TB), sexually transmitted infections (STI), and PEP. One counsellor noted that her training was research based; she described research she had conducted during her tertiary education on "B12: HIV/AIDS on school going children at Eastern Cape rural areas". It must be noted that the discrepancy which arises between having matched numbers for receiving training and the overall sample size is in some cases due to the fact that some participants did not provide the details of the content of their courses.

Table 9: Counsellors' training courses (content)

Course content	Frequency
HIV and Aids	30
VCT procedure.	30
General counselling skills	25
PMTCT	16
Adherence	11
TB	6
STI	6
PEP	3
Research-based training	1

4.3.2 Counselling procedures adopted

In assessing the nature and experience of VCT counselling it is important to examine the counselling procedures adopted in practice. As highlighted previously, VCT has two counselling components which are conducted before and after the HIV and Aids testing respectively. Counsellors were provided with a list of core elements of pre- and post- test sessions and asked to respond whether they implement these practices in their sessions. Further, they were invited to specify other elements of their practice which were not included in the instrument items.

4.3.2.1 Pre-test counselling

Counsellors were asked whether their facilities offered pre-test counselling to their presenting clients. 43 of the respondents noted that their respective facility did offer pre-test counselling services. Three counsellors did not respond, while two explicitly stated that their facility did not offer pre-test counselling. In this instance, these two counsellors' responses were compared with others from their facility who stated that this was a part of their procedures. This discrepancy in answers may have arisen perhaps due to a misunderstanding of the language of the questionnaire, or the fact that these particular counsellors do not recognise or practice HIV and Aids specific pre-test counselling explicitly within their sessions.

The table which follows serves to indicate the frequency with which the counsellors who participated in the current study employ certain core characteristics of pre-test VCT counselling. In all cases, it is clear that the majority of counsellors are using all the identified practices highlighted in the literature and instrument development sections (Mindset Network Health Division, 2008). Ensuring to the client that the contents of their session and test results would be held as confidential emerged as the procedure employed consistently by most counsellors (89.6%). Counsellors' assessment of the client's available coping skills and support networks was the least consistently employed strategy in pre-test sessions.

Table 10: Pre-test counselling procedures adopted

Pre-test counselling procedure	Frequency	Percent
Ensure Informed consent	39	81.2
Ensure Confidentiality	43	89.6
Assess level of HIV and Aids knowledge	41	85.4
Assess Lifestyle and risk behaviours	40	83.3
Assess available coping skills and support networks	32	66.7
Describe testing procedure and types of available tests	38	79.2
Explain the window period	42	87.5
Discuss implications of both a positive and negative result	40	83.3

13 of the 48 responding counsellors elected to provide further specification and details about their pre-test counselling practice. The table which follows indicates the other pre-test counselling procedures highlighted by these 13 counsellors, and the frequencies with which these practices were mentioned.

Table 11: Pre-test counselling procedures additionally mentioned by counsellors

Pre-test counselling procedure	Frequency
Appropriate lifestyle and behaviour changes	2
CD4 counts- understanding and implications	3
Client's expectations and emotions	2
Condom education	1
Disclosure	2
Referral	4
Time	1
Understanding the test kits	1

Counsellors were also asked to note the approximate length of their pre-test counselling sessions. Their responses are reflected in the table which follows. In the majority of cases, counsellors reported taking up to 15 minutes for their pre-test sessions with clients.

Table 12: Length of pre-test counselling sessions

Length of pre-test session (minutes)	Frequency
No response	9
0-15	20
15 -30	9
30-45	6
45-60	3
It depends	1

4.3.2.2 Testing procedures

In order to assess their knowledge of and familiarity with the testing process in its entirety, counsellors were asked to note the types of tests used at the facility at which they were employed. They identified five types of tests; the frequencies with which counsellors reported their use are reported in the table that follows.

Table 13: HIV and Aids tests identified as used by counsellors

Pre-test counselling procedure	**Frequency**
Rapid Test	27
Elisa	19
PCR	6
First Response	5
Confirmation	7

These results suggest that counsellors make most frequent use of the Rapid Test; 27 counsellors indicated that this test was used at their facility. The First Response was by counsellors identified as the least frequently used test. Discrepancies noted between counsellors' responses at the same facilities may be due to personal preference or familiarity with particular testing procedures. It is important to consider the possibility that this may also be due to a lack of knowledge about the core testing procedure. If this

is the case it certainly warrants attention, as the counsellor's ability to explain testing procedures is a core component of effective VCT.

4.3.2.3 Post-test counselling procedures

After clients have undergone the HIV and Aids diagnostic test, they receive their results in the post-test session. For the purposes of clarity, the questionnaire items separated the procedure protocol for negative and positive diagnoses. The table which follows presents the frequencies with which certain procedures are adopted in a counselling session which follows a negative diagnosis.

Table 14: Post-test counselling procedures employed in the case of a negative diagnosis

Post-test counselling procedure (negative diagnosis)	Frequency	Percent
Provide information regarding risk behaviours and recommend lifestyle changes to ensure maximum health	39	81.2
Remind client about the window period	44	91.7
Advise future testing	38	79.2

Again, it appears that the majority of counsellors do utilise the identified counselling practices. Counsellors noted that they would address lifestyle changes, risk behaviours and associated complications, as well as recommend testing in the future in these sessions. Most significantly, counsellors most frequently reported that they would remind their clients about the window period (91.7%). This represents an essential component of VCT- the window period refers to the time between infection with the HI virus and the time it takes for the antibodies to become detectable in the blood. This period can take up to approximately six months. Worthington and Myers' (2003) study confirmed that this period represents a significant source of anxiety presenting at the time of testing. For this reason it is important for clients to know that if they fear that they are at risk then it is essential that they do not partake in risky behaviours that may allow the virus to spread to others (this could include engaging in sexual activities with a number of partners or the sharing of needles). Counsellors represent a central resource in their capacity to intervene in further transmission of the virus in this way.

Once again, counsellors were invited to note or specify the details of particular procedures they utilise which were not mentioned in the questionnaire; 17 counsellors did so. Most frequently emphasised were the use of condoms, and the "A.B.C" strategy (which advocates that clients should "Abstain. Be faithful. Condomise."). Abstinence was emphasised once outside of this context. Issues surrounding disclosure, as well as prevention strategies were also noted.

Table 15: Post-test counselling procedures (negative diagnosis) additionally mentioned by counsellors

Post-test counselling procedure (negative diagnosis)	Frequency	Percent
"A.B.C"	5	29.4
Abstain	1	5.9
Condom education	5	29.4
Disclosure/ partner communication and testing	3	17.6
Prevention/ "Stay negative"	2	11.8

In the case of a positive diagnosis, the post-test counselling session becomes extremely delicate in nature. It is crucial for counsellors to be able to navigate its nuances in order to maximise the effectiveness of this intervention. When one examines the procedures employed by counsellors, the most frequently used among these in a session post positive diagnosis include emphasising positive living, explaining the difference between being HIV and Aids infected and having AIDS, and also discussing the implications of being HIV and Aids-positive in terms of behaviours and potential risks. Each of these three components was employed by 83.3% of the responding counsellor group.

The strategy noted least frequently was a counsellor's provision of reassurance and emotional support to the client about diagnosis. This raises some concern- as highlighted previously, the diagnosis of an individual as HIV and Aids-positive can be regarded as a traumatic event (Olley *et al.*, 2005). The counsellor holds a unique position in assisting the client to weather this trauma. It stands to reason that for the client to be supported through this trauma by a genuine, empathetic and well-informed counsellor could make a

significant impact on his or her experience of diagnosis, as well as his or her lifestyle and treatment choices thereafter. Once more it is important to remember that these results must be interpreted with caution- there are some areas of overlap between items, and aspects of counselling such as the provision of emotional support may be embedded within the context of the other activities identified. As a result, counsellors may not have identified this as an explicit counselling activity.

Table 16: Post-test counselling procedures employed in the case of a positive diagnosis

Post-test counselling procedure (positive diagnosis)	Frequency	Percent
Discuss client's feelings regarding diagnosis	37	77.1
Reassure the client and provide emotional support	29	60.4
Discuss available coping skills and support networks	32	66.7
Emphasise positive living	40	83.3
Explain the difference between being HIV and Aids infected and having AIDS	40	83.3
Discuss implications of being HIV and Aids positive (behaviours, risks etc.)	40	83.3
Discuss the value of disclosure to partners	39	81.2
Discuss the availability of anti-retroviral treatments (ARV's)	39	81.2

As mentioned in previous instances, counsellors were invited to elaborate or provide additional procedures they adopted in their post-test counselling in the case of a positive diagnosis. The 16 counsellors who provided these details most frequently emphasised the importance of having one's CD4 count monitored and regularly tested. Additionally, they repeatedly mentioned that they encourage those individuals diagnosed as HIV and Aids positive to join support groups or seek ongoing counselling. Referrals of both clients and their partners were mentioned, and interestingly one counsellor highlighted the importance of encouraging clients to be tested for tuberculosis as they are particularly vulnerable. Finally, the confidentiality of the client's results and information were noted as another important aspect of post-test counselling procedure in the case of a positive diagnosis.

Table 17: Post-test counselling procedures (positive diagnosis) additionally mentioned by counsellors

Post-test counselling procedure (positive diagnosis)	Frequency
CD4 counts- understanding and implications	7
Client referral	1
Condom education	1
Confidentiality- emphasise and reassure the client	1
Importance of ongoing counselling and support groups	4
Importance of T.B screening	1
Partner referral	1

Counsellors were also asked to note the length of their post-test counselling sessions. Similarly to the results of the pre-test counselling, post-test were most frequently reported to last up to 15 minutes. Although this was only a verbatim response in two cases, counsellors repeatedly emphasised that the length of the session would vary as per the client's diagnosis and individual emotional needs.

Table 18: Length of post-test counselling sessions

Length of post-test session (minutes)	Frequency
No response	9
0-15	19
15 -30	8
30-45	8
45-60	2
It depends	2
Total	48

4.3.3 Number of sessions conducted per week.

Finally, counsellors were requested to note the number of sessions they normally facilitate per week. Counsellors' responses are reflected in the table that follows. The most frequent categories which emerged locate the majority of counsellors as counselling

either below ten, or between 20 and 40 sessions a week. This equates to approximately four to eight sessions per day. Additionally it is important to consider the range of responses- the lowest value for a response obtained places the least number of counselling sessions per week at three sessions a week, and the highest between 85 and 90 sessions a week- this equates to between 13 and 18 sessions per day. While this case is the highest reported value, the effect of such an intense workload on the counsellor, both physically and emotionally, must be considered. A counsellor may begin to develop symptoms of burnout- for instance, one counsellor stated, "A2: I feel drained and so tired of one thing every day." The emergence of such emotions may compromise the efficacy of the VCT process.

Table 19: Number of counselling sessions facilitated per week

Number of counselling sessions per week	**Frequency**
Unknown	10
0-10	8
10-20	6
20-30	8
30-40	8
40-50	1
50-60	1
60-70	1
70-80	1
80-90	1
"It depends"	3
Total	48

4.4 The good, the bad and the ugly: Respondents' perceptions of their roles

4.4.1 Acknowledgement and Compensation

It appears that a significant number of the counsellors who participated in the study feel a sense of frustration related to acknowledgement and compensation for the work that they do, both in terms of their title and role definitions, as well as with respect to their financial compensation. These feelings are clearly reflected with one counsellor's report that her work did not feel rewarding "B1: Because out of our hard work we are not being paid enough and we are taken for granted".

With regard to the first aspect, counsellors seem to feel that they are expected to take on a workload far greater than they are able to handle. Counsellors reported feelings of dissatisfaction with the manner in which they are treated by their institutions and colleagues (for example, social workers). Interestingly, this was raised broadly in the data set, not just where counsellors were directly asked about whether their work left them frustrated. Reflecting on his ideal supervision process, one of the site managers noted that it would include, "A1: Creating and awareness around role of counsellors and responsibility of manager to ensure that counsellors also are given a workable condition of employment. Not stipend and being called lay-counsellor. Rather say passionate counsellors". Notably, his sentiments were echoed later in his answers where he stated that "no being recognized or labelled as lay-person" left him frustrated about his job. This response highlights that counsellors would like to renegotiate perceptions of their roles in the health care system- they feel that they have received training, and play an important role in the diagnostic process and management of clients, and wish to be acknowledged for this. These sentiments were echoed by other participants; for example, another counsellor, also reflecting on an ideal supervision process stated that it would include,

> "A13: To make sure that we get debriefing. We get more trainings that we need. Make sure that we get enough money- because we are doing a good work- helping doctors, nurses to help patients to get better without counsellors. No appreciation- no treatment for children. PR

> to be done. You need counsellors. She must make us feel (Welcome) professionally."

This counsellor emphasises clearly that VCT counsellors represent an important resource in the health care chain, one which plays an important adjunctive role to that played by bio-medically-trained professionals (who would be responsible for medical diagnosis and prescription of medication). VCT represents an important means for sustaining prevention of future infection in the case of a negative diagnosis, as well as adherence to and compliance with treatment plans (for example, ART) in the case of a positive diagnosis.

Notably, the issue of training comes to the fore in discussions surrounding counsellors meriting acknowledgement- professional courtesy appears to be held as an issue for counsellors. They appear to seek a cordial respect from doctors and nurses, one which acknowledges that they too function from a trained and informed knowledge base. One counsellor noted "D3: Sometimes the doctors and nurses undermine us as counsellors." Another (A10) stated in the final lines of her response:

> "I think it's about time they consider us counsellors as we are as well playing a role in the health industry. It's very sad to work very hard and getting peanuts at the end of the day. I will be very pleased to see changes in this end to be honest to see the salary going up."

It has become clear that the counsellors see the work they do as one of the most central initiatives in curbing the spread of HIV and Aids, and as such feel they should be compensated accordingly. One of the respondents noted, "A16: In terms of salary (stipend) the money is not enough, the work that we are doing is too much..." In fact, when invited to give additional comments and feedback at the close of the questionnaire one of the counsellors stated, "D3: I would be very happy if you can assist us as counsellors concerning the money that we earn."

Thus, it seems that counsellors feel that they are inadequately recognised as health care professionals, and that they are not appropriately remunerated for the distinctly trying work that they undertake. As such, with a heavy workload, and a mounting sense of frustration over a lack of acknowledgement and compensation, it seems that the threat of burnout within this group is of crucial concern. It appears that the amalgamation of these factors has the potential to compromise severely the valuable role VCT has to play.

4.4.2 Training, Professionalism and Counselling Efficacy

As mentioned in the previous section, one counsellor highlighted the discrepancies in perceived levels of professionalism when referring to her desired supervision process. She stated, "A13: She must make us feel (Welcome) professionally." She later mentions, "We also need certificate as a proof that we have trained for other courses // May registering us as professional". The implication here is that counsellors desire to be recognised for their contribution to the health care profession.

This was supported in other instances; for example, discussing her feelings regarding supervision, one counsellor stated: "A3: Supervision should contain at least career path for counsellors, encourage counsellors to grow in other field like social worker". This statement suggests that some counsellors do desire to develop further in this field and want to be recognised as important members of the health care professional population. Confirming this, another counsellor noted: "E9: I love this job a lot and I want to grow further in this job & career".

At present, it seems that although there are certainly commonalities in the content of the training received by counsellors, it appears that there is little consistency amongst them, not least within the institutions in which they are employed. Counsellors, more often than not have received vastly different levels of training, with this discrepancy being indicated by variations reported ranging from a number of hours', to more than a year's training.

Certainly, it should be noted that the ability to counsel effectively is not *entirely* dependent on the length of training received; there are core characteristics necessary in

any efficacious counselling setting. Among these, the ability to present the core features of a productive counselling relationship mentioned previously in the literature review, for example, empathy and genuineness (Thorne, 2005) are critical. However, one of the main and perhaps most important features of VCT is the dissemination of appropriate and *correct* information regarding the nature and spread of HIV and Aids. It is essential that the counsellor's ability to do so is at its optimum level, with knowledge that is both accurate and up-to-date.

Perhaps, one might consider the suggestion that future counsellors be far more carefully screened before being allowed to undergo training; it is important to consider their motivations and psychological well-being. It seems that these factors are extremely influential in the counsellor's capacity development over the course of their careers, both in terms of technique and also psychological and emotional development. Mental health care practitioners in other settings receive up to six years training, and it seems almost illogical that such essential workers in this field are not given more than a few hours training on average. Further, it is suggested that monitoring and supervising the counsellors at all times during which they are providing counselling services may greatly enhance the quality and efficacy of the VCT process.

4.4.3 Problematic or negative aspects of counsellors' experiences

The questionnaire endeavoured to address the full spectrum of emotional experiences counsellors may attach to their counselling roles. For this reason, it included items intended to assess some of the potentially negative experiences to which the respondents may have been exposed. Counsellors were asked to reflect on their levels of stress and frustration, as well as the possibility of conflict emerging in, or as a result of the counselling sessions.

In some instances, counsellors did report a sense of conflict which emerged between their values, and the values extolled by counselling process. However this was not the case with the majority; only twelve of the responding 48 counsellors explicitly noted this. It remains important to attend to their reasons for such opinions. One counsellor noted,

"A13: Yes: Some of the client they have same problems that I have". This suggests that identification with their clients can make it increasingly difficult to engage with clients emotively. If one considers how many of the counsellors reported their entry into the field was motivated by their desire to incite change in, and assist loved ones in their communities, this would confirm the hypothesised interweaving of their personal, communal and professional lives. Such investment in the lives of their clients could potentially lead to significantly increased levels of stress.

In another instance, a counsellor noted the following with regard to her experiences of counselling related conflict:

> "A10: Yes: I sometimes do, as we get different clients every day. You can get those difficult, unreasonable ones when counselling then you have to play that role of your own values. E.g. I won't take treatment now and I will never use a condom. How are you going to counsel that irresponsible person?"

One must assess such a response carefully. Counsellors represent well educated sources of information for clients, and they appear to see themselves as such. However they appear to experience a sense of internal conflict when they are faced with clients who will not alter their risky lifestyles. Where the counsellor uses words such as "unreasonable" and "irresponsible" it portrays a sense that counsellors feel frustration, at the restrictions imposed by the boundaries of counselling protocol.

23 of the responding counsellors noted that they do in fact feel frustrated by their work. Similarly, 23 counsellors noted finding their jobs as counsellors stressful. This was identified as being due to a number of factors, among them income and remuneration (as highlighted previously), feelings of insufficiency due to client attitudes and behaviours, bureaucratic and logistical problems, and also testing outcomes.

Consider the following extract of one respondent's questionnaire:

> "E12: *Do you ever feel frustrated because of your work?*
>
> Yes: When quality is compromised for numbers. It has a huge weight on me as a person who see the clients face to face and not the stats on paper.
>
> *How do you feel after a session with a client?*
> Like I haven't done my job to the best of my ability. The client on the other hand is not helped fully."

This counsellor has succinctly highlighted the tension which exists between the provisions of quality versus quantity counselling services. VCT counsellors in South Africa are faced with improbable numbers of clients potentially infected by the HI virus. The sheer volume of clients that counsellors see forces them to come face to face with these individuals who are more than just "the stats on paper". In this, they are confronted with the many suffering faces of the epidemic. This feeling of being overwhelmed was supported in other instances, for example, when one counsellor replied to the question of whether she felt frustrated due to her work by stating: "B6: Yes: Because I mainly deliver quantity not quality, as large number of patients are seen at one time". In yet another case, a counsellor described the physical exhaustion which accompanies such an intense workload: "B4: Yes: If there are a lot of patients who need to be tested sometimes you find that I'm already exhausted by only seeing just +/- 4 patients before twelve".

In addition to this, in many cases counselling facilities are sponsored by large, often governmental and international, organisations (such as the South African government, UNAID, and USAID). As a result the counsellors are often required to fill specific quotas of clients reached in order to maintain funding levels. In a personal discussion with one counsellor during the course of data collection, the counsellor reported feeling

emotionally drained and her empathetic resources depleted due to the number of clients to whom she needed to attend each day. Indeed where the counsellor cited previously states that after seeing a client she feels like she has not done her job to the best of her ability and resultantly does not help the client "fully" suggests that counsellors may be left with a sense of frustrated guilt due to the limitations imposed due the logistical demands with which they are faced.

Counsellors reflected feelings of frustration and stress as a consequence of seeing the lifestyles and choices of their clients. For example, one counsellor described her frustration "B8: because of people who do not come back again// When they come back after a 2 months I feel frustrated and sometimes they are not well." In the context of the community-connectedness expressed by many of the respondents, it seems counsellors appear to find it difficult to separate themselves emotionally from the consequences of their clients' behaviours. Being educated in the facts and figures of HIV and its implications likely increases the difficulty counsellors experience when they are made to see clients in their communities continue to pursue risky behaviours. Additionally, in cases that have been difficult from the time of their initial presentation, counsellors can be affected emotionally by the outcomes of the session. One counsellor noted : D2: Yes: Sometimes I do more especially if I'm having a difficult case that I feel like I'm not winning it I feel like I have failed myself and the patient that I'm trying to help"

It is clear that the content and consequences of the counselling sessions can take their toll on the counsellors. In one instance, reflecting on her emotions after a session, one counsellor stated the following: "A2: Traumatize and sometimes I feel bad about everything". In the initial literature review which was presented in the first chapter of this document, the traumatic nature of the HIV positive diagnosis, and the potential for vicarious traumatisation and secondary traumatic stress were highlighted (Olley, Zeier, Seedat & Stein, 2005; Martin, 2006). The response presented by this counsellor provides a clear indication that counsellors *are* being affected by the emotional content of their sessions. This was further illustrated when another of the counsellors reflected on her frustration "B1: Yes: When I have tested lots of people who are HIV positive". The

respondents consistently appeared to attach meaning and emotional energy to the outcomes of their clients' diagnosis. For this reason it is of great importance that counsellors are equipped to handle the emotions they are forced to face as part of their jobs. This could potentially be enhanced by appropriate training and support systems, the latter of which is discussed shortly.

4.4.4 Passion, pride and privilege: The upside to counselling

Despite certain contentious issues that emerged across counsellors' responses, it appears that many counsellors do feel a sense of passion for, and a pride in the work that they do. When asked whether they found their work rewarding, the majority of counsellors reported that this was the case. One of the responding counsellors reported the following about her feelings about her role as a counsellor:

> "B7: I feel great and honoured to be counsellor, because I am a community person, I do have humanity, compassion. This worked I love it so much. I do sacrifice a lot its hard working. I am determined to worked from the bottom of my heart. I feel great helping, education giving information I have and also support and maintaining confidentiality of the patient"

This response showcases the commitment, determination and drive present in many of the responding counsellors. Counsellors' personal attitudes and orientations can certainly influence the quality and efficacy of the intervention. She highlights that VCT involves a commitment to the community in which a counsellor works, as well as to the individual presenting clients, and also the drive to educate others. Additionally the determination, and at times sacrifices, needed which she highlights *are* inescapable aspects of the counselling role. It is certainly not an easy role, but those counsellors, who are committed to the furthering of the field, and the maintenance of a continued standard of quality amongst counsellors, represent a core resource to the South African population in the fight against HIV and Aids.

A significant portion of the responding sample supported these statements. This was clearly highlighted in their passion for their roles. Indeed, one counsellor stated that instead of being referred to as a "lay counsellor" he suggests that "A1: Rather say passionate counsellors." Another highlighted the role of self-motivation in this regard. When asked if she found her job stressful, this counsellor stated: "B12: No: I chose it because I love it. No-one inspires me to be a counsellor that was a self-decision, through my passion". Counsellors also indicated that this passion for the work helps them to cope with the demands of counselling.

Counsellors also reflected on the rewarding nature of their work. Among the positive responses, one counsellor stated: "A1: I make a difference in someone's life every day."Another One of the participants, responded positively, and noted that, "A17: It gives you and equips you with communication skills as well as teaching you human characters." This response highlights how sensitivity to human nature, as well as the ability to communicate information to one's clients, is central to the efficacy of the counselling process.

The benefits of a productive session were also highlighted by counsellors. One stated that "A3: I have tried hard to make a difference in pt's [patient's] life and seeing one pt's viral load being suppressed and CD4 up makes me feel proud about myself and job". The pride counsellors feel in a productive session and their work in general emerges clearly in this statement. She also noted that she was able to feel that she was making a productive difference to the state of the HIV and Aids crisis in South African when "some people are adhering correctly to their ART".

In another instance, when one counsellor reflected on her feelings after a session with a client, she stated:

> "D2: I sometimes feel relieved that I have make a different in someone life and feel that I have learned and gained more experience through that session because I become

> across different situation EACH day. But most of all I feel proud about myself and my job as a counsellor."

Counsellors' engagement with their clients, coupled with the potential to incite change that characterises their work, appears to act as a significant source of motivation. Thus, it is the contention of the researcher that this passion and pride, and the feeling of privilege counsellors express with respect to their involvement in the field, represents an area for investment by training and supervising structures. This may well have positive implications for enhanced quality of the services provided by counsellors.

4.4.5 Support systems

It was considered important to assess counsellors' perceived levels of support, as well as the support systems available to them. In addition to the details of their supervision procedures, counsellors described their external support systems. With regard to former, four counsellors did not specify whether they received supervision, whilst 33 counsellors did receive some form of supervision. The remaining eleven counsellors explicitly stated that they did not received supervision. Of the 33 counsellors who did receive supervision, 24 stated that they found their supervision helpful, while the remaining nine counsellors found it unhelpful. Counsellors also cited a lack of supervision as a cause of increased stress; in one case a counsellor stated that for her, her stress levels increase "E5: When you can't have any supervision for last than the year." While it is important to note that the efficacy of supervisory practice is not directly dependent on the frequency of its occurrence, it does provide one useful representation for comparison. Following this, when asked to report on the frequency of the supervision received, the responses showed a considerable range, with the lowest reported occurrence of supervision activities occurring yearly if at all, to the most regular supervision occurring on a daily basis. Most often, it seems that counsellors who are receiving supervision do so either once a month (twelve counsellors), or on a weekly basis (five counsellors).

In a further illustration of the value of supervision, one counsellor reflected this about her desired supervision process: "A10: Sometimes you as a counsellor need more information. Being my first year doing this I sometimes feel that there was someone I

could share my counselling session with to correct me were possible. To help me where needed." Counsellors repeatedly expressed the desire for feedback on their counselling capabilities. In another example one counsellor stated a desire for "B4: Checking my working conditions // Checking my skills and providing counselling where needed" and another still highlighted the need for "E4: Checking if the counsellor is still following the protocol // Do the debriefing with the counsellors to checking if they are still enjoying the job that they are doing because it is also affect them somehow"

Counsellors repeatedly highlighted the issue of "debriefing" (this was explicitly raised in 13 instances) -this was raised as a positive aspect by those engaging in the process, in some instances this was post-counselling session procedure, while those who did not highlighted this as a deficit in their counselling experience. Following this, a number of counsellors expressed a desire for one-on-one counselling; for example, consider this extract "D1: I sometimes prefer groups and one-on-one supervision // To understand what other counsellors are going through // And I should be lead by a psychologist or a social worker, preferably one on one". This counsellor expresses the value of both group and one-on-one sessions, but emphasised his desire for more personalised supervision. In another instance, for example, one of the respondents stated: "D2: I would love or like to have one-on-one session with my supervisor and to have debriefing sessions."

Supervision was not the only support system identified. Counsellors were asked whether they had ever attended any stress management workshops or similar sessions- only five of the responding counsellors were able to confirm ever having attended such a session. This represents a possible avenue for improvement in support services that could potentially be provided to counsellors in the future.

The questionnaire also endeavoured to describe the support networks upon which counsellors draw in times of work-related stress. 32 of the participants confirmed that they would talk about this stress when it occurred. Of these responses counsellors most frequently mentioned turning to their colleagues for moral support (14 cases). One counsellor explained it thus: "A17: Yes: I talk to my colleagues so that we can discuss it

together and become stress free." The table below represents the frequency with which support systems were mentioned by counsellors.

Table 20: Support networks cited by counsellors

Supporter/ Support system	Frequency
Colleagues	14
Supervisors/ site managers	8
Partners	6
Other counselling professionals	5
Friends	4
Family	3
Clients	1

One counsellor mentioned that when experiencing stress as a result of their counselling role, they would speak about this to their clients. The appropriateness of such behaviour should be considered strictly against counselling protocol, and the positive regard and empathy counsellors are expected to present. Counsellors should be made aware that beyond the context of reflecting their feelings with regard to the session where appropriate, they should not share their feelings with regard to their work stress with their clients.

In addition to the availability of support systems in counsellors' lives, it is important to acknowledge their personal, internal coping resources. For this reason, counsellors' coping skills are discussed next.

4.4.6 Counsellors' Coping Skills

When counsellors were asked to reflect on whether they felt that they were coping with the demands placed upon them by their counselling roles, 25 of the responding counsellors stated that they felt that they were able to cope adequately. Answering this question, one counsellor reported, "A13: Yes: Out of 8 people that I have counselled, 6 will agree to test it is a big break-through for me". This counsellor's response confirms previously cited results and also highlights how VCT counsellors draw pleasure and

reinforced motivation from their successes in counselling sessions. Additionally, although this represents only one case, it provides one exemplary instance of how VCT can ensure that presenting clients consent to undergo testing. The implications of 75% of presenting clients knowing their serostatus and being actively informed about the consequences of their particular diagnosis are certainly far-reaching and should not be under-appreciated.

Another counsellor supported her contention that she felt she was coping well with the demands of her role as a counsellor when she stated, "D3: Yes: I can deal with their problems, behaviours and their attitudes". The ability to adequately handle the pressure and demands of both the clients and the nature of the work required by VCT counsellors is central to the efficacy of the interventions they provide.

The importance of adequate coping skills was illustrated when one counsellor responded: "A15: Yes: Because I counselled more than 50 people per week." The coping skills and emotional resources required to face this workload is immense, and the fact that this counsellor cites her capacity to bear this load reflects invaluable fortitude and commitment. However, one must at all times remember that the constant strain likely placed on counsellors who take on such loads places them at a significantly higher level of stress and vicarious traumatisation.

In contrast to the sentiments expressed by the counsellors described above, eight of the responding counsellors felt that that were unable to cope with the demands they faced. This was illustrated in such statements as "B8: No, each every per week I'm not coping // I don't know cause sometimes I feel like is not all of us to become a really counsellor." It seems that this counsellor feels that she is not always able to cope, and may not have the personal predisposition to fulfil the requirements of the role. Another counsellor expressed similar sentiments when in response to this question she noted, "A2: No: I feel that sometimes I cannot fulfil a pt's [patient's] needs"

Additionally, counsellors were asked to reflect on their coping skills and the coping mechanisms employed. The most frequently used coping mechanism employed by counsellors was prayer (n=37). The literature cited in the first chapter has highlighted how religion, which may be seen as a largely emotion focused coping strategy, has been described as more widely used by "people facing chronic stressors such as care-giving, especially those in lower socioeconomic status groups" (Aldwin & Yancura, 2004; p.6). It is important to recall that the responding sample was almost exclusively Christian, and it appears that these counsellors found significant comfort in their faith-based practice. This was followed closely by spending time with family and friends (n=35). Evidence suggests that the companionship of loved ones, including family and friends can significantly enhance one's feelings of being supported and therefore able to cope effectively with presenting adverse situations (Ross & Deverell, 2004). Exercise and sports, hobbies, and represent other positive coping mechanisms.

Drinking, smoking and the use of prescription medication, which were identified as perhaps more negatively oriented coping mechanisms, were also evident in counsellors' responses. It must be noted however, that the frequency with which counsellors turned to these coping strategies was far less than those positive examples mentioned previously. Of these, drinking was the most often reported, however; the frequency with which counsellors reported drinking was more often a single occurrence within a month. The use of prescription medication, however, while slightly less frequently noted, did have a higher rate of day-to-day use, with six counsellors turning to medication daily. However, it must also be noted that since one counsellor alluded to having been diagnosed as infected with HIV, this may imply the use of daily anti-retroviral therapy. The table that follows presents the findings regarding the employment of certain coping mechanisms amongst counsellors.

Table 21: Counsellors' coping mechanisms

Coping mechanism	Frequency with which coping mechanism was employed	How often?			
		Once a month	Once a week	More than once a week	Every day
Exercise/ Sports	22	6	5	4	5
Drinking	18	14	2	0	1
Prayer	37	1	6	3	23
Smoking	4	1	0	1	1
Meditation	14	4	2	0	4
Hobbies	27	4	6	5	8
Prescription Medication	16	7	1	0	6
See friends/ family	35	3	4	8	18

4.5 Reflections on counselling identities, power and the South African body

As mentioned previously, this study adopted, in part, a qualitative approach in framing its investigation. The methods section highlighted that such an approach places a distinct emphasis on the value of prolonged engagement in the research setting, reflexivity and in-depth immersion into the context of study. The potential contribution of these procedures is so often highlighted by methodologists and this has become increasingly apparent throughout the course of this process.

Thus, it is a useful reminder at this point to consider that a more concise version of this project, which functions now as a pilot study, was conducted at an Honours level during the author's first year of post-graduate study. In doing so, it was necessary to learn to understand the vocabulary employed by the participants. An examination thereof yielded the emergence of a number of counselling identities.

4.5.1 Counselling identities

Attending to these conceptions of counsellor identities it became essential to examine the use of saviour metaphors in the answers provided by counsellors. Proving this, in the current incarnation of the study, a particular counsellor stated, "E3: Because I was once saved by VCT. So I've decided that I should do the same to others. Cause really people need more information about VCT."

Through the thematic analysis of counsellors' responses three saviour figure identities appeared: the parent-, the military- and the preacher-teacher saviours. The discussion which follows describes the emergence of these saviour identities chronologically throughout the course of the study, and reflects on the implications of counsellors' adoption of these.

4.5.1.1 The parent saviour

When one examines this record from a more classical psychodynamic perspective, the "rescue fantasy" described by Greenacre (1971, as cited in Berman, 2004) becomes a useful concept in understanding the counsellors' emotive responses to their role. In her discussions around the nature of counter-transference, Greenacre discusses how the therapist seeks to become the "ideal parent" to the client, and thus projects this conceptualisation onto him/her (Masterson, 1983; Greenacre, 1971, as cited in Berman, 2004). Therefore, it seems that at some level, therapists attempt to 'rescue' their patients from their situations. Greenacre (1971, as cited in Berman, 2004) states that "the analyst then becomes the savior through whom the analysand will be launched" (p.97).

Perhaps the same may be said of the VCT counsellors. The extracts cited below engage the concept of VCT as a "saving" act, and the framing of the counsellor, as such, as the saviour figure. The determination of the client's serostatus has literally become a "life or death" situation, from which he or she needs to be saved.

It is useful to recall a particular example which emerged in the pilot study (Goldberg, 2007). One respondent stated that "counselling full time gives … an opportunity to reach

out especially to young people as a counsellor and a parent to give them guidance and advice regarding HIV and Aids." The counsellor thereafter further stated: "Most of my clients feel enlightened after having a session with me. I *save* more students from contracting HIV and Aids by teaching them how to become responsible." (Emphasis added). It seems that this parenting role, one in which the counsellor-parent attempts to save the client-child, is one which warrants attention.

Indeed this notion has found support in the current investigation. One counsellor noted, "I feel tired and at the same time I feel happy because I saved somebody's soul". Additionally, the role of such imagery is supported in statements such as, "A16: In order to help our youth, as we see them taking drugs/alcohol and ending up having unprotected sex. And again to encourage them to test for HIV and Aids".

Now, to reflect accurately, and engage in the requisite reflexive audit central to a qualitative study, it is necessary note that having engaged in the initial stages of this study, it was impossible to enter the new sites without having been primed and made sensitive to this aspect of the counsellors' narrative. The statements cited above have highlighted that this aspect was not unique to the counsellors or counselling units described in the pilot.

One counsellor, B11, reflecting on her feelings at the end of the counselling session, stated that, "E3: Because I was once saved by VCT. So I've decided that I should do the same to others. Cause really people need more information about VCT." If one examines this statement, it becomes evident that the parenting imagery assessed previously is not the only dynamic at play. The counsellor in question notes that she will indeed adopt a "saviour" role. In the construction of this statement there exists an unspoken implication that as a counsellor, one has the power to save.

The power implicit in the counselling relationship, as well as counsellors' complicity to it, has become a particularly interesting aspect of the study. For the author, this emerged as a surprising consequence of the analytic process. There were, it seemed, other types of

power roles at play within the counselling relationship. These include military and religious-didactic positions, which are discussed in the sections which follow.

4.5.1.2 The military saviour

Initially, it was hypothesised that in addition to the parenting themes initially explored, there existed a significant use of military metaphoric themes. So often we hear how nations are seeking to "fight the war against HIV and Aids". Indeed, Waldby (1996, as cited in Gagnon & Holmes, 2008, p.264) stated that "warfare analogies, concepts of attack and retreat, triumph and defeat, infiltration and discovery, are drawn upon to describe the machinations of the virus at every level of scale, from microscopic to those of community and nation". This language has become a clear part of day-to-day dialogue; its use in academia, health policy and media alike has become increasingly common. In a clear example of this, when one counsellor was asked about whether she felt she was making a difference to the national HIV and Aids crisis, she answered, "E5:No: I believe we fighting the loose battle". The use of words like "fight" and "battle" clearly present the epidemic as an enemy who needs to be fought.

Similarly, if one follows the logic of the HI virus being an invasive element, the human body is correspondingly constructed as the *victim* to the "machinations of the virus". Turning once more to saviour metaphors, it might then be said that VCT counsellors represent a means of being saved from victimhood- an early enough intervention by these frontline soldiers might mean a return to safety. One counsellor, closed his responses with this narrative,

> "B4: HIV and Aids is a global epidemic. And if we all worked together to fight the spread of HIV and Aids by stopping to discriminate against each other. By being involved in community awareness programmes and spreading the right information about HIV and Aids we can all fight the spread of HIV and Aids. By also trying our utmost best to fight poverty by means of volunteering in

> orphanages and soup kitchens. After all a little goes a long way".

The counsellor frames the work of VCT and HIV and Aids prevention in a positive light, but it notable that throughout this response, he repeatedly uses the word "fight". This subscribes to the proposed identity of the counsellor as a "fighter" on the frontlines of HIV and Aids prevention. Whether stated explicitly or not, it appears that counsellors invest a considerable amount of passion in their work, and allegiance to the collective aim prescribed by their role definition.

4.5.1.2.1 "Roll-call!": Meet the company

If for a moment one considers the metaphor of the counsellor as a soldier, it is useful to note the parallels that may be drawn between militaristic and counsellor identities. For example, consider a new recruit to any army. These individuals are typically young in their roles, and full of passion and zeal for the work that they do. In this vein, the author notes that the word "love" appears a number of times in counsellors' reflections on their attitudes to the work that they do, and one might consider how this choice of such an emotively-laden word in response would parallel the zest, eagerness and commitment of a new recruit. For example, one counsellor notes that her work does not frustrate her, she instead states"A14: I love my work to bits..." Another (B7) says, "I feel great because I love my job very much. // My life is in counselling". These responses represent only a few of the times where such imagery emerged. Indeed, the last example cited highlights that the counsellor saw her life as "in counselling"- her life purpose intimately interwoven with her work-role. The author notes however that in the context of this aspect of the discussion "love" is understood as paralleled with a passion and drive for one's cause and work- similar to the passion and purpose portrayed by an eager new recruit.

What is interesting to note is that within the context of the "war" identified previously, there is a significant sense of emotive attachment to the counsellor-role and the work inherent therein. In this, it is likely that a diagnosis of a client as negative may be

conceived of as a ‘battle’ won, and may resultantly impart a sense of gratification and motivation to the counsellor. However, one side of the coin must always be in shadow- the darker side to this facet of the counsellors’ battles is the sense of failure attached to the diagnosis of a client as positive. The use of words like *tired, sad* and *stressed* emerged repeatedly, reiterating a sense of negativity and disappointment in a ‘failed’ session.

One respondent, when asked about how she felt after a counselling session, notes that “E6: Days are not the same. Sometimes angry or happy”. A large portion of the participants responded to the same question by stating that their feelings after a session “depend” on the content of the counselling session, highlighting once again the emotional investment of the counsellor in the outcome of the VCT process. The importance of this emotive attachment displayed by counsellors in what Gagnon and Holmes call the “counteroffensive in the war against HIV-AIDS” (2009, p.264), rests in that counsellors, like soldiers, are most often driven by their motivation. It is not difficult to draw to mind the image of an impassioned soldier going to war for a cause in which he strongly believes. So too can the attitude and drive of the counsellor when considered as a resource in the war.

In order to adequately extend the military parallels, the paragraphs that follow propose a number of other characterisations, attempting once again to draw parallels between military and counselling career roles and the emotional experiences associated therewith.

As an initial example, one might consider the character of a soldier who is currently fighting his battle. This solider is active in the ‘war’, and remains driven by a passion for his cause. Although this soldier is now more aware of the strain posed by the job, he remains committed. One of the respondents confirmed this, in her statement that “E12: I don’t think the people surrounding me understand the emotional strain. They think “you have a lovely job just sit and chat the whole day””. She continues, “I love my job am willing to grow. I have the ability to build or break of which I chose to build” and reflecting on her role in the community stated that she feels “great- sometimes I’m

welcomed other times I'm not. When you start to say HIV and Aids in other places they want to kill you or think you came to expose their status. Others greatly appreciate the job I do." In this she highlights the tension between the positive and negative attributes of the counselling procedure. Her use of such loaded expressions as "want to kill" and "expose" confirm the hypothesised power with which the diagnosis delivered is imbued. In addition to the emotive, impassioned outcome-related experiences highlighted earlier, this counsellor's reflections illustrate the addition, with increased experience, of an implicit need to understand the attitude of the client, as well as the community from which he or she comes. As such, the ability to understand and tailor this intervention to the recipient and his/her context is equal to that of the soldier familiar with his immediate terrain.

In addition, this counsellor's motivation rests in sometimes believing that a difference has been made. Counsellors often cited how even a simple "thank you" could be a significant source of motivation. This is clearly indicated where one counsellor notes "E6: I know I make difference to my client every day. I love it when the session is finish when the client say thank you." Another respondent, reflecting on her experiences with her "typical client" stated, "A16: Yes, helping people and they come back to say thank you- now I know what to do. I have no fear now- It is good." This report confirms the encouragement felt by the counsellor, but also sheds light on an additional interesting aspect of the counselling relationship.

The client appears to cast the counsellor (who seems to accept this role) as a liberator. That is to say in the pre-test session the counsellor would 'free' the client from the "fear" of testing, and perhaps in the post-test setting, this action could be understood to 'combat' the typically disastrous construction of a positive diagnosis. If one returns to the metaphor of the virus as the invader, diagnosis would imply capture and thus a hopeless negative outcome for the captive. Instead, through their informed positions, counsellors are able to liberate their client from the worst possible effects of the 'invading' virus, and instead bring them to a place of safety whereby they are equipped to stand against the invasion and avoid capture and demise.

Now, the experienced soldier, in turn, may sometimes be somewhat hardened emotionally, but he still remembers his call to action, to defend the people of his nation. One of the more experienced counsellors in the response cohort, when describing his motivation, noted, "A11: I wanted to make a difference to my country and other people's life".

It is clear that coping resources or mechanisms are largely stabilised by this point in his career. Support networks, if in place, are generally established by this point and methods for action are likely to have settled into a recognisable pattern or routine. Counsellors referred to numerous coping mechanisms (discussed previously) ranging from familial and relational support, to supervision, as well as the departments/organisations within which they work. In addition they highlighted the role of hobbies and activities outside of their working context.

Even the manager of one of the facilities noted the value of his own training and coping mechanisms. This counsellor has one of the most long-term counselling records among the participants; he has been involved in counselling in general for twelve years, and with HIV and Aids-related counselling for seven. He states "A1: I am trained to deal and cope with my own short comings". Despite this enhanced capacity, the emotional strain of the work may, at times, begin to become evident at this stage. Certain client-cases for the counsellor may by their nature still have the potential to cause significant psychological distress. Also, occasionally regardless of their commitment, these individuals express frustration. This may be as a result of feeling insufficiently compensated, or a sense of hopelessness that the situation may not ultimately be changeable. Consider one counsellor's response to a questioning of whether she felt like she was coping with the demands of counselling. She noted that she did not feel she was coping, as her job is "A2: Stressful and very risk", whilst other counsellors state, "A10: Although we doing this stressful, difficult job, no-one will say to you at end and say well done unless you give yourself a pat in the shoulder" and "A11: I help other people and no-one appreciate me". It appears thus, that counsellors do experience, at times, some degree of frustration, despite their commitment to helping others.

The final cast-member is the burned-out soldier. Although it is not exclusively the case, more often than not it is the veteran soldier who has been too long exposed to the harsh realities of war who begins to suffer burnout and Post-Traumatic Stress Disorder. In the life of the counsellor, in his/her *war* this is likened to the threat of secondary traumatic stress and vicarious traumatisation. These concepts were highlighted in the literature review where Olley, Zeier, Seedat and Stein (2005) described how recently diagnosed patients may present with symptoms indicative of PTSD as a result of the acutely traumatic event of being diagnosed as HIV and Aids positive. Like a soldier who has been traumatised by the horrors of war, the secondary stress and vicarious trauma experienced by the counsellor who has to repeatedly watch the effects of positive (and negative) diagnoses can begin to take their toll on the counsellor. One counsellor, reflecting on her feelings post-session noted that she feels "A2: traumatize and sometimes I feel bad about everything".

It is clear that at times it is difficult for counsellors to cope with their role. Another counsellor describes how she feels "A12: Yes: Exhausted of the job// Say one thing all over again and again// The personal problems or issues that patients tell me about". Reports of " D2: [feeling] like I'm not winning it I feel like I have failed myself and the patient that I'm trying to help" once again highlight the emotional strain experienced by counsellors, which like the intrusive recollections which characterise PTSD, can become inescapable for counsellors. Sadly, in one case, one counsellor states: "I feel drained and so tired...I hate counselling." Burnout is thus a very real consequence of a prolonged participation and involvement in the field of VCT. If the reader considers that experience is often the best teacher, it is certain that if we are indeed to "win" this war on HIV and Aids it is necessary to capitalise on the battle-stories of these veterans to both enhance the strategies currently employed, and also to prevent the future loss of counsellors, who represent such a significant defence-force, due to burnout.

4.5.1.3 "Preacher-teacher": The didactic saviour

With continued analysis, a third saviour figure emerged, described as the "preacher-teacher". Pedagogic and religious language use served to create images of a guide with a wealth of knowledge that draws on this knowledge-base to save the client from danger. The construction of this metaphoric image hinges on the fact that the saviour figure is imbued with the power inherent to the privileged position of knowing. By their mutual complicity in consenting to this image, the counsellor-client dyad reaffirms the power distribution in the relationship.

If one examines the use of the language of pedagogy, the educational aspect of this figure is further illustrated when, for example, one counsellor described her motivations for entering the field of VCT as, "A10: I feel great being the one teaching people about HIV & AIDS.// It was the best opportunity as me, myself also gain knowledge." She later describes how she feels making a difference to the HIV and Aids crisis in South Africa by "Teaching people about the use of condoms, the choices they make in their lives. Helping them make the right decisions for themselves". Inherent in her statements is the sense that counsellors are equipped with an enhanced and refined knowledge base. It is with this superior capacity that counsellors are able to impart knowledge to and educate others, leading them towards the "right" path.

One participant, when asked to reflect on the nature of her typical client, stated "E13: They are not typical they don't have knowledge about other issues they need to be teached or shown directions". Describing her motivation for becoming a counsellor, another noted, "E1: I wanted to make a difference in other people's life // To make people understand about HIV and Aids // And to teach others about protecting themselves from getting HIV and Aids". The idea that counsellors are able to "make people understand" suggests a specific power dynamic in the counselling relationship. The counsellor is conceptualised as a powerful didactic figure that is actively able to save presenting clients from themselves, by reforming, through education, their 'less informed' behaviours and beliefs. In this way counsellors seem to strive to invoke a direct change in their clients, and to make sure they are "shown direction".

Returning to the religious aspects of the descriptive vocabulary adopted by counsellors, there emerged the repeated use of phrases such as "practice what I preach", and "spreading the word" about HIV and Aids. This casts an almost evangelical tone to the activities of the counsellor. Like the preacher who is able to spread the teachings of his or her faith to the communities served, counsellors seem to see themselves as charged with 'spreading' the correct information and the truth about the nature of HIV and Aids. This is clearly supported when, responding to her motivation for entry into the field, one counsellor noted: "A6: I love the job // I want to spread the word of HIV and Aids// Tell help people with information." Similarly, an additional counsellor noted feeling that she was making a difference to the HIV and Aids crisis in South Africa, stating, "Spreading the word [about] HIV and Aids// Help pregnant mother to know their status- More children born negative due to the dual therapy program// More people adhering to ARV's". In this way, counsellors see themselves as able to initiate and maintain change, through the power of the truth- "the word"- they spread.

Another counsellor presented an interesting response; she employed repeated use of religious imagery, drawing, in at least three instances, on the phrase "spread the word". Notably, when this counsellor was asked about her feelings regarding her role in the community, she stated: "A12: I'm playing a major role in the community because I educate them, so that they can also be educators. They can also spread the Gospel." This statement clearly demonstrates the relevance of the preacher-teacher construction. Interestingly, for the researcher, the final statement of this extract can be understood in two possible ways. In the first case, the counsellor might be implying that by spreading the true word- the empirical truth about HIV and Aids- to their clients, their clients would be able to spread this truth, in turn, to their peers, colleagues, family and friends. In the second instance, one must remember that this counsellor is of the Christian faith, and this may be infused with her training and knowledge to produce a counselling experience that represents an amalgamation of her empirical and religious viewpoints.

4.5.2 Power in the context of counselling for HIV and Aids in South Africa

Thus far, this section has sought to draw attention to the emergence of the saviour figure in counsellors' responses. The implicitly powerful nature of this figure is very much a latent theme which consistently undercuts the data corpus. The counsellors who responded throughout the course of the study, although varied in their attitudes, repeatedly made use of this imagery which cast them in a position of power.

Perhaps to best understand the implications of this implied power, it is necessary to return momentarily, to the client's experience of the VCT process. Worthington and Myers (2003, p.645-646) have noted how many clients in their study described feelings of "shame" and being "guilty", "judged" "dirty", and "at fault" for being at risk. They further note that there is significant stigma attached to the decision to go for an HIV test and anxiety during the testing encounter was strongly related to the demeanour of and interaction with the counsellor. The authors describe how clients often see their need to test as a sign of personal weakness as well as a threat to their communities and, citing Alonzo and Reynolds (1995), also note that presentation for diagnosis is often negatively perceived by health care professionals.

It is a combination of these factors which appear to cast the client in a disempowered position, and the counsellor by extension in one characterised by a privileged knowledge and enhanced ability. In seeking to confront the empathetic strain that is naturally part of the work of VCT, it is the contention of the researcher that counsellors are drawn to this privileged position and power. This empowered role seems to provide a sense of comfort to counsellors, as well as a cohesive confirmation of the collective identity of counsellors at a broader level.

The three types of counsellor identities which were discussed in the previous section serve to highlight the different ways in which counsellors meet their call to save others from the perils of HIV and Aids. As a collective unit, counsellors are charged with a sense of responsibility for the South African population, and in so doing seek to protect the collective health of the nation.

Now if one considers this collective, the South African body, like that of any individual, may be governed through the practice of parents, religious and pedagogic leaders as well as the military. Holmes & Gagnon (2008) have highlighted how nurses represent an empowered group working at the junction of the individual and collective body to maintain health. By extension this research suggests that a similar case exists for VCT counsellors. Foucault's conception of governmentality- which brings together discipline, domination (sovereignty), and the government of self and others, suggests a specific role of such governance in the maintenance of social order (Holmes & Gastaldo, 2002, as cited in Holmes & Gagnon, 2008). Health, and by extension, a decrease in the influence of the pandemic, is deemed as a priority to be undertaken by these power systems.

These dynamics highlight a particular socio-political conceptualisation of the HIV and Aids pandemic that has become increasingly evident in recent years. Indeed consistent with, and in support of, the military metaphors mentioned previously, for example, the United Nations Security Council, in Resolution 1308 (United Nations, 2000) declares that the HIV and Aids pandemic, if action is not taken, may pose a risk to international safety, stability and security. The militarist metaphors which characterise so much of the literature, both academic and laic, bear further testimony to this.

Elbe (2005; p.403) has highlighted HIV and Aids as an issue of security and bio-politics; He states that:

> "The immense scale of this pandemic has recently animated a host of governments, public health officials, and leaders of international institutions to frame the AIDS pandemic not just as a health and development issue, but also as an international security issue"

He further cites Foucault's notion of 'biopower' which identifies the biological existence of man as the target of deliberate strategies of control and intervention. In a power dynamic based analysis of the process of VCT, this intervention has an inherent power to

strive for health and a resolution to the pandemic. As suggested previously, it seems that counsellors take comfort in the power of this intervention, and in this, the three types of power-related counselling identities mentioned previously are reiterated. It seems that counsellors manifest these power discourses in their attitudes to and styles of counselling.

The importance of a collective identification with the power of the VCT counsellor to save represents a potentially useful resource. If training and counselling institutions are able to mobilise this facet of the counselling personas described here, it may enhance and support the efficacy of VCT interventions in the future. However, in closing it is also important to bear in mind that a long-term identification with this saviour role may negatively impact the counsellor, particularly in terms of the results of prolonged empathetic strain on one who is imbued with the responsibility to save not only individual victims but the South African body and nation as a whole.

4.6 Reflexive Review

Terre Blanche, Kelly and Durrheim (2006) have highlighted the important role that the researcher's 'self' plays in interpretive, qualitative research. For this reason it was important for the researcher to present a reflexive review of the research process and experience. This section seeks to provide a reflection of the process of engaging in the context and world of VCT counsellors.

The literature and results discussed in the previous sections have served to highlight how the nature of the VCT process is distinguished by its aiming to facilitate the client's diagnostic process in the most secure and supportive manner possible. It is clear that the professionals who provide this service have a critical role to play in facing the HIV and Aids crisis. However, for the researcher, a questioning of counsellors' efficacy arose as a result of a prolonged engagement in the context of study, as well as with the individuals who inhabited it. In light of this, this reflexive piece serves a particular role. It was important to acknowledge the researcher's experiences during the course of this study and how these have shaped the attitudes and opinions adopted towards this population

adopted throughout the study. An explicit description of the researcher's interpretive lens is central to this process.

Since beginning this research project over two years ago it has been the researcher's belief that VCT counsellors render a critical service to the South African population. The researcher's experiences in conducting this research have only served to confirm this belief. The continued presentation of clients for testing confirms the importance of this work. Additionally this engagement has enhanced the researcher's awareness of a number of factors which have moulded and shaped her perceptions and constructions of VCT, both as a large-scale service, and as an independent entity.

The researcher's greatest initial insight into and understanding of the forum in which VCT exists, and the crucial role it plays in the both the current state and future of this country, was when prior to beginning her own data collection, the researcher was assisting a peer with her data collection process, and passed through the VCT waiting room of a particular Gauteng government hospital. The image was unforgettable, and to reflect honestly, it underpins the drive to ensure the utility of the current research. The clients were squashed together, and there was barely enough room for people to sit on the few chairs available. Men and women, both young and old were cramped together.

Notably, the most overwhelming facet of this experience was the empty, vacant expressions on the faces of these people. This was strange for the researcher - in attempting to imagine herself in that position, the expected thoughts and expressions centred on feeling as though one was waiting to be faced with a verdict of fate, and a potential life or death sentence. However, retrospectively, and with her subsequent experiences in the field, the researcher has come to query these expressions, and whether they were apathetic, hopeless, disengaged or worried. Faced with this scenario one could not help but wonder if HIV and Aids had become nothing more than a state of 'the way things are'. Perhaps the prevailing sentiment was one that suggested that no matter the outcome, there was only hopelessness to look forward to, with apathy as the only 'logical' resultant reaction. This view is a pessimistic one, and must force one to

consider whether South African life is now characterised by the presence of HIV and its constant threat in day to day life.

The researcher was exposed, during the course of the study, to a number of facilities and their waiting and consultation rooms, and in so doing was forced to reflect on how difficult it must be to sit in the often small counselling rooms day in and day out, rehashing the same stories, and being faced with what she beheld as a tragedy- that is of a negative diagnosis- every few hours. In a conversation with one of the counsellors during the previous study, she explained to how she felt like a "traffic cop". According to her, particularly in the case of clients diagnosed as HIV-positive, she felt helpless, as so often she was unsure of how to advise these clients, despite being one of the two most qualified counsellors who partook. She questioned whether she should recommend private care, which she was fully aware they could ill-afford, or should she send them on to government and other facilities where she knew that they would have to stand in queues for a significant amount of time- time that all too often equates to a loss of resources, with financial, academic and familial consequences. She called herself a "traffic cop", expressing her feeling that she functioned merely as a director of the "bodies" that flowed through her door. While this was never explicitly mentioned, there was a sense among some of the counsellors that the inordinate numbers of clients who pass through testing centres can at times make it difficult for counsellors to adopted a personalised attitude to each case. Institutional quotas seemed to be influential in such instances. The counsellor cited previously was not the only one to express feelings of frustration about an inability to initiate a productive intervention. Inadequate institutional support, as well lack of resources and facilities were among the factors that emerged to have been repeatedly cited by the counsellors as the reasons for such limitations.

In attempting to engage with potential participants, the researcher noted a sense of disengagement on the part of the counsellors. Initially, when approached for assistance, counsellors were in most cases incredibly receptive to becoming involved in the research, however, subsequently, the attrition in participants' commitment, let alone response rates, has been notable. In their responses counsellors readily bemoan their faulty or absent

support systems. However, in what began at times to seem too many cases, the researcher was left wondering why, when someone extended a hand to help them, they, despite their noted distress and frustration, have failed to grasp the chance. When invited to make additional comments at the close of the questionnaire one counsellor stated: "B8: My thoughts is that I do appreciate Deanne about the research of the counsellors". This suggested a commitment to a productive research outcome with benefits to all participants. However, despite such positive feedback, coordinators, facilitators and counsellors alike left the researcher insecure in their commitment to the quality and improvement of the services they offer. This was certainly not to say that there were no counsellors who participated actively in any manner; there were a number of incredibly helpful, giving counsellors who went out of their way to assist and become involved in the project. Others, however, disappeared in any interaction beyond the initial meetings. In some cases counsellors failed to return questionnaires after repeatedly asking for additional copies, while in another instance, an entire focus group which the researcher had organised (including transportation fees and catering) with the exception of their supervisor, did not attend. The researcher remarks here merely on the conflict and contrast which emerged when verbal and actual responses are juxtaposed.

It began to seem, therefore, that a subtext exists both within the counselling role, and amongst the counsellors themselves. Largely, it was the perception of the researcher that this aspect was related to the counsellors' motivations for doing the work that they do. Many counsellors reported feelings that suggest manifest pride in the work that they do. Consistent with the metaphors discussed in the previous sections, at times they almost seemed zealous soldiers who had 'signed up' so that they may do their part in 'fighting the *war* against HIV and Aids'. Like the soldier too long exposed to the harsh reality of war may develop PTSD or display symptoms of VT, VCT counsellors seem to have become over-exposed to the actual severity of the situations with which they are faced every day. This certainly has the potential to lead to the manifestation of burnout and compassion fatigue, and it has been clear in this study series that this is the case. A poignant example cited previously was when one counsellor, reflecting on her feelings

after a session, stated that she felt: “A2: Traumatize and sometimes I feel bad about everything”.

While this fact central to the motivation for the development of the study, it began to raise certain concerns for the researcher. It is the contention of the researcher that counsellors, having been so over-exposed to the multiple faces of the Aids epidemic, have become disenchanted with and disengaged from the work that they do. An ability to maintain a truly empathetic perspective within the counselling relationship when one is expected to see in the region of 300 clients in one week (as one counsellor explained in conversation she was required to do) is extremely difficult, if not impossible. Perhaps, in this way, disengagement is the manifestation of a defence mechanism used to cope in the face of the battle they are trying to win in the “war against Aids”. As highlighted by Dunkley & Whelan (2006), such behaviours provide clear examples of maladaptive or avoidant coping mechanisms.

This phenomenon has led to a stripping away of this surface meaning, and like the raw wounds of war, left the deepest layers open and vulnerable. The results of the study have highlighted that counsellors’ own psychological needs are deeply ingrained within their motivations for choosing to do this work. This point is illustrated in the cases cited below.

For example, an aspect of particular interest to the researcher that has emerged in the study, since its earliest incarnation, is the concept of a ‘rescue-fantasy’. This concept stems from psychoanalytic literature, however it is the view of the researcher that it translates and is relevant to the current study in that many counsellors reported feelings consistent with the desire to ‘save’ their clients. The original concept draws on parenting imagery and suggests, fundamentally, that the counsellor or therapist becomes the ‘ideal parent’ to the client, who in turn is seen as the child figure. Illustrating the relevance of this concept, one counsellor described her feelings after a session in this way: “B11: I feel happy because I saved somebody’s soul”. Confirming this, counsellors have mentioned feelings of wanting to guide and ‘parent’ their clients, assuming the role of guardian and

guide to their less knowledgeable wards. This aspect is both intriguing and worrisome, as one must question the reliability of an intervention of as critical a nature as this, when imbued with the dynamic interplay of emotional and psychological factors natural to a parenting relationship. Some counsellors have, in the past, reported feelings of conflict that arose in this forum- a sense of accountability when talking to clients of similar age to one's own children (Goldberg, 2007). It seems that counsellors have invested within and integrated into their work their own need to 'save' their clients from the perils associated with HIV and Aids.

Further, the researcher submits that each and every counsellor has had his or her life touched in some way by the HIV and Aids epidemic. Throughout the course of the study, multiple emergent narratives have highlighted this. Among those that stand out, are the numerous counsellors who have come to the field after having had to learn how hard it was to assist and care for family members and friends who had been diagnosed. A nurse reported being motivated to go for training after having received a needle-stick injury at work. Still another counsellor reported wanting to be able to utilise his *own* experience of being diagnosed as HIV positive to assist others. What is common to all these stories is that counsellors have acknowledged insight into the current crisis, having seen it as it exists 'in the real world', affecting loved ones, *real* people.

Having been affected so closely by the virus, it is not hard to conceptualise why such individuals would want to save others from facing the same harrowing experiences they have encountered. These may be more experienced soldiers in the 'war' and able to guide and assist others; however, this does not imply that as the days wear on, their scars disappear. All too often, they remain, and like their physical counterparts, older psychological wounds may be more vulnerable to further damage. One can easily imagine how the daily reminders of the consequences of infection inherent in their work might affect counsellors emotionally. In this respect, one should examine the root of psychological motivation to 'save'; perhaps it is seen by some as a path to repentance. It often seems that counsellors have come into their roles driven by this desire to 'save', and retain this explanation. Yet, in these cases it appears that a failure to save may be

psychologically destructive to the counsellor's self-concept and psyche, manifesting in demoralisation and apathy. This internal war between motivation and capacity also seem to yield a great deal of frustration. It is essential that this be channelled appropriately, so that the intervention is not compromised by the counsellors' emotional states. Extreme care should be taken to ensure that the counsellor's capacity extends beyond self-serving interests in favour of those of the client.

Additionally, some counsellors seemed to find a heady sense of gratification in the work that they do, so much so that at times, it appeared their experiences were geared toward an advancement of ego and an inflated self-concept. Counsellors appear to be proud of their work, as well they should be, however, in some cases this pride felt usurped by a need to be perceived as a paragon of virtue and knowledge. The position of a 'role-model' is one of high esteem and regard. The researcher concedes to having reached a point in her exploration that lead to questioning whether some of these individuals make the choice to become counsellors for the power inherent in and conferred by the job, as well as the guiding, didactic role available in this forum.

For the researcher, the issues mentioned above have proven increasingly difficult to explore, especially reflexively. This facet of the research process may be related to the very issue mentioned above- counsellors ascend to this status of paragon, and it seems that with this role comes certain infallibility. Surely someone as devoted as the counsellor, who gives so selflessly of him- or her-self to the 'war' is beyond reproach? The root of this phenomenon is untraceable- whether it rests with the counsellors, clients or their communities is uncertain- however it remains the case. This likely informed the researcher's initial position- a protective role, campaigning for counsellors, and constantly seeking to gain support on their behalves. Thus, having become far deeper immersed within the socio-cultural contexts surrounding VCT, as well as the more intimately emotional experiences that come with seeing the faces of counsellors and clients, the counselling rooms and conditions, the researcher notes the development of a sense of responsibility towards the counsellors and a drive to right the flawed systems with which they are faced. This drive remains, but over months of data collection, having

been stopped and rerouted at almost every junction and turn, both by bureaucracy and by the individuals themselves, the initial fervour with which the study began was sometimes hard to maintain.

At times, the researcher developed a significant sense of demoralisation, and on multiple occasions wondered if anyone- counsellor and client alike- still believed in the process. Beyond the scope of the researcher's own emotive experiences, the development of deep doubt as a result of the factors mentioned previously was an issue of some concern. The researcher continues to maintain that VCT has an essential role, a critical role to play in combating Aids, and contend that the original supposition still stands- that quality interventionists produce quality interventions. However when there exists a conflict between the fundamental principles upon which counselling is based, and the motivations of its practitioners, it is clearly necessary to re-examine the current state of VCT practice.

Thus the product of the researcher's personal engagement in this study has led to this understanding: VCT counsellors are an invaluable weapon in the arsenal against the 'war on HIV and Aids', one that should not be overlooked. A prolonged over-exposure to this 'war' and its consequences, coupled with a lack of social and institutional support at the basic level, has resulted in a significant sense of apathy and moral disenfranchisement among them. Further, counsellors have reported feeling that they are inadequately recognised as health care professionals and that they are not appropriately remunerated for the distinctly trying work that they undertake. As such, accounting for these facts, it seems that the threat of burnout within this group is of crucial concern. It appears that the amalgamation of these factors has the potential to compromise severely the valuable role VCT has to play.

4.7 Counsellors' reflections on the study

Consider the following extracts, taken from the segments of the questionnaires in which counsellors were invited to provide "additional comments". Counsellors appeared to value their roles as individuals of interest in the study. This was illustrated where one counsellor stated: "D2: It think it was very nice for the person who is doing this research

to find out how we work how are we feeling most of all how are we coping with different issues that revolve and involve us every day of our lives". Another noted that, "E9: It was a good thing to write all the things I wrote here, I feel like I was debriefing in a way and stress relieve.// Keep up the good work that you are doing. It is good to see that some people are concerned about our job as counsellors." These responses highlight that counsellors have a great deal of input to make and represent a core resource in contributing to known information about the face of HIV and Aids. However, in another instance, a counsellor noted, "E2: After me reading this I felt more distress coz I have explained my work." This extract reminds one that there *are* problems implicit in the counselling role. In both the positive and negative instances, recommendations may be made and the reader is reminded that counsellors and their opinions warrant significant attention for future research.

4.8 Recommendations based on the findings of this study

It is the suggestion of the researcher that a way forward should include the recipients and stakeholders coming together to assess carefully, change and refine the training, orientation and nature of VCT services. This would seek to enhance the efficacy of the process as well as its realistic accessibility to both the implementers and recipients. The counsellors who have not yet been lost to burnout and apathy, if not merely frustration at current conditions should be valued and certainly not disregarded; their institutions would do well to acknowledge them at this level. It is essential that all those involved in HIV prevention and health promotion begin to value these individuals and to foster their pride in the work. This may present one way of encouraging counsellors to grow and learn in this field. However, it appears clearly evident when examining counsellors' experiences, that if a change is not made imminently, the counselling force will be significantly reduced, and the considerable value that VCT has to offer will be crippled by its lack of ground level support.

The results of the study suggest that future counsellors could be far more carefully screened before being allowed to undergo training; it is important to consider their motivations and psychological well-being. It seems that these factors are extremely

influential in the counsellor's capacity development over the course of their careers, both in terms of technique and also psychological and emotional development. Mental health care providers in other instances receive up to six years training, and there is no valid reason that such essential workers in this field are not given more than a few hours training on average. Further, they should also be monitored and supervised at all times during which they are providing counselling services.

As highlighted repeatedly throughout the study, this research contends that the only way to ensure quality interventions is to produce quality interventionists. It is the belief of the researcher that careful consideration of the points made above would be useful in enhancing the efficacy of the current VCT process as it stands today. This may have vast implications for its utility and effectiveness in preventing future spread of the HI virus.

4.9 Future research

This research has sought to make a contribution to the body of knowledge surrounding HIV and Aids health care practice. As South Africans, we are faced with the influence of this illness at a pandemic level, and it is the hope of the researcher that the findings of the study will contribute to the development of enhanced interventions to curb its spread. Future research could perhaps include an investigation of the consistencies and discrepancies in training programmes undertaken during VCT training. Counsellors' emotional experiences certainly warrant further investigation, and standardisation of training and supervision protocol to support this should be a possible focus of future research. Power narratives represented a unique aspect of this study, and the extents and limitations of these, as well as their advantages in developing a cohesive collective identity amongst counsellors is an avenue for further investigation.

4.10 Conclusion

The counselling population revealed a multi-faceted and nuanced nature. Counsellors had certain factors in common, and shared experiences that united them across demographic differences. For example, the loss of a loved one was identified consistently as an

extremely influential motivational factor in catalysing a counsellor's entry into the field. Levels of training and experience varied amongst counsellors; however, their value as resources in the arsenal of those fighting the war against HIV and Aids can never be underestimated. Counsellors' desire to save their clients surged beneath the manifest content of their responses. If harnessed, this may represent an incredibly valuable tool and advantage in creating a class of efficacious, competent and passionate interventionists committed to decreasing the influence of the HIV and Aids pandemic at both a national and international levels.

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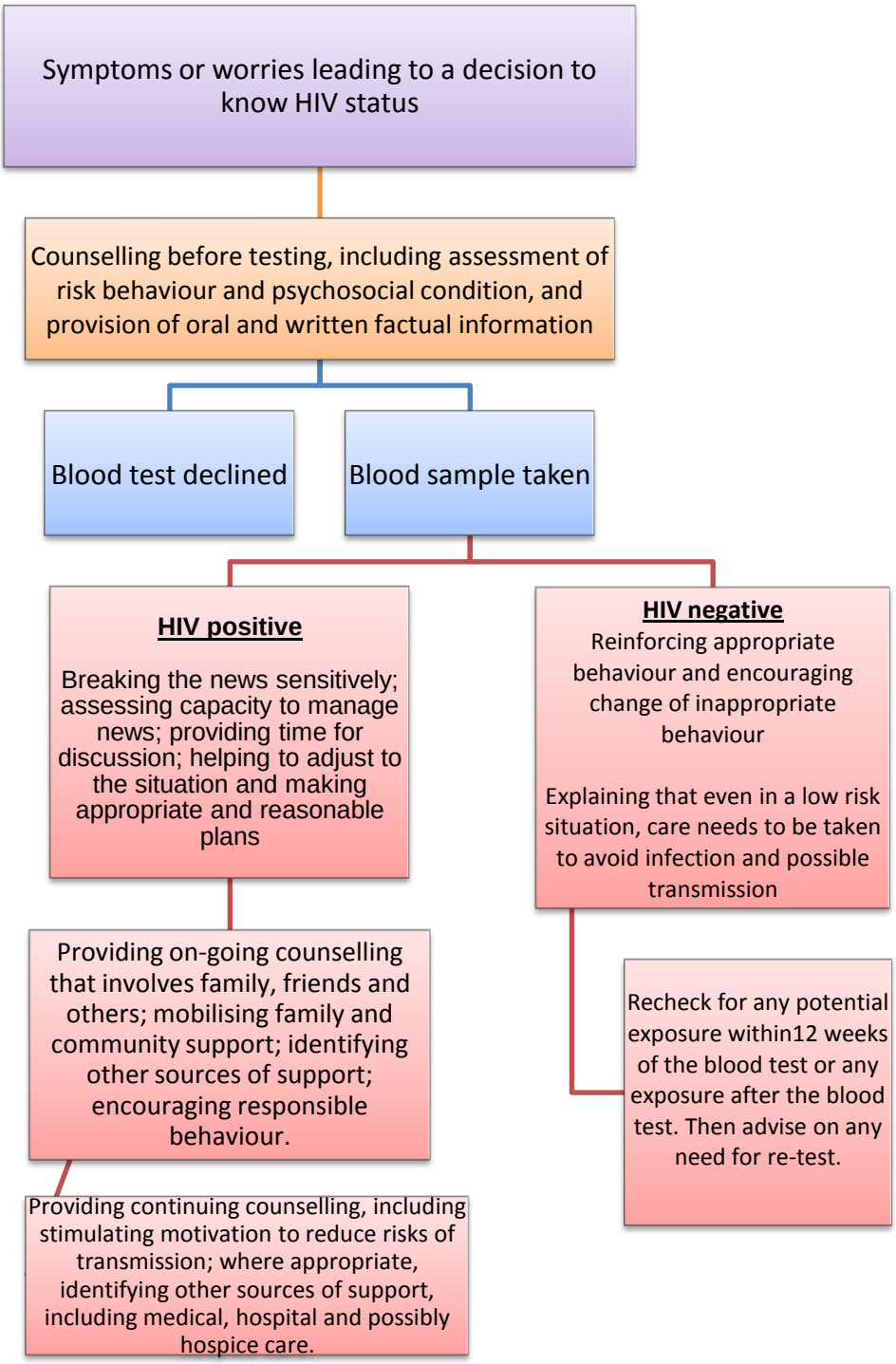
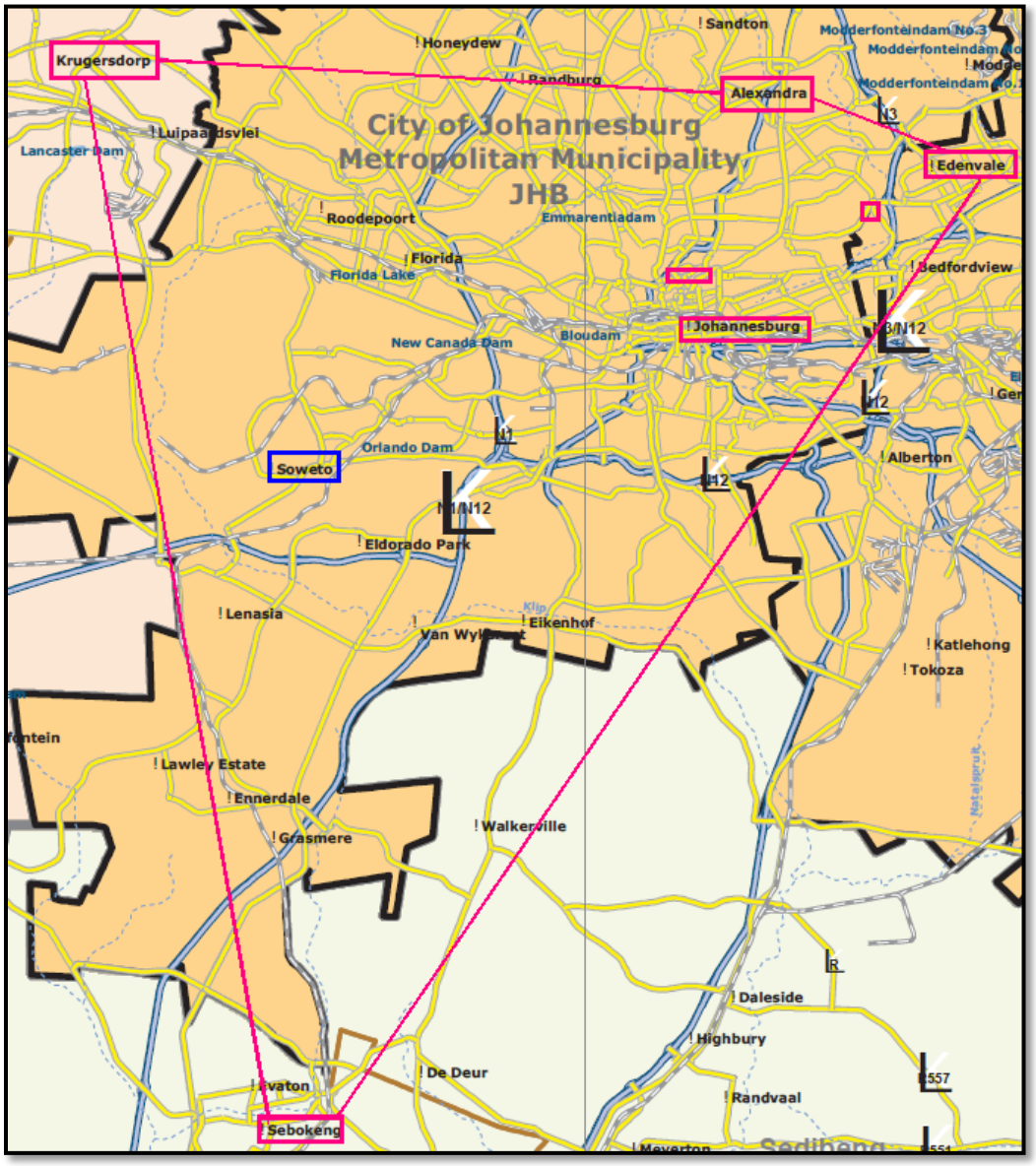
Appendices

Appendix 1: Gold Standard Model for VCT



Appendix 2: Geographical Catchment Area



Appendix 3: Ethics Clearance

Appendix 4: Instrumentation

A: Letter of Introduction

B: Instructions and Demographic Questionnaire

C: The Counsellor's Experiences Questionnaire

Appendix 4A: Letter of Introduction

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: (011) 717-4500
Fax: (011) 717-4559
Email: 018lucy@muse.wits.ac.za

Good day,

My name is Deanne Romy Goldberg, and I am conducting research for the purposes of obtaining a Masters degree at the University of the Witwatersrand. The aim of my research is to explore the counsellor's experience of counselling for HIV and Aids in South Africa. The effectiveness of this counselling has been well documented in research, however there is little information surrounding the counsellor's perceptions and experience. It is logical, though, to assume that the counsellor's experience and wellbeing are fundamental to the success of the recommended interventions. Therefore, this study will attempt to document the nature of the counselling experience and its effects. I would like to invite you to participate in this study.

Participation in this research will entail completing the attached questionnaires. The questionnaire will take approximately 30-45 minutes to complete. Participation is voluntary, and no counsellor will be advantaged or disadvantaged in any way for choosing to complete or not complete the questionnaire. No identifying information, such as your name or I.D. number, is asked for, and as such you will remain anonymous. Your completed questionnaire will not be seen by any person at either facility at any time, and will only be processed by myself. Please note that when analysing your individual responses, they will only be looked at in relation to all other participants' responses. That is, no counsellor will be identifiable from their response.

If you choose to participate in the study please complete the attached questionnaires as carefully and honestly as possible. Once you have answered the questions, place the

survey in the envelope provided and deposit it in the sealed box provided. This will ensure that no one will have access to the completed survey, and will ensure your confidentiality. Please note that if you do return your surveys, this will be considered consent to participate in the study.

For those counsellors who are willing to fill out the counselling experience questionnaire, this is not a compulsory section, and it is in no way obligatory, but this would be greatly appreciated. The questionnaire will take approximately 1 hour to complete. Participation is voluntary, and no counsellor will be advantaged or disadvantaged in any way for choosing to complete or not complete the questionnaire. Once again, while questions are asked about your personal circumstances, no identifying information, such as your name or I.D. number, is asked for, and as such you will remain anonymous. Your completed questionnaire will similarly not be seen by any person at either facility at any time, and will only be processed by myself. Please note that individual responses will only be looked at in relation to all other responses.

Should you require any assistance after completing the questionnaire, in terms of debriefing or counselling, please contact your supervisor. Alternatively, both the supervisor and researcher will be able provide you with the necessary information or referrals.

Your participation in this study would be greatly appreciated. The outcomes of such a study would not only contribute to improving current knowledge of this topic, but also be useful in optimising the effectiveness of this important intervention.

Kind Regards

Deanne Goldberg

Email: dinky.dee@gmail.com
Phone: 082 561 8089
Fax: 086 610 0717

Appendix 4B: Instructions and Demographic Questionnaire

Instructions

Please do not write your name on the form

Please answer all questions to the best of your ability; however, if there is anything you feel uncomfortable answering, you are not obligated to do so.

There will be NO repercussions for your answers and CONFIDENTIALITY is assured.

If there is anything you do not understand, feel free to ask questions and they will be answered as best as possible

THANK YOU IN ADVANCE FOR YOUR TIME AND COOPERATION

DEMOGRAPHIC INFORMATION OF PARTICIPANT

Please tick the boxes where appropriate.

1) Age: _____

2) Gender:

❑ Male

❑ Female

3) Race/Ethnic Group

❑ Black

❑ White

❑ Indian

❑ Asian

❑ Coloured

❑ Other: _____

4) Marital Status:

❑ Single

❑ In a relationship

❑ Married

❑ Divorced

❑ Widowed

5) Do you have any children?

❑ Yes.

❑ No

If you answered yes, how many? _____

6) Languages:

Please tick the boxes which represent the language/s you speak at home and when you are counselling:

Language	**Home Language**	**Language of Counselling**
Afrikaans		
English		
Ndebele		
Sepedi		
Sesotho		
Swati		
Tsonga		
Tswana		
Venda		
Xhosa		
Zulu		
Other:		

7) Level of Education:

❑ Primary (Grade 1-7)

❑ Secondary (Grade 8-12)

❑ Tertiary (University/ College)

Please Specify:

❑ Undergraduate Degree

❑ Postgraduate Degree

❑ Certificate/ Diploma

8) Occupation:

❑ Full time Counsellor

❑ Part-time Counsellor

If so, do you hold another job?

❑ Yes.

❑ No

Please specify: _____

9) Religious/ Spiritual Affiliation:

- ❑ Christian
- ❑ Jewish
- ❑ Muslim
- ❑ Hindu
- ❑ Atheist
- ❑ Agnostic
- ❑ Other

Please specify: _____

Appendix 4C: Counsellor's Experiences Questionnaire

COUNSELLING EXPERIENCE OF PARTICIPANT

GENERAL

1) How long have you been involved in counselling in general? _____
2) How long have you been involved in HIV and Aids counselling? _____

PERSONAL

1) What made you decide to become a VCT counsellor?

_____
_____
_____
_____
_____
_____
_____

COUNSELLING TRAINING

1) Have you received **general** counselling training?

Please tick one:

YES	NO

2) How long did this training take? _____

3) How many general counselling courses have you completed? _____

4) Please explain what training sessions these were and what your training consisted of.

_____
_____
_____
_____
_____
_____

5) Have you received specific training for **HIV and Aids** counselling?

Please tick one:

YES	**NO**

6) How long did this training take? _____

7) How many HIV and Aids Counselling courses have you completed: _____

8) Please explain what training sessions these were and what your training consisted of.

_____
_____
_____
_____
_____
_____
_____

9) Do you feel that your training has prepared you for your role as a counsellor?
Please tick one:

YES	**NO**

10) Please explain why you feel this way:

_____
_____
_____
_____
_____
_____
_____

NATURE OF THE COUNSELLING

1) Does the facility provide pre-test counselling?
Please tick one:

YES	**NO**

2) Does the facility provide post-test counselling?
Please tick one:

YES	**NO**

3) If applicable: How long is the average
a. Pre-test counselling session? _____
b. Post-test counselling session? _____

4) How many counselling sessions do you facilitate per week? _____

5) Please indicate which aspects of the VCT counselling procedure you perform:
(Tick the appropriate box if this is part of the VCT counselling you carry out)

Pre-test counselling:

- Ensure Informed consent ☐
- Ensure Confidentiality ☐
- Assess level of HIV and Aids knowledge ☐
- Assess Lifestyle and risk behaviours ☐
- Assess available coping skills and support networks ☐
- Describe testing procedure and types of available tests ☐
- Explain the window period ☐
- Discuss implications of both a positive and negative result ☐
- Other (please specify): _____ ☐

Type of tests used at the facility: _____

Post-test counselling:
If negative:

- Provide information regarding risk behaviours and recommend lifestyle changes to ensure maximum health ☐
- Remind client about the window period ☐
- Advise future testing ☐
- Other (please specify): _____ ☐

If positive:

- Discuss client's feelings regarding diagnosis □
- Reassure the client and provide emotional support □
- Discuss available coping skills and support networks □
- Emphasise positive living □
- Explain the difference between being HIV infected and having AIDS □
- Discuss implications of being HIV positive (behaviours, risks etc.) □
- Discuss the value of disclosure to partners □
- Discuss the availability of anti-retroviral treatments (ARV's) □
- Other (please specify): _____ □

6) What aspect/s of these procedures do you think is/are most important?

_____
_____
_____
_____
_____
_____
_____

SUPERVISION

1) Do you receive supervision?

Please tick one:

YES	**NO**

2) If yes, how often is this supervision? _____
3) What does your supervision involve? _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

4) Do you feel that the supervision you receive is helpful?
Please tick one:

YES	**NO**

5) Describe what your ideal supervision process would be:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SUPPORT

1) Do you feel that you have external support (i.e. outside of work) to help you manage your work stress?
Please tick one:

YES	**NO**

2) Please explain your answer:

_____
_____
_____
_____

3) Have you attended any official 'stress management' or 'coping' workshops?
Please tick one:

YES	**NO**

4) Please explain your answer:

_____
_____
_____

THE EXPERIENCE OF COUNSELLING

1) How do you feel about your role as a counsellor?

_____
_____
_____
_____
_____
_____
_____
_____
_____

2) How do you feel about your role in the community?

_____
_____
_____
_____
_____
_____
_____
_____

3) How would you describe your typical client?

_____
_____
_____
_____

4) Do you ever experience conflict between your own values and the process of counselling?
Please tick one:

YES	**NO**

5) Please explain your answer:

_____
_____
_____
_____
_____
_____

6) Do you find your job as a counsellor stressful?
Please tick one:

YES	NO

7) Please explain your answer:

_____
_____
_____
_____
_____
_____
_____
_____

8) Do you find your job as a counsellor rewarding?
Please tick one:

YES	NO

9) Please explain your answer:

_____
_____
_____
_____
_____
_____
_____

10) Do you feel that you are making a difference to the HIV and Aids crisis in South Africa?
Please tick one:

YES	NO

11) Please explain your answer:

_____
_____
_____
_____
_____

12) Do you ever feel frustrated because of your work?
Please tick one:

YES	**NO**

13) Please explain your answer:

_____
_____
_____
_____

14) How do you feel after a session with a client?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

COPING

1) If you do experience stress due to work, do you talk to about it?
Please tick one:

YES	**NO**

If so, to whom do you talk?

_____
_____
_____
_____

2) What do you do at the end of a counselling session?

_____
_____
_____
_____

3) What do you do after work?

_____
_____
_____
_____

4) Do you feel like you are coping with the demands of counselling?
Please tick one:

YES	**NO**

5) Please explain your answer:

_____
_____
_____
_____
_____

6) Do you participate in any of the following activities:
Please tick:

Coping Mechanism	**Yes/No**	**How often?**			
		Once a month	**Once a week**	**More than once a week**	**Every day**
Exercise/ Sports					
Drinking					
Prayer					
Smoking					
Meditation					
Hobbies					
Prescription Medication					
See friends/ family					

ADDITIONAL COMMENTS/ THOUGHTS:

_____
_____
_____
_____
_____
_____
_____
_____

How difficult did you find completing this questionnaire?

_____
_____
_____

Thank you very much for your cooperation and time!!